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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS OF NASHVILLE	1022 EASTERN AVENUE NASHVILLE, NC 27856

(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 survey and complaint investigation on 04/22/26 - 04/24/26 with an exit conference via telephone on 04/27/26.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure health care coordination and follow-up for 1 of 5 sampled residents (#4) including failing to coordinate labwork to monitor for therapeutic levels of a medication used to treat bipolar disorder and failure to ensure a follow-up appointment with a mental health provider related to medication changes and to monitor behaviors. The findings are: Review of the facility's undated Health Care Referral and Follow-up Policy revealed: -It was the policy of the facility to assure referral and follow-up to meet the routine and acute health care needs of residents with notifications to providers and documentation in the resident's record. -This included visits to providers or onsite visits by providers including any new orders, for medications, treatments, or procedures. -This included hospital discharges, follow-up	D 273		

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care, and medication reconciliation.
-This included labs, vitals, and parameters, falls, and any other routine or acute health care need of the resident.
-Labs were to be drawn based on the physician's orders.
-Lab technicians would notify facility management when on-site for lab draws and sign the visitor's log.
-The lab technician would notify management when on-site and if unable to complete all lab draws as ordered providing a list of residents and documentation of labs not completed.
-Management would complete a Health Care Notification and fax to the physician notification of an incomplete lab draw with confirmation and document in the resident record.
-Lab results received by the facility would be faxed to the physician timely with confirmation or placed in the facility's physician folder if on-site for review and signature.

Review of Resident #4's current FL-2 dated 01/05/26 revealed:
-Diagnoses included bipolar disorder, generalized anxiety disorder, primary insomnia, gastroesophageal reflux disease without esophagitis, conjunctival hemorrhage of the right eye, and diarrhea.
-There was an order for Lithium 150mg 1 capsule 3 times a day for bipolar disorder. (Lithium is used to treat bipolar disorder. Lithium has a narrow therapeutic range, so regular blood tests are essential to ensure safe and effective levels. Lithium toxicity occurs when levels of Lithium are too high and can cause symptoms such as nausea, vomiting, diarrhea, course hand tremors, confusion, ataxia (lack of coordination), agitation, slurred speech, and dizziness.)

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Review of Resident #4's lab results revealed:
-The resident's Lithium level was 0.3 on 02/20/25. (The therapeutic reference range for Lithium was 0.6 - 1.2mmol/L.)
-The resident's Lithium level was 0.5 on 08/26/25.
-The resident's Lithium level was 0.2 on 10/24/25.

Review of Resident #4's mental health provider (MHP) visit note dated 01/09/26 revealed:
-The resident had chronic, stable bipolar disorder.
-No adverse side effects, signs of psychosis, mania, or behavioral issues had been reported by staff.
-No recent cognitive decline was reported by staff.
-The resident reported he was not feeling well due to dizziness.
-The resident reported no concerns with sleep.

Review of Resident #4's MHP visit note dated 01/21/26 revealed:
-The resident reported his mood was "not good".
-The resident reported feeling dizzy, which he attributed to his medications.
-The resident feeling dizzy was not new and he had seen a cardiologist in the past for this symptom.
-Facility staff reported the resident's medication regimen was effective in maintaining stability at that time.
-Facility staff did not report any disruptive behaviors.
-The resident was continue the current medication regimen and follow-up in 4 weeks.

Review of Resident #4's primary care provider (PCP) visit note dated 02/16/26 revealed:
-The resident stated he wanted to commit suicide about 4 to 5 days ago, but not today.
-The resident did not have a plan to harm himself.

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-The PCP notified the facility and also sent a message to the resident's MHP.

Review of Resident #4's MHP visit note dated 02/17/26 revealed:
-The resident was currently on Lithium 150mg 3 times daily for bipolar disorder management.
-The resident previously expressed suicidal thoughts, primarily driven by severe anxiety.
-There was no active suicidal ideation noted on exam today.
-The resident experienced significant anxiety, exacerbated by current situational stressors.
-There was to be a follow-up MHP visit in 2 weeks.

Review of Resident #4's MHP visit note dated 02/26/26 revealed:
-The resident had a recent increase in agitation, aggression, and decreased sleep.
-The resident's Lithium level was previously subtherapeutic at 0.2, likely contributing to mood destabilization.
-There was an order to repeat the resident's Lithium level.
-The MHP noted she would review the Lithium level prior to making dose adjustments.
-The MHP planned to increase Lithium for mood stabilization if the level remained subtherapeutic.
-The staff was to notify the MHP of worsening aggression, insomnia, mood changes, or safety concerns.
-The resident was to follow-up in 1 week to reassess behaviors and review lab results.

Review of Resident #4's lab results revealed no documentation of a Lithium level being drawn as ordered on 02/26/26.

Review of Resident #4's MHP visit note dated

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D 273	Continued From page 4 03/05/26 revealed: -The resident had recent increased anxiety and confusion. -The resident's prior Lithium level was subtherapeutic at 0.2 despite adherence to medication. -There was an order to discontinue Lithium 150mg 3 times daily. -There was an order to initiate Lithium 300mg twice a day at 9:00am and 2:00pm. -There was an order to initiate Lithium 150mg at bedtime. -There was an order to recheck Lithium level 5 - 7 days after dose adjustment. -The resident was to be monitored closely for signs of lithium toxicity including confusion, tremor, gastrointestinal upset, and ataxia (lack of coordination). -The resident was to follow-up in 2 weeks. -The MHP would reassess the resident in 14 days for response and tolerability. -The resident's anxiety had significantly worsened. -The MHP would reassess the resident's anxiety after Lithium stabilization. Review of Resident #4's lab results revealed no documentation of a Lithium level being drawn in 5 - 7 days as ordered on 03/05/26. Review of Resident #4's Triage Note dated 03/11/26 revealed: -There was an order to discontinue Lithium 300mg twice a day and 150mg at bedtime. -There was an order to initiate Lithium 300mg every morning and 150mg at bedtime. Review of Resident #4's PCP visit note dated 03/16/26 revealed: -The resident was seen for a routine visit.	D 273		

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-The resident stated he did not feel good and he felt sick.
-The resident stated he did not feel well and he was unable to walk down the hall.
-The resident was noted to have new falls on 02/27/26 and 03/11/26.
-The resident was unable to further describe symptoms due to cognitive impairment.
-The resident exhibited signs of dehydration, including poor skin turgor and request for water.
-The resident would be sent to the emergency room (ER) for further evaluation.

