STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060152	A. BUILDING: _____ B. WING _____	R 04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HEIGHTS SENIOR LIVING COMMUNITY	11230 BALLANTYNE TRACE COURT CHARLOTTE, NC 28277

(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 and the Department of Social Services conducted a follow-up survey from April 20, 2026 to April 21, 2026.	{D 000}		
{D 358}	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 3 of 5 sampled residents (Residents #1,#3, & #5) for medications to treat high blood pressure, and fluid retention (#1), to treat inflammation(#3), and prevent swelling, and infections after eye surgery, and open the airway (#5). The findings are: 1. Review of Resident #1's current FL2 dated 02/10/26 revealed: -Diagnoses included hepatic encephalopathy, essential hypertension, stage 4 chronic kidney disease, cognitive impairment, type 2 diabetes and liver cirrhosis. -Resident #1's level of care was the special care unit.	{D 358}		

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{D 358}	Continued From page 1 a. Review of Resident #1's physician's order dated 02/18/26 revealed an order for carvedilol (a medication used to treat high blood pressure) 6.25mg, one tablet by mouth at bedtime. Review of Resident #1's March 2026 electronic medication administration record (eMAR) revealed: -There was an entry for carvedilol 6.25mg tablet, one tablet by mouth at bedtime. -There was documentation carvedilol 6.25mg was administered as ordered from 03/11/26 to 03/15/26 due to "medication unavailable". Observation of Resident #1's medications available for administration on 04/21/26 at 11:11am revealed: -Resident #1 had carvedilol 6.25mg tablets, take one tablet by mouth every night at bedtime. -The dispense label on the bubble pack showed 28 tablets were dispensed on 03/16/26 and 18 tablets were remaining. Interview with a medication aide (MA) on 04/21/26 at 11:15am revealed: -She was not aware Resident #1 missed five days of carvedilol 6.25mg. -If medications were not available or received from the pharmacy she was to inform the Special Care Coordinator (SCC) or the pharmacy and or the provider. -The facility would have used the back up pharmacy to make sure medication were not missed. Interview with a pharmacist from the facility's contracted pharmacy on 04/21/26 at 12:05pm revealed: -They received an order for Resident #1's	{D 358}		

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{D 358}	Continued From page 2 carvedilol 6.25mg tablets, take one tablet by mouth every night at bedtime, on 03/11/26. -Resident #1's carvedilol 6.25mg, quantity of 23 tablets, was not dispensed until 03/16/26. -Since Resident #1's carvedilol 6.25mg was not dispensed for five days, the facility could have used their back-up pharmacy to get a few days of medication needed. -Five days of missed carvedilol could result in an increased heart rate or blood pressure. Interview with the SCC on 04/21/26 at 12:35pm revealed: -Resident #1's carvedilol 6.25mg was transferred to the new contracted pharmacy on 03/11/26. -She did not know why it took five days for the carvedilol to be dispensed to the facility. -She expected the MAs to inform her if a medication was not received from the pharmacy in a timely manner. -If she knew Resident #1's carvedilol had not been received, she would have contacted the provider and used the back-up pharmacy to obtain a few days of Resident #1's carvedilol medication and to avoid the medication not being administered as ordered. Interview with the Nurse Practitioner (NP) on 04/21/26 at 11:35am revealed: -Resident #1 had an order for carvedilol 6.25mg tablets, take one tablet by mouth daily at bedtime. -She was not aware Resident #1 missed 5 days of her carvedilol medication due to pharmacy issues. -She was not aware of any adverse effects Resident #1 may have had from missing five days of carvedilol. -She expected the facility to contact her if medications were missed.	{D 358}		

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{D 358}	Continued From page 3	{D 358}		

Refer to interview with the Administrator on 04/21/26 at 3:25pm.

b. Review of Resident #1's current FL2 dated 02/10/26 revealed there was an order for furosemide (a medication to treat fluid retention) 40 mg, 1 tablet by mouth daily.

Review of Resident #1's physician's order dated 02/18/26 revealed there was an order to discontinue furosemide 40mg, 1 tablet by mouth daily.

Review of Resident #1's February 2026 electronic Medication Record (eMAR) revealed:
-There was an entry for furosemide 40mg, 1 tablet by mouth daily, at 8:00pm.
-There was documentation furosemide 40mg was administered from 02/01/26 to 02/18/26 at 8:00pm.