Review of Resident #4's ER After Visit Summary dated 03/16/26 revealed:
-The resident was seen for abdominal pain.
-There was no documentation of any Lithium levels being checked while in the ER.
-The resident's diagnoses were abdominal pain and aneurysm.

Review of Resident #4's MHP visit note dated 03/19/26 revealed:
-The resident had no manic symptoms observed over the last 5 weeks.
-The MHP noted the Lithium lab order was still pending.
-There was an order to discontinue Lithium due to inability to obtain ordered Lithium levels and ongoing medical instability.
-Lithium discontinuation was clinically appropriate due to adverse cognitive impact and inability to safely monitor serum levels.
-There was to be a follow-up in 7 days to reassess the resident's mood stability.

Review of Resident #4's MHP visit notes revealed:
-There was no documentation of a follow-up visit in one week after the visit on 03/19/26.

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D 273	Continued From page 6 -Resident #4's next MHP visit was on 04/09/26. Review of Resident #4's MHP visit note dated 04/09/26 revealed: -The resident was scattered and distracted in his speech. -The resident did not appear sedated or lethargic. -The resident reported he was "worried about a lot of stuff". -The resident would not stay seated and had 4 recent falls. Review of Resident #4's February 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Lithium 150mg 1 capsule 3 times a day for bipolar disorder scheduled at 9:00am, 3:00pm, and 9:00pm. -Lithium 150mg was documented as administered 3 times a day from 02/01/26 - 02/28/26. Review of Resident #4's March 2026 eMAR revealed: -There was an entry for Lithium 150mg 1 capsule 3 times a day for bipolar disorder scheduled at 9:00am, 3:00pm, and 9:00pm. -Lithium 150mg was documented as administered 3 times a day from 03/01/26 - 03/05/26. -There was a second entry for Lithium 150mg 1 capsule at bedtime scheduled at 9:00pm. -Lithium 150mg was documented as administered at 9:00pm from 03/06/26 - 03/20/26 then noted to be discontinued. -There was a third entry for Lithium 300mg 1 capsule twice daily scheduled at 9:00am and 2:00pm. -Lithium 300mg was documented as administered twice daily from 9:00am on 03/07/26	D 273		

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- 9:00am on 03/11/26 then noted to be discontinued.
-There was a fourth entry for Lithium 300mg 1 capsule every morning scheduled at 9:00am.
-Lithium 300mg was documented as administered at 9:00am from 03/12/26 - 03/20/26 and then noted to be discontinued.

Review of Resident #4's April 2026 eMAR revealed there was no entry for Lithium and none was documented as administered.

Interview with Resident #4 on 04/24/26 at 1:23pm revealed:
-Sometimes his stomach got messed up and he got anxious.
-He got lightheaded sometimes, but he did not recall having any falls.
-He did not know if he had any labwork done.

Interview with a medication aide (MA) on 04/24/26 at 1:01pm revealed:
-Resident #4 was unbalanced and had falls; he complained of his stomach hurting, dizziness, and lightheadedness.
-Resident #4 did not refuse Lithium when he had an order to take it.
-Resident #4 did not usually have behavior issues but would curse once in a while.
-Resident #4 did not report having any visual or audio hallucinations.

Interview with the Resident Care Coordinator (RCC) on 04/24/26 at 5:10pm revealed:
-She was new and worked as the RCC for the last 4 to 5 months.
-There was no system in place to ensure labs were done as ordered at the time the Lithium levels were ordered for Resident #4.
-The facility's contracted providers usually sent

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lab orders electronically to the contracted lab provider.
-The contracted lab provider usually left a daily log noting which residents they obtained labwork for while at the facility.
-There was no system at that time to check the daily lab log and there was no system to check provider progress/visit notes for lab results.
-She now contacted the contracted lab provider if a resident's labwork had not been obtained within two days of being ordered.
-She was responsible for making sure follow-up appointments were coordinated and done.
-She overlooked documentation on Resident #4's MHP visit note dated 03/19/26 for a follow-up in one week.
-The MHP who saw Resident #4 on 03/19/26 quit working with the contracted MHP group shortly after that visit (not sure of date).
-If she had seen the order to follow-up in one week, she would have contacted the MHP group to coordinate the follow-up visit.
-Around the beginning or middle of February 2026, Resident #4 was more fidgety and anxious, losing his balance, unsteady, and had more frequent falls.
-When Resident #4's MHP was at the facility for the visit on 03/05/26, the MHP stated she did not know what to do with the resident except to increase his Lithium without having Lithium lab results.
-The same MHP then discontinued Resident #4's Lithium on 03/19/26 and did not say why she stopped it.
-She felt like Resident #4 got better after the Lithium was discontinued because he would listen when redirected by staff and he was not as anxious.

Interview with the Administrator on 04/27/26 at

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D 273	Continued From page 9 9:45am revealed: -Resident #4 had been having issues where he would say he could not walk or he had an upset stomach. -Resident #4 had issues with falls, stomach ache, weakness, and dizziness since around January 2026, after another resident he was close friends with became ill. -There was one incident where the resident talked about suicidal ideation with a provider but that was not normal for the resident. -The RCC was responsible for making sure the contracted lab provider drew labs. -The providers usually sent lab orders to the contracted lab provider. -The contracted lab provider usually sent lab results to the contracted provider group and the labs results were usually noted on provider visit notes. -The RCC was responsible for reviewing provider visit notes and orders and contacting the provider for lab results if not received by the facility. -She did not recall her conversation with the RCC as to why Resident #4's Lithium levels were not done. -On 03/23/26, the Director of Clinical Operations and Engagement for the facility's contracted MHP group reported Resident #4's MHP had quit working with the contracted MHP group. -The Director of Clinical Operations and Engagement stated she would get another MHP to do telehealth visits soon, but she did not give a date. -The Director of Clinical Operations and Engagement also stated she was also working on getting a new MHP to do on-site visits at the facility again. -She did not contact anyone with the MHP group to set up a one-week follow-up visit for Resident #4 after the visit with the former MHP on	D 273		

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D 273	Continued From page 10 03/19/26. Telephone interview with Resident #4's PCP on 04/24/26 at 4:48pm revealed: -Resident #4 always had some minor anxiety here and there. -When she returned from a leave of absence in January 2026, Resident #4 was more confused and had more anxiety. -The resident was checked out at the ER and cleared medically. -She felt his issues were more related to his mental health. -Resident #4 had a good friend at the facility who got sick and passed away during that time that could have triggered some mental health issues. -She did not manage Resident #4's Lithium when he took it as it was managed by the MHP. -She did not have any information about the resident's Lithium or Lithium levels and was not comfortable speaking about it since she did not manage it. Telephone interviews with Resident #4's fill-in MHP on 04/24/26 at 4:11pm and 04/27/26 at 8:38am revealed: -She saw Resident #4 for the first time on 04/09/26 for a chronic visit. -She was not aware Resident #4 was supposed to have a one-week follow-up visit with a MHP from the visit on 03/19/26. -No one reached out to her about an acute visit for Resident #4. -She did not know anything about Lithium levels for Resident #4. -Resident #4 was not receiving Lithium when she first saw the resident on 04/09/26. Attempted telephone interview with Resident #4's former MHP on 04/24/26 at 9:50am was	D 273		

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D 273	Continued From page 11 unsuccessful. _____ The facility failed to ensure health care coordination and follow-up for Resident #4 who was diagnosed with bipolar disorder and had voiced suicidal thoughts on one occasion at the facility. Resident #4 had orders for and received Lithium for treatment of bipolar disorder. Resident #4's mental health provider (MHP) ordered Lithium levels on at least two occasions due to the last level in October 2025 being subtherapeutic and the resident having an increase in agitation, aggression, and decreased sleep noted by the MHP. The facility failed to ensure Lithium levels were obtained even after the MHP had increased the resident's Lithium dose and the resident exhibited increased complaints of dizziness and had increased unsteadiness and falls. The facility failed to ensure the resident was seen for a follow-up visit within one week of Lithium being discontinued to assess the resident's mood stability and behaviors. This failure of the facility 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 04/24/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 11, 2026.	D 273		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the	D 358		

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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:
TYPE B VIOLATION

Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 residents (#4) sampled for record review including an error with a controlled substance used to treat anxiety for a resident who exhibited symptoms of severe anxiety.

The findings are:

Review of the facility's undated Medication Administration of a New Order Policy revealed:
-All medication orders not categorized as "emergency" (or STAT) or antibiotic shall be considered routine.
-If medication was ordered prior to 5:00pm, it should be started with the next regularly scheduled dose following the next regular pharmacy delivery.
-Orders received after 5:00pm should be started no later than the regularly scheduled dose following the regular pharmacy delivery of the next business day.

Review of Resident #4's current FL-2 dated 01/05/26 revealed diagnoses included bipolar disorder, generalized anxiety disorder, primary insomnia, gastroesophageal reflux disease without esophagitis, conjunctival hemorrhage of

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the right eye, and diarrhea.

Review of Resident #4's facility progress notes dated 01/05/26 revealed:
-The resident's anxiety was high and the resident was experiencing dizziness.
-The resident was being sent to the emergency room (ER) due to dizziness and anxiety.

Review of Resident #4's primary care provider (PCP) visit note dated 01/19/26 revealed:
-The resident had chronic, worsening anxiety disorder.
-The resident experienced anxiety which was evident during the visit.
-The resident was currently managed by psychiatry and received medication but despite this regimen, the resident's anxiety remained uncontrolled.

Review of Resident #4's PCP visit note dated 02/09/26 revealed:
-The resident was nervous and anxious.
-The resident had ongoing anxiety with racing thoughts and nervousness.
-The resident's anxiety disorder was managed by psychiatry.

Review of Resident #4's mental health provider (MHP) dated 02/13/26 revealed an order for Lorazepam 0.5mg 1 tablet twice daily. (Lorazepam is a controlled substance used to treat anxiety.)

Review of Resident #4's PCP visit note dated 02/16/26 revealed:
-The resident stated he wanted to commit suicide about 4 to 5 days ago, but not today.
-The resident did not have a plan to harm himself.
-The PCP notified the facility and also sent a

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message to the resident's MHP.
-The resident was currently taking Lorazepam for anxiety management.
-The resident reported that while he still experienced anxiety, it had somewhat subsided.

Review of Resident #4's MHP visit note dated 02/17/26 revealed:
-The resident previously expressed suicidal thoughts, primarily driven by severe anxiety.
-There was no active suicidal ideation noted on exam today.
-The resident experienced significant anxiety, exacerbated by current situational stressors.
-The resident was currently taking Lorazepam 0.5mg twice daily.
-The MHP would increase Lorazepam to 3 times a day to better manage anxiety symptoms.
-There was to be a follow-up MHP visit in 2 weeks.
-There was an order to discontinue Lorazepam 0.5mg 1 tablet twice daily.
-There was an order to start Lorazepam 0.5mg 1 tablet 3 times a day.

Review of Resident #4's PCP visit note dated 03/02/26 revealed:
-The resident was being seen for a routine visit.
-The resident was being managed by psychiatry for anxiety.
-The resident was taking Lorazepam 0.5mg 3 times a day with significant symptom improvement.

Review of Resident #4's MHP order dated 03/10/26 revealed:
-There was an order to discontinue Lorazepam 0.5mg 3 times a day.
-There was an order to start Lorazepam 0.5mg twice a day.