Review of Resident #1's March 2026 eMAR revealed:
-There was an entry for furosemide 40mg, 1 tablet by mouth daily.
-There was documentation furosemide 40mg was administered on 03/12/26.

Observation of Resident #1's medications available for administration on 04/21/26 at 11:11am revealed there was no furosemide available for administration.

Interview with a pharmacist from the facility's contracted pharmacy on 04/20/26 at 2:05pm revealed Resident #1's furosemide was not dispensed from their pharmacy.

Interview with a medication aide (MA) on 04/21/26 at 11:15am revealed:

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{D 358}	Continued From page 4 -She documented accurately on Resident #1's handwritten February 2026 MAR and handwritten MAR from 03/01/26 to 03/11/26. -She could not locate Resident #1's handwritten MAR from 03/01/26 to 03/11/26 that was used during the pharmacy transition. -The facility transitioned to electronic MARs on 03/12/26. -She may have mistakenly documented on Resident #1's eMAR that she administered furosemide on 03/12/26, although it was discontinued on 02/18/26. Interview with the SCC on 04/21/26 at 12:35pm revealed: -Resident #1's furosemide should not have been transferred to the March 2026 eMAR since it was discontinued on 02/18/26. -She suspected furosemide was inadvertently transferred to the March 2026 eMAR during the transition to the new pharmacy provider. -She expected MAs to review the discontinue order and document accurately. Refer to interview with the NP on 04/21/26 at 11:35am. Refer to interview with the Administrator on 04/21/26 at 3:25pm. c. Review of Resident #1's current FL2 dated 02/10/26 revealed there was an order for spironolactone (a medication to treat high blood pressure) 100mg, 1 tablet by mouth daily. Review of Resident #1's physician's order dated 02/18/26 revealed there was an order to discontinue spironolactone 100mg, I tablet by mouth daily.	{D 358}		

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{D 358}	Continued From page 5 Review of Resident #1's February 2026 eMAR revealed: -There was an entry for spironolactone 100mg, 1 tablet by mouth daily. -There was documentation spironolactone 100mg was administered from 02/01/26 to 02/28/26. Review of Resident #1's March 2026 eMAR revealed: -There was an entry for spironolactone 100mg, 1 tablet by mouth daily. -There was no documentation spironolactone was administered from 03/01/26 to 03/11/26 and 03/21/26. -There was documentation spironolactone 100mg was administered from 03/12/26 to 03/25/26. Observation of medications available for administration on 04/21/26 at 11:11am revealed there was no spironolactone available for administration. Interview with the facility's contracted pharmacy on 04/20/26 at 12:05pm revealed: -They dispensed Resident #1's 28-day supply of spironolactone 03/06/26. -They received Resident #1's discontinue order for spironolactone (dated 02/18/26) on 03/11/26. -Continued use of spironolactone after it was discontinued to lead to a drop in blood pressure, increased falls and increased confusion. -It was the facility's responsibility to send a discontinue order and approve it on their end, in order for the eMAR to be reflected. Interview with a MA on 04/21/26 at 11:15am revealed: -She did not know Resident #1's spironolactone 100mg was discontinued on 02/18/26. -She administered Resident #1's spironolactone	{D 358}		

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{D 358}	Continued From page 6 100mg in March 2026 because it was on the eMAR. Interview with the SCC on 04/21/26 at 3:40pm revealed: -Resident #1's spironolactone was discontinued 02/18/26 and she was not sure why the new pharmacy provider did not remove it from the March 2026 eMAR. -She suspected it was inadvertently transferred to the new pharmacy provider in March 2026. -She expected MAs to report inconsistencies with medication orders during the transition from the old facility pharmacy to the new facility pharmacy and to accurately implement medication orders. Refer to interview with the NP on 04/21/26 at 11:35am. Refer to interview with the Administrator on 04/21/26 at 3:25pm. _____ Interview with the NP on 04/21/26 at 11:35am revealed: -She did not know why Resident #1's continued to receive spronolactone after is was discontinued by anothwe provider on 02/18/26. -Continued use of furosemide and spironolactone after it has been discontinued could lead to dehydration and/ or abnormal lab results. -She did not receive any reports related to any side effects aside from Resident #1's baseline. -She expected the facility to have checks and balances between the facility, her provider communication folder, the eMAR and the pharmacy. Interview with the Administrator on 04/21/26 at 3:25pm revealed:	{D 358}		