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D 358	Continued From page 15 Review of Resident #4's facility progress notes dated 03/21/26 at 2:05am revealed: -The Resident Care Coordinator (RCC) called the pharmacy to check on the status of Resident #4's Lorazepam 0.5mg that they had been trying to get in the facility since 03/10/26. -The RCC spoke with the MHP about the order, which the MHP ensured the RCC it was coming Friday because she had spoken to the pharmacy and fixed the issue. -The pharmacy stated the medication would not be sent out because the prescriber was not authorized to write the prescription. Review of Resident #4's facility progress notes for March 2026 revealed there was no documentation regarding Resident #4's Lorazepam ordered on 03/10/26 prior to the note dated 03/21/26. Review of Resident #4's MHP visit note dated 04/09/26 revealed: -The resident was scattered and distracted in his speech. -The resident reported he was "worried about a lot of stuff". -The resident would not stay seated and had 4 recent falls. -There was an order to continue Lorazepam 0.5mg 1 tablet twice daily. -There was an order to start Lorazepam 0.5mg 1 tablet once daily as needed (prn) for agitation/anxiety, hold for sedation. Review of Resident #4's February 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Lorazepam 0.5mg 1 tablet twice daily for anxiety scheduled at 9:00am	D 358		

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and 9:00pm.
-Lorazepam 0.5mg was documented as administered twice daily from 02/13/26 - 02/18/26.
-There was an entry for Lorazepam 0.5mg 1 tablet 3 times daily scheduled at 9:00am, 3:00pm, and 9:00pm.
-Lorazepam 0.5mg was documented as administered 3 times daily from 9:00pm on 02/19/26 - 9:00pm on 02/28/26 except at 3:00pm and 9:00pm on 02/23/26.
-There were 38 doses of Lorazepam 0.5mg documented as administered from 02/13/26 - 02/28/26.

Review of Resident #4's March 2026 eMAR revealed:
-There was an entry for Lorazepam 0.5mg 1 tablet 3 times daily scheduled at 9:00am, 3:00pm, and 9:00pm.
-Lorazepam 0.5mg was documented as administered 3 times daily from 9:00am on 03/01/26 - 3:00pm on 03/10/26 and noted to be discontinued starting 03/11/26.
-There was a second entry for Lorazepam 0.5mg 1 tablet twice daily scheduled at 9:00am and 9:00pm.
-Lorazepam 0.5mg was documented as "drug not available" at 9:00am on 03/15/26, 03/17/26 - 03/19/26, 03/21/26, and 03/23/26.
-Lorazepam 0.5mg was documented as "drug not available" at 9:00pm on 03/12/26, 03/16/26 - 03/19/26, 03/21/26, and 03/22/26.
-There were 13 doses documented as not administered due to the medication being unavailable from 03/12/26 - 03/23/26.
-There was a total of 54 doses of Lorazepam 0.5mg documented as administered from 03/01/26 - 03/31/26.

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D 358	Continued From page 17 Review of Resident #4's April 2026 eMAR revealed: -There was an entry for Lorazepam 0.5mg 1 tablet twice daily scheduled at 9:00am and 9:00pm. -Lorazepam 0.5mg was documented as administered twice daily from 04/01/26 - 04/24/26 (9:00am). -There was a second entry for Lorazepam 0.5mg 1 tablet once daily as needed for anxiety/agitation, hold for sedation. -There was no prn Lorazepam documented as administered in April 2026. Review of Resident #4's controlled substance record (CSR) for Lorazepam 0.5mg revealed: -Lorazepam 0.5mg was documented as administered and declined from the count twice on 03/10/26 with the last documented dose at 3:37pm, leaving a balance of 57 tablets. -On 03/11/26, staff documented the medication was discontinued and 57 tablets were documented for medication disposal, leaving a balance of 0. -On 03/11/26, "new order" was documented but a quantity of 0 tablets. -There was no documentation of any Lorazepam 0.5mg being administered to Resident #4 from 03/12/26 - 03/23/26 (9:00am). -Documentation of the administration of Lorazepam 0.5mg resumed on 03/23/26 at 8:56pm with one tablet documented as administered. Telephone interview with a pharmacist at the facility's contracted pharmacy on 04/24/26 at 5:47pm revealed: -There were 90 Lorazepam 0.5mg tablets dispensed on 02/19/26 for Resident #4. -There were 30 Lorazepam 0.5mg tablets	D 358		

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dispensed on 04/09/26 for Resident #4.
-There were 28 Lorazepam 0.5mg tablets dispensed on 04/18/26 for Resident #4.

Observation of Resident #4's medications on hand on 04/24/26 at 12:51pm revealed:
-There was a supply of Lorazepam 0.5mg tablets dispensed on 04/18/26 with instructions to take 1 tablet twice daily.
-There were 21 of 28 tablets remaining.
-There was a second supply of Lorazepam 0.5mg tablets dispensed on 04/09/26 with instructions to take 1 tablet once daily as needed for anxiety/agitation, hold for sedation.
-There were 30 of 30 tablets remaining.

Interview with Resident #4 on 04/24/26 at 1:23pm revealed:
-He could not recall which medications he took.
-He did not know if he missed any medication doses.
-Sometimes his stomach got messed up and he got anxious.

Interview with a medication aide (MA) on 04/23/26 at 2:35pm revealed:
-Resident #4's Lorazepam order changed from 3 times a day to twice a day in March 2026.
-Resident #4 missed several days of Lorazepam after the order changed.
-She was not sure what happened, but the Resident Care Coordinator (RCC) would know.
-She did not recall any changes in Resident #4's behavior when he missed the doses of Lorazepam.

Interview with a second MA on 04/24/26 at 1:01pm revealed:
-Resident #4 started to decline around January 2026 after his friend at the facility declined in

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health.
-Resident #4 went into a state of depression and became very anxious.
-After Resident #4's friend passed away last month, Resident #4's anxiety got worse and he kept asking what he was supposed to do next.
-Resident #4 ran out of his Lorazepam in March 2026.
-The RCC and the MHP were going back and forth trying to get the Lorazepam.
-Resident #4 was still real anxious when he was out of the Lorazepam and she thought he needed a prn medication to help with the anxiety at that time.
-The MAs were responsible for sending medication orders to the pharmacy when received.
-The MAs were supposed to notify the RCC if a medication was not received from the pharmacy.

Interview with the RCC on 04/24/26 at 5:10pm revealed:
-She was new and worked as the RCC for the last 4 to 5 months.
-Resident #4's MHP decreased his Lorazepam from 3 times a day to twice a day on 03/10/26.
-Prior to 03/10/26, another resident's controlled substance order was changed from 1mg to 0.5mg so she used the same card with 1mg and just cut the tablets in half.
-She was told by the Administrator that she could not cut the tablet in half and waste half the dose.
-When Resident #4's order changed she assumed she could not use the same supply of Lorazepam.
-She did not think about it being the same strength, just a different frequency.
-She pulled Resident #4's Lorazepam because she thought the pharmacy would send a new supply for the new order.

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-She put Resident #4's Lorazepam in the locked box in the Administrator's office to be destroyed.
-They did not receive a new supply of Lorazepam for Resident #4 for the order dated 03/10/26 so she sent emails to the MHP and called the pharmacy.
-A pharmacist at the facility's contracted pharmacy told her there was a problem with the MHP's Drug Enforcement Agency (DEA) number.
-Someone from the facility's contracted MHP group mentioned there were 57 Lorazepam 0.5mg tablets for Resident #4 that were unaccounted for and that's when she realized it was the Lorazepam supply she had pulled from the cart after the order changed on 03/10/26.
-It took 13 days to figure out that the Lorazepam tablets Resident #4 needed were in the facility and could have been used to administer to the resident when the order frequency changed.
-She did not think Resident #4's anxiety was worse when he missed the Lorazepam doses but she felt like the resident was calmer now.

Telephone interview with a second pharmacist at the facility's contracted pharmacy on 04/27/26 at 11:27am revealed:
-They received Resident #4's order change for Lorazepam 0.5mg on 03/10/26.
-There was a note on 03/11/26 that the provider's DEA number was not associated with the insurance plan.
-A pharmacy technician with the pharmacy spoke with someone at the facility and they were going to get a new prescription from a different provider.
-The prescription dated 03/10/26 for Resident #4's Lorazepam was actually dispensed on 04/18/26 under the MHP's name who originally wrote the prescription.
-They could have gotten a mix up with the insurance plan fixed or it could have been billed

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D 358	Continued From page 21 as private pay. Interview with the Administrator on 04/27/26 at 9:45am revealed: -Resident #4's MHP changed the Lorazepam 0.5mg from 3 times a day to twice a day in March 2026. -She thought the pharmacy staff told the RCC that Resident #4's MHP could not write prescriptions for controlled substances. -They reached out to the contracted MHP group and they were going to get another MHP with the group to send the order to the pharmacy. -The medication never came to the facility so the RCC and the MAs contacted the pharmacy. -They thought the pharmacy was going to send an emergency 3-day supply of Lorazepam but it was never sent. -She contacted the contracted MHP group on 03/23/26 and the MHP group's Director of Clinical Operations and Engagement came to the facility that day. -The Director of Clinical Operations and Engagement came to the facility on 03/23/26 because the MHP who wrote the order on 03/10/26 reported drug diversion with Resident #4's Lorazepam. -On 03/23/26, she realized the order change on 03/10/26 was for the same dosage of Lorazepam 0.5mg but the frequency changed from 3 times a day to twice a day. -She realized Resident #4's previous supply of Lorazepam 0.5mg had been pulled from the medication cart when the order was changed on 03/10/26 and put in a locked box in her office to be destroyed when the pharmacy representative came to the facility. -The previous supply of Lorazepam 0.5mg should have been used when the order changed on 03/10/26 and a direction change sticker should	D 358		

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have been put on the label to indicate a change.
-On 03/23/26, the previous supply of Lorazepam 0.5mg was put back in the medication cart and Resident #4 started receiving Lorazepam again on 03/23/26.
-The RCC was new in her role and did not realize the previous supply of Lorazepam 0.5mg could be used with a direction change sticker because it was the same strength as the previous order.
-She in-serviced the RCC on 03/23/26 about the proper process for that type of order change.
-The RCC had gotten confused because she had been told by the pharmacy in the past about a different resident's medication not to use a direction change sticker.
-The MAs were responsible for doing medication cart audits daily.
-The RCC was responsible for doing medication cart audits weekly.

Review of Resident #4's Controlled Substance Medication Destruction Form revealed:
-There was a sticker on the form for Lorazepam 0.5mg tablets dispensed on 02/19/26.
-There was handwritten documentation that 57 tablets of Lorazepam 0.5mg were to be destroyed.
-There was no documentation the Lorazepam was destroyed, and no witnesses had signed the destruction form.
-There was a handwritten note at the bottom of the form dated 03/23/26.
-The note indicated the medication was put on the medication cart due to same strength as new order.
-The handwritten note was signed by the Administrator.

Telephone interview with Resident #4's PCP on 04/24/26 at 4:48pm revealed:

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-Resident #4 always had some minor anxiety here and there.
-When she returned from a leave of absence in January 2026, Resident #4 was more confused and had more anxiety.
-The resident was checked out at the emergency room (ER) and cleared medically.
-She felt his issues were more related to his mental health.
-Resident #4 had a good friend at the facility who got sick and passed away during that time that could have triggered some mental health issues.
-Not receiving Lorazepam could create more anxiety for the resident and cause some type of withdrawal symptoms.
-She would not say what type of withdrawal symptoms since she did not manage the resident's Lorazepam.