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{D 358}	Continued From page 7 -The facility nurse and the SCC were responsible for reviewing/ auditing medication reports through the newly acquired eMAR system. -He was not sure why Resident #1 did not receive carvedilol medication through their backup pharmacy as expected or why the physician was not contacted. -He expected medication to be administered and discontinued as ordered. -He expected medications to be administered as ordered. 2. Review of Resident #3's current FL2 dated 04/16/26 revealed diagnoses included chronic obstructive pulmonary disease and lung cancer. Review of Resident #3's electronic Physician's Order dated 03/09/26 revealed an order for prednisone (a medication to treat inflammation) 20mg, two tablets daily for 3 days. Observation of Resident #3's medications on hand on 04/21/26 at 11:30am revealed: -There was a bubble card for Resident #3 for prednisone 20mg, two tablets daily for 3 days. -The label indicated prednisone 20mg, six tablets were dispensed for Resident #3 on 03/11/26. -There were four tablets of prednisone 20mg remaining in the bubble card. Review of Resident #3's March 2026 electronic medication administration record (eMAR) revealed: -There was an entry for prednisone 20mg, two tablets daily for three days. -The prednisone 20mg entry had a "date written" of 03/09/26 and a stop date of 03/12/26. -Prednisone 20mg, two tablets was documented not administered on 03/11/26 at 12:00pm because the medication was not delivered from	{D 358}		

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the pharmacy.
-Prednisone 20mg, two tablets was documented administered to Resident #3 on 03/12/26 at 12:00pm.

Interview with Resident #3 on 04/21/26 at 1:33pm revealed he did not know the names of the medications the medication aides (MA) administered to him.

Telephone interviews with a Pharmacist with the facility's contracted pharmacy on 04/21/26 at 9:45am and 1:24pm revealed:
-The pharmacy received an order for prednisone 20mg, 2 tablets daily for three days for Resident #3 on 03/09/26.
-The pharmacy dispensed prednisone 20mg, six tablets for Resident #3 on 03/11/26.
-The pharmacy entered orders into the residents' eMARs and the facility needed to review and approve them before they would become active on the resident's eMAR.
-Resident #3 could experience difficulty breathing and difficulty clearing the lung infection if he did not receive prednisone 20mg, two tablets daily for three days.

Interview with a MA on 04/21/26 at 11:23am and 11:51am revealed:
-She did not know why there was prednisone 20mg, 2 tablets daily remaining in the bubble pack for Resident #3.
-She thought the prednisone 20mg may have been discontinued for Resident #3 and not removed from the medication cart.

Interview with the facility's licensed practical nurse (LPN) on 04/21/26 at 2:55pm revealed:
-The pharmacy was responsible for entering orders, including stop dates when applicable, into

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the eMAR system.
-The Health and Wellness Director (HWD), Special Care Unit Coordinator (SCC) or the Administrator was responsible for reviewing orders entered into the eMAR system by pharmacy and accepting them if the order was correct.
-The MAs should have investigated why Resident #3 had prednisone 20mg tablets remaining in the bubble pack when it was scheduled for three days.

Interview with the Administrator on 04/21/26 at 3:19pm revealed:
-The pharmacy entered orders into the eMAR system.
-The HWD, SCC or LPN were responsible to ensure the orders the pharmacy entered were accurate.
-If an order had a stop date, the pharmacy would enter the stop date.
-The HWD, SCC or LPN were responsible for ensuring medication stop dates was accurate before accepting the order entered into the eMAR system.
-He expected the MAs to investigate why Resident #3 had prednisone 20mg remaining and it was not showing on the eMAR to administer.

Attempted telephone inteview with Resident #3's Primary Care Provider on 04/21/26 at 1:18pm was unsuccessful.
3. Review of Resident #5's current FL2 dated 03/27/26 revealed diagnoses included lumbar compression fracture, weakness and hypertension.

a. Review of Resident #5's Physician order dated 03/10/26 revealed there was an order for prednisolone-moxiflox-bromfenac (to prevent

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swelling and infection after eye surgery) 5ml, instill one drop to left eye four times daily starting on 03/28/26, three days prior to surgery on 03/31/26, prednisolone-moxiflox-bromfenac 5ml, instill one drop to left eye four times daily for seven days starting on 03/31/26, prednisolone-moxiflox-bromfenac 5ml, instill one drop to left eye, three times daily for seven days, prednisolone-moxiflox-bromfenac 5ml, instill one drop to left eye, two times daily for seven days and prednisolone-moxiflox-bromfenac 5ml, instill one drop to left eye, once daily for seven days.