Telephone interview with Resident #4's fill-in MHP on 04/24/26 at 4:11pm revealed:
-She saw Resident #4 as a fill-in MHP on 04/09/26.
-She started prn Lorazepam on 04/09/26 because facility staff reported Resident #4 was anxious and would not sit still.
-She was not aware of any issues with the resident not receiving Lorazepam as ordered in the past.
-Not receiving Lorazepam could cause Resident #4 to be more anxious.

Attempted telephone interview with Resident #4's former MHP on 04/24/26 at 9:50am was unsuccessful.

_____

The facility failed to administer medications as ordered to Resident #4 who was diagnosed with generalized anxiety disorder and exhibited severe anxiety at times, including voicing suicidal

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D 358	Continued From page 24 thoughts on one occasion. Resident #4 had an order to decrease Lorazepam 0.5mg from 3 times day to twice a day on 03/10/26. The Resident Care Coordinator (RCC) did not follow the facility's protocol of using a direction change sticker and exhausting the current supply of medication when the strength of the medication to be administered did not change. Lorazepam was not administered to Resident #4 as ordered for 13 consecutive days in March 2026 putting the resident at risk of withdrawal symptoms and increased anxiety. This failure of the facility 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 04/24/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 11, 2026.	D 358		
D 392	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure readily retrievable records that accurately reconciled the receipt and administration of controlled	D 392		

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substances for 2 of 4 residents (#1, #4) sampled with orders for controlled substances used to treat anxiety.

The findings are:

1. Review of Resident #4's current FL-2 dated 01/05/26 revealed diagnoses included bipolar disorder, generalized anxiety disorder, primary insomnia, gastroesophageal reflux disease without esophagitis, conjunctival hemorrhage of the right eye, and diarrhea.

Review of Resident #4's mental health provider (MHP) dated 02/13/26 revealed an order for Lorazepam 0.5mg 1 tablet twice daily. (Lorazepam is a controlled substance used to treat anxiety.)

Review of Resident #4's MHP visit note dated 02/17/26 revealed:
-There was an order to discontinue Lorazepam 0.5mg 1 tablet twice daily.
-There was an order to start Lorazepam 0.5mg 1 tablet 3 times a day.

Review of Resident #4's MHP order dated 03/10/26 revealed:
-There was an order to discontinue Lorazepam 0.5mg 3 times a day.
-There was an order to start Lorazepam 0.5mg twice a day.

Review of Resident #4's MHP visit note dated 04/09/26 revealed:
-There was an order to continue Lorazepam 0.5mg 1 tablet twice daily.
-There was an order to start Lorazepam 0.5mg 1 tablet once daily as needed (prn) for agitation/anxiety, hold for sedation.

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D 392	Continued From page 26 Review of Resident #4's February 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Lorazepam 0.5mg 1 tablet twice daily for anxiety scheduled at 9:00am and 9:00pm. -Lorazepam 0.5mg was documented as administered twice daily from 02/13/26 - 02/18/26. -There was an entry for Lorazepam 0.5mg 1 tablet 3 times daily scheduled at 9:00am, 3:00pm, and 9:00pm. -Lorazepam 0.5mg was documented as administered 3 times daily from 9:00pm on 02/19/26 - 9:00pm on 02/28/26 except at 3:00pm and 9:00pm on 02/23/26. -There were 38 doses of Lorazepam 0.5mg documented as administered from 02/13/26 - 02/28/26. Review of Resident #4's March 2026 eMAR revealed: -There was an entry for Lorazepam 0.5mg 1 tablet 3 times daily scheduled at 9:00am, 3:00pm, and 9:00pm. -Lorazepam 0.5mg was documented as administered 3 times daily from 9:00am on 03/01/26 - 3:00pm on 03/10/26 and noted to be discontinued starting on 03/11/26. -There was a second entry for Lorazepam 0.5mg 1 tablet twice daily scheduled at 9:00am and 9:00pm. -Lorazepam 0.5mg was documented as "drug not available" at 9:00am on 03/15/26, 03/17/26 - 03/19/26, 03/21/26, and 03/23/26. -Lorazepam 0.5mg was documented as "drug not available" at 9:00pm on 03/12/26, 03/16/26 - 03/19/26, 03/21/26, and 03/22/26. -There were 13 doses documented as not	D 392		

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administered due to the medication being unavailable from 03/12/26 - 03/23/26.
-There was a total of 54 doses of Lorazepam 0.5mg documented as administered from 03/01/26 - 03/31/26.

Review of Resident #4's April 2026 eMAR revealed:
-There was an entry for Lorazepam 0.5mg 1 tablet twice daily scheduled at 9:00am and 9:00pm.
-Lorazepam 0.5mg was documented as administered twice daily from 04/01/26 - 04/23/26, a total of 46 doses.
-There was a second entry for Lorazepam 0.5mg 1 tablet once daily prn for anxiety/agitation, hold for sedation.
-There was no prn Lorazepam documented as administered in April 2026.

Review of Resident #4's February 2026 electronic controlled substance record (eCSR) for Lorazepam revealed:
-There were 38 Lorazepam 0.5mg tablets documented and declined from the count as administered from 02/13/26 - 02/28/26.
-On 02/15/26 at 9:23pm, there was a medication check-in documented and one tablet was added back to the count with no explanation.
-On 02/16/26 at 4:57pm, there was a medication check-in documented and one tablet was added back to the count with no explanation.
-On 02/24/26 at 8:51pm, there was a medication check-in documented and one tablet was added back to the count with no explanation.
-There were 2 occasions when the 9:00am scheduled dosage was documented as being administered and declined from the count from 11:02am - 11:41am.
-On 02/27/26, the 9:00am dosage was

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documented as administered and declined from the count at 11:41am over 2 hours after it was documented as administered at 9:00am on the eMAR.
-There were 7 occasions when the 3:00pm scheduled dosage was documented as being administered and declined from the count from 5:42pm - 9:28pm.
-On 02/27/26, the 3:00pm and 9:00pm scheduled doses were documented as administered and declined from the count both at the same time at 8:21pm.
-The eCSR did not accurately reflect the administration of Lorazepam for Resident #4.