Review of Resident #5's March 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for prednisolone-moxiflox-bromfenac 5ml, instill one drop to left eye, four times daily at 9:00am, 12:00pm, 4:00pm and 9:00pm.
-Prednisolone-moxiflox-bromfenac 5ml, instill one drop to left eye four times daily was documented as administered from 03/28/26 through 03/31/26 at 9:00am, 12:00pm, 4:00pm and 9:00pm.

Review of Resident #5's April 2026 eMAR revealed:
-There was an entry for prednisolone-moxiflox-bromfenac 5ml, instill one drop to left eye, four times daily at 9:00am, 12:00pm, 4:00pm and 9:00pm.
-Prednisolone-moxiflox-bromfenac 5ml, instill one drop to left eye four times daily was documented as administered from 04/01/26 through 04/10/26 at 9:00am, 12:00pm, 4:00pm and 9:00pm.
-Resident #5's prednisolone-moxiflox-bromfenac 5ml, instill one drop to left eye four times daily should had been completed on 04/06/26 however he received an additional 16 doses.
-There was an entry for

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prednisolone-moxiflox-bromfenac 5ml, instill one drop to left eye, three times daily.
-Prednisolone-moxiflox-bromfenac 5ml, instill one drop to left eye three times daily was documented as administered from 04/11/26 through 04/20/26.
-Resident #5's prednisolone-moxiflox-bromfenac 5ml, instill one drop to left eye three times daily should had been completed on 04/17/26 however he received an additional 8 doses.

b. Review of Resident #5's Physician order dated 03/10/26 revealed there was an order for prednisolone-moxiflox-bromfenac 5ml, instill one drop to right eye four times daily starting on 04/04/26, three days prior to surgery on 04/07/26, prednisolone-moxiflox-bromfenac 5ml, instill one drop to right eye four times daily for seven days starting on 04/07/26, prednisolone-moxiflox-brromfenac 5ml, instill one drop to right eye, three times daily for seven days, prednisolone-moxiflox-bromfenac 5ml, instill one drop to right eye, two times daily for seven days and prednisolone-moxiflox-bromfenac 5ml, instill one drop to right eye, once daily for seven days.

Review of Resident #5's April 2026 eMAR revealed:
-There was an entry for prednisolone-moxiflox-bromfenac 5ml, instill one drop to right eye, four times daily at 9:00am, 12:00pm, 4:00pm and 9:00pm.
-Prednisolone-moxiflox-bromfenac 5ml, instill one drop to right eye four times daily was documented as administered from 04/04/26 through 04/17/26 with the dose given at 12:00pm.
-Resident #5's prednisolone-moxiflox-bromfenac 5ml, instill one drop to right eye four times daily should had been completed on 04/13/26 however he received an additional 14 doses.
-There was not an entry for

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prednisolone-moxiflox-bromfenac 5ml, instill one drop to right eye, three times daily.
-Resident #5 should have received prednisolone-moxiflox-bromfenac 5ml, instill one drop to right eye, three times daily starting on 04/14/26 through 04/20/26.
-There was an entry for prednisolone-moxiflox-bromfenac 5ml, instill one drop to right eye, two times daily at 8:00am and 8:00pm.
-Prednisolone-moxiflox-bromfenac 5ml, instill one drop to right eye two times daily was documented as administered from 04/18/26 through 04/19/26 at 8:00am and 8:00pm and on 04/20/26 at 8:00am.
-Resident #5's prednisolone-moxiflox-bromfenac 5ml, instill one drop to right eye two times daily should had been been administered starting on 04/21/26.

Interview with Resident #5 on 04/21/26 at 1:34pm revealed:
-He had been receiving his eye drops.
-He knew the eye drops were to be given four times a day for the seven days, three times a day for the seven days, two times a day for seven and then once a day for seven days.
-He wasn't sure if he had been given the correct doses.