Review of Resident #4's March 2026 eCSR for Lorazepam revealed:
-There were 47 Lorazepam 0.5mg tablets documented and declined from the count as administered from 03/01/26 - 03/31/26, but 54 tablets were documented as administered on the eMAR.
-The eCSR did not match the eMAR for the administration of Lorazepam for Resident #4.
-On 03/06/26 at 1:42am, there was a medication check-in documented and one tablet was added back to the count with no explanation.
-On 03/11/26 at 6:13pm, there was a medication check-in documented and one tablet was added back to the count with no explanation.
-There were 7 occasions when the 9:00am scheduled dosage was documented as being administered and declined from the count from 11:08am - 2:16pm.
-On 03/10/26, the 9:00am dosage was documented as administered and declined from the count at 2:16pm over 5 hours after it was documented as administered at 9:00am on the eMAR.
-There were 8 occasions when the 3:00pm

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scheduled dosage was documented as being administered and declined from the count from 6:18pm - 10:05pm.
-On 03/08/26, the 3:00pm and 9:00pm scheduled doses were documented as administered and declined from the count both at the same time at 10:05pm.
-The eCSR did not accurately reflect the administration of Lorazepam for Resident #4.

Review of Resident #4's April 2026 eCSR for Lorazepam revealed:
-There were 46 Lorazepam 0.5mg tablets documented and declined from the count as administered from 04/01/26 - 04/23/26.
-On 04/20/26 at 4:47pm, there was a medication check-in documented and one tablet was added back to the count with no explanation.
-There were 4 occasions when the 9:00am scheduled dosage was documented as being administered and declined from the count from 11:31am - 2:41pm.
-On 04/03/26, the 9:00am dosage was documented as administered and declined from the count at 2:41pm over 5 hours after it was documented as administered at 9:00am on the eMAR.
-The eCSR did not accurately reflect the administration of Lorazepam for Resident #4.
-There was a balance of 22 tablets noted on the eCSR on 04/23/26 at 8:46pm for scheduled Lorazepam.
-There was a balance of 30 tablets noted on the eCSR for prn Lorazepam.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 04/24/26 at 5:47pm revealed:
-There were 30 Lorazepam 0.5mg tablets dispensed on 02/12/26 for Resident #4.

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D 392	Continued From page 30 -There were 90 Lorazepam 0.5mg tablets dispensed on 02/19/26 for Resident #4. -There were 30 Lorazepam 0.5mg tablets dispensed on 04/09/26 for Resident #4. -There were 28 Lorazepam 0.5mg tablets dispensed on 04/18/26 for Resident #4. Observation of Resident #4's medications on hand on 04/24/26 at 12:51pm revealed: -There was a supply of Lorazepam 0.5mg tablets dispensed on 04/18/26 with instructions to take 1 tablet twice daily. -There were 21 of 28 tablets remaining (reflecting one dosage administered on 04/24/26 at 9:00am). -There was a second supply of Lorazepam 0.5mg tablets dispensed on 04/09/26 with instructions to take 1 tablet once daily prn for anxiety/agitation, hold for sedation. -There were 30 of 30 prn Lorazepam 0.5mg tablets remaining. Interview with a medication aide (MA) on 04/23/26 at 2:15pm revealed: -Resident #4's Lorazepam was not administered too close together or at the same time as another dosage of Lorazepam. -The administration of Lorazepam was either clicked late on the eMAR by the MAs, or it was a "glitch" in the eMAR system. Refer to interview with a MA on 04/23/26 at 2:15pm. Refer to interview with a second MA on 04/23/26 at 2:18pm. Refer to interview with the Resident Care Coordinator (RCC) on 04/24/26 at 5:10pm.	D 392		

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D 392	Continued From page 31 2. Review of Resident #1's current FL-2 dated 02/09/26 revealed: -Diagnoses included anxiety disorder, essential primary hypertension, hyperlipidemia, hearing loss, and anorexia. -There was an order for Alprazolam 0.5mg 1 tablet 3 times a day for generalized anxiety disorder. (Alprazolam is a controlled substance used for anxiety.) Review of Resident #1's February 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Alprazolam 0.5mg 1 tablet 3 times a day for generalized anxiety disorder scheduled at 9:00am, 3:00pm, and 9:00pm. -Alprazolam 0.5mg was documented as administered 3 times a day from 02/01/26 - 02/28/26, except on 02/09/26 at 3:00pm when it was documented as refused. -There was a total of 83 Alprazolam 0.5mg tablets documented as administered from 02/01/26 - 02/28/26. Review of Resident #1's March 2026 eMAR revealed: -There was an entry for Alprazolam 0.5mg 1 tablet 3 times a day for generalized anxiety disorder scheduled at 9:00am, 3:00pm, and 9:00pm. -Alprazolam 0.5mg was documented as administered 3 times a day from 03/01/26 - 03/31/26, except on 03/11/26 at 9:00am when it was documented as refused. -There was a total of 92 Alprazolam 0.5mg tablets documented as administered from 03/01/26 - 03/31/26. Review of Resident #1's April 2026 eMAR	D 392		

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revealed:
-There was an entry for Alprazolam 0.5mg 1 tablet 3 times a day for generalized anxiety disorder scheduled at 9:00am, 3:00pm, and 9:00pm.
-Alprazolam 0.5mg was documented as administered 3 times a day from 04/01/26 - 04/22/26 (9:00am), except on 04/15/26 at 9:00pm when it was documented as drug not available.
-There was a total of 63 Alprazolam 0.5mg tablets documented as administered from 04/01/26 - 04/22/26 (9:00am).