Telephone interview with a Pharmacist with the facility's contracted pharmacy on 04/21/26 at 10:41am revealed:
-The pharmacy received an order on 03/28/26 for prednisolone-moxiflox-bromfenac 5ml, instill one drop to left eye four times daily starting on 03/28/26, three days prior to surgery on 03/31/26, prednisolone-moxiflox-bromfenac 5ml, instill one drop to left eye four times daily for seven days starting on 03/31/26, prednisolone-

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LEGACY HEIGHTS SENIOR LIVING COMMUNITY	11230 BALLANTYNE TRACE COURT CHARLOTTE, NC 28277

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moxiflox-brromfenac 5ml, instill one drop to left eye, three times daily for seven days, prednisolone-moxiflox-bromfenac 5ml, instill one drop to left eye, two times daily for seven days and prednisolone-moxiflox-bromfenac 5ml, instill one drop to left eye, once daily for seven days.
-The pharmacy received an order for prednisolone-moxiflox-bromfenac 5ml, instill one drop to right eye four times daily starting on 04/04/26, three days prior to surgery on 04/07/26, prednisolone-moxiflox-bromfenac 5ml, instill one drop to right eye four times daily for seven days starting on 04/07/26, prednisolone-moxiflox-brromfenac 5ml, instill one drop to right eye, three times daily for seven days, prednisolone-moxiflox-bromfenac 5ml, instill one drop to right eye, two times daily for seven days and prednisolone-moxiflox-bromfenac 5ml, instill one drop to right eye, once daily for seven days.
-The pharmacy enters all orders onto the facility eMAR system.
-Once orders are entered onto the eMAR, the facility must approve or decline the order.
-The pharmacy entered Resident #5's order for prednisolone-moxiflox-bromfenac 5ml incorrectly.
-The prednisolone-moxiflox-bromfenac 5ml, four times daily to Resident #5's left eye should have had a stop date on the eMAR for 4/06/26 instead of 04/10/26.
-The prednisolone-moxiflox-bromfenac 5ml, four times daily to Resident #5's right eye should have had a stop date on the eMAR for 04/13/26 instead of 04/17/26.
-The facility did approve Resident #5's orders for prednisolone-moxiflox-bromfenac.
-Resident #5's eye drops were steroidal to help reduce inflammation after his surgeries and the doses should have been appropriately tapered.

Interview with a medication aide (MA) on

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{D 358}	Continued From page 14 04/21/26 at 11:31am revealed: -She was not aware Resident #5's prednisolone-moxiflox-bromfenac orders were not entered correctly on the eMAR and had not received the eye drops as ordered. -She did not compare the order to eMAR before administering Resident #5's eye drops. -The pharmacy enters all order on to the eMAR system. -MAs did not have access to accept or decline any new orders. -She was not sure who in the facility was able to complete orders by accepting or declining. Interview with the facility Licensed Practical Nurse (LPN) on 04/20/26 at 3:42pm revealed: -She was aware that Resident #5's prednisolone-moxiflox-bromfenac orders were not entered correctly on the eMAR. -The pharmacy enters all orders on to the eMAR system and the Health and Wellness Director (HWD), Special Care Unit Coordinator (SCC) and/or the Administrator were able to accept or decline orders. -MAs did not have access to accept or decline orders. -The RCC completed eMAR audits, but she was uncertain of how often audits were completed. Interview with the Administrator on 04/21/26 at 3:19pm revealed: -He was not aware that Resident #5 prednisolone-moxiflox-bromfenac orders were not entered correctly on the eMAR and had not received the eye drops as ordered. -He expected all orders to be verified prior to the RCC or SCC accepting the order. -The RCC completed eMAR audits weekly. Attempted telephone interview with Resident #5's	{D 358}		

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{D 358}	Continued From page 15 Ophthalmologist on 04/21/26 at 9:26am was unsuccessful.	{D 358}		
D 375	10A NCAC 13F .1005 (a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure 1 of 1 sampled residents (#3) had orders to self-administer medications for a pain medication and a fish oil supplement used to lower cholesterol levels (#3). The findings are: Review of Resident #3's current FL2 dated 04/16/26 revealed diagnoses included diabetes type 2, chronic obstructive lung disease and lung cancer. a. Review of Resident #3's current FL2 dated	D 375		

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04/16/26 revealed:
-There was an order for aspirin (a medication to treat pain) 325mg, one tablet daily.
-There was no order for Resident #3 to self-administer the aspirin.