Review of Resident #1's February 2026 electronic controlled substance record (eCSR) for Alprazolam revealed:
-There were 83 Alprazolam 0.5mg tablets documented and declined from the count as administered from 02/01/26 - 02/28/26.
-On 02/14/26 at 8:49pm, there was a medication check-in documented and one tablet was added back to the count with no explanation.
-On 02/26/26 at 10:29pm, there was a medication check-in documented and one tablet was added back to the count with no explanation.
-There were 10 occasions when the 9:00am scheduled dosage was documented as being administered and declined from the count from 11:01am - 10:12pm.
-On 02/14/26, the 9:00am dosage was documented as administered and declined from the count at 2:12pm and the 3:00pm dosage was documented as administered at 4:02pm, 1 hour and 50 minutes apart.
-There were 17 occasions when the 3:00pm scheduled dosage was documented as being administered and declined from the count from 6:16pm - 10:21pm.
-On 02/08/26, the 9:00am and 3:00pm scheduled doses were documented as administered and

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declined from the count both at 10:21pm and the 9:00pm dosage was documented 16 minutes later at 10:37pm.
-The eCSR did not accurately reflect the administration of Alprazolam for Resident #1.

Review of Resident #1's March 2026 eCSR for Alprazolam revealed:
-There were 91 Alprazolam 0.5mg tablets documented and declined from the count as administered from 03/01/26 - 03/31/26, but 92 tablets were documented as administered on the eMAR.
-There were 10 occasions when the 9:00am scheduled dosage was documented as being administered and declined from the count from 11:02am - 3:45pm.
-On 03/20/26, the 9:00am dosage was documented as administered and declined from the count at 3:45pm over 6 hours after it was documented as administered at 9:00am on the eMAR.
-There were 22 occasions when the 3:00pm scheduled dosage was documented as being administered and declined from the count from 6:30pm - 10:20pm.
-On 03/22/26, the 3:00pm and 9:00pm scheduled doses were documented as administered and declined from the count both at the same time at 9:24pm.
-The eCSR did not accurately reflect the administration of Alprazolam for Resident #1.

Review of Resident #1's April 2026 eCSR for Alprazolam revealed:
-There were 63 Alprazolam 0.5mg tablets documented and declined from the count as administered from 04/01/26 - 04/22/26 (9:00am dose).
-There were 4 occasions when the 9:00am

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scheduled dosage was documented as being administered and declined from the count from 11:23am - 1:39pm.
-On 04/18/26, the 9:00am dosage was documented as administered and declined from the count at 1:39pm over 4 hours after it was documented as administered at 9:00am on the eMAR.
-There were 12 occasions when the 3:00pm scheduled dosage was documented as being administered and declined from the count from 7:20pm - 10:27pm.
-On 04/18/26, the 3:00pm and 9:00pm scheduled doses were documented as administered and declined from the count both at the same time at 10:27pm.
-The eCSR did not accurately reflect the administration of Alprazolam for Resident #1.
-There was a balance of 71 tablets noted on the eCSR on 04/22/26 at 9:46am.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 04/24/26 at 5:47pm revealed:
-There were 90 Alprazolam 0.5mg tablets dispensed on 01/09/26 for Resident #1.
-There were 90 Alprazolam 0.5mg tablets dispensed on 02/09/26 for Resident #1.
-There were 90 Alprazolam 0.5mg tablets dispensed on 03/13/26 for Resident #1.
-There were 9 Alprazolam 0.5mg tablets dispensed on 04/10/26 for Resident #1.

Observation of Resident #1's medication on hand on 04/22/26 at 10:15am revealed:
-There was a supply of Alprazolam 0.5mg tablets dispensed on 04/15/26 with instructions to take 1 tablet 3 times a day for generalized anxiety disorder.
-There were 71 of 90 tablets remaining.

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D 392	Continued From page 35 Interview with a medication aide (MA) on 04/23/26 at 2:15pm revealed: -Resident #1's Alprazolam was not administered too close together or at the same time as another dosage of Alprazolam. -The administration of Alprazolam was either clicked late on the eMAR by the MAs, or it was a "glitch" in the eMAR system. Refer to interview with a MA on 04/23/26 at 2:15pm. Refer to interview with a second MA on 04/23/26 at 2:18pm. Refer to interview with the Resident Care Coordinator (RCC) on 04/24/26 at 5:10pm. _____ Interview with a medication aide (MA) on 04/23/26 at 2:15pm revealed: -Controlled substances were supposed to automatically subtract from the eCSR when they clicked on a controlled substance as administered in the eMAR system. -If a resident refused, they chose that option from the drop-down menu on the eMAR and it would not decline the count on the eCSR. -The MAs counted the controlled substances at each shift change. -After 3 attempts, the MAs would get locked out of the system if it did not match. -If the counts did not match, they had to contact the Resident Care Coordinator (RCC) and the RCC had to correct the count in the system. -No controlled substances were missing. -If the count was off, it was usually because the internet was down or the MAs clicked off on medication administration late.	D 392		

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D 392	Continued From page 36 Interview with a second MA on 04/23/26 at 2:18pm revealed: -The MAs did a controlled substance count at the change of each shift. -The electronic system was sometimes "messed up" and the internet would sometimes go down for an hour at a time. -There had been no missing controlled substances. -If the count was off, it was because the electronic system was not working properly. Interview with the RCC on 04/24/26 at 5:10pm revealed: -She was new and had been working as the RCC for 4 to 5 months. -The MAs did controlled substance counts each shift. -The MAs were supposed to count the controlled substances twice and if it did not match, the MAs were supposed to call her. -She usually checked the eMAR system if the count was off so she could figure out the discrepancy. -Once she checked everything, she could correct the count in the eMAR system using her PIN number. -They had some problems with the current eMAR and eCSR system. -With the current computer system, she could check the eMAR and eCSR from home if something did not match, but she could not access the screen to enter her PIN number to correct a discrepancy. -She had to give the MAs her PIN number so they could correct the discrepancy when she was not at the facility, and she would immediately change the PIN number once the correction was made. -She thought some of the discrepancies may have been caused by the MAs not clicking	D 392		

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D 392	Continued From page 37 medication administration when a controlled substance was administered. -Other than the shift counts, there was no system to check the eCSRs to make sure they were accurate.	D 392		