Review of Resident #3's signed nurse practitioner's (NP) orders dated 01/18/26 revealed:
-There was an order for aspirin 325mg, one tablet daily.
-There was no order for Resident #3 to self-administer the aspirin.

Review of Resident #3's NP order dated 05/21/25 revealed:
-Resident #3 self-administered over-the-counter (OTC) medications.
-The order listed the names of medications Resident #3 self-administered.
-Aspirin was not listed as a medication Resident #3 self-administered.
-Resident #3's NP signed the order dated 05/21/25.

Review of Resident #3's Self Administration of Medication Assessment dated 12/18/25 revealed:
-Resident #3 was assessed to self-administration of over-the-counter (OTC) medications and eye drops.
-The assessment was not signed by Resident #3's NP.

Review of Resident #3 March 2026 and April 2026 electronic medication administration records (eMARs) revealed:
-There was an entry for aspirin 325mg, one tablet daily.
-The entry included a note indicating aspirin 325mg, one tablet daily was not administered by

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the facility indicating the resident was self-administering the medication.

Observation of Resident #3's room on 04/21/26 at 1:33pm revealed:
-He had a bottle of aspirin 325mg on his bedside table.
-The bottle was not labeled with the resident's name and was not labeled with administration instructions for Resident #3.

Interview with Resident #3 on 04/21/26 at 1:33pm revealed he self-administered aspirin 325mg, one tablet daily.

Refer to the interview with a medication aide (MA) on 04/21/26 at 11:51am.

Refer to the interview with the facility's Licensed Practical Nurse (LPN) on 04/21/26 at 2:55pm.

Refer to the interview with the Administrator on 04/21/26 at 3:19pm.

b. Review of Resident #3's current FL2 dated 04/16/26 revealed:
-There was an order for fish oil (used to lower cholesterol levels) 1000mg, one capsule daily.
-There was no order for Resident #3 to self-administer the fish oil.

Review of Resident #3's signed nurse practitioner's (NP) orders dated 01/18/26 revealed:
-There was an order for fish oil 1000mg, one capsule daily.
-There was no order for Resident #3 to self-administer the fish oil.

Review of Resident #3's Self Administration of

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Medication Assessment dated 12/18/25 revealed:
-Resident #3 was assessed to self-administration of over-the-counter (OTC) medications and eye drops.
-The assessment was not signed by Resident #3's NP.

Review of Resident #3 March 2026 and April 2026 electronic medication administration records (eMARs) revealed:
-There was an entry for fish oil 1,000mg, one capsule daily.
-The entry included a note indicating fish oil 1000mg, one capsule daily was not administered by the facility indicating the resident was self-administering the medication.

Observation of Resident #3's room on 04/21/26 at 1:33pm revealed:
-He had a bottle of fish oil 1200mg on his bedside table.
-The bottle was not labeled with the resident's name and was not labeled with administration instructions for Resident #3.

Interview with Resident #3 on 04/21/26 at 1:33pm revealed he self-administered fish oil 1200mg, two capsules daily.

Refer to the interview with a medication aide (MA) on 04/21/26 at 11:51am.

Refer to the interview with the facility's Licensed Practical Nurse (LPN) on 04/21/26 at 2:55pm.

Refer to the interview with the Administrator on 04/21/26 at 3:19pm.

_____

Interview with a medication aide MA on 04/21/26 at 11:51am revealed:

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D 375	Continued From page 19 -Resident #3 self-administered his fish oil, aspirin and eye drops. -Resident #3's fish oil, aspirin and eye drops did not appear on his eMAR when she administered his medications. Interview with the facility's LPN on 04/21/26 at 2:55pm revealed: -The previous Health and Wellness Director (HWD) completed Resident #3's Self Administration of Medication Assessment on 12/18/25. -Resident #3's Self Administration of Medication Assessment dated 12/18/25 did not indicate by name the medications Resident #3 was safe to self-administer. -The staff member completing the Self Administration of Medication Assessment should ensure there was a self-administration order for all medications the resident was self-administering. Interview with the Administrator on 04/21/26 at 3:19pm revealed: -The staff member completing the Self Administration of Medication Assessment was responsible for ensuring the resident was self-administering his medication as ordered. -The staff member completing the Self Administration of Medication Assessment was responsible for ensuring the resident had a self-administration order for the medications that were being self-administered. Attempted telephone interview with Resident #3's NP on 04/21/26 at 1:18pm was unsuccessful.	D 375		