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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF CHARLOTTE	6000 PARK SOUTH DRIVE CHARLOTTE, NC 28210

(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 Mecklenburg County Department of Social Services conducted an annual and follow-up survey on April 28, 2026 through April 30, 2026.	D 000		
D 118	10A NCAC 13F .0311 (i) Other Requirements 10A NCAC 13F .0311 Other Requirements (i) In licensed facilities without live-in staff, there shall be an electrically operated call system meeting the following requirements: (1) the call system shall connect residents' bedrooms and bathrooms to a location accessible to staff; (2) residents' bedrooms shall have a resident call system activator at the resident's bed; (3) the resident call system activator shall be within reach of a resident lying on the bed; (4) the resident call system activator shall be such that it can be activated with a single action and remain on until deactivated by staff at point of origin; and (5) when activated, the call system shall activate an audible and visual signal in a location accessible to staff. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations and interviews, the facility failed to ensure the electrical call bell system in the Assisted Living (AL) was maintained in an operating condition and failed to provide residents with an audible sounding device.	D 118		

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D 118	Continued From page 1 The findings are: 1. Review of Resident #5's FL-2 dated 09/09/25 revealed: -Diagnoses included hypertension, atherosclerotic heart disease, hyperlipidemia, gastro-esophageal reflux disease, cirrhosis of liver, osteoporosis, depression, and anemia. -She was ambulatory. -The recommended level of care was Assisted Living (AL). Review of Resident #5's Resident Registry revealed an admission date of 01/10/24. Review of Resident #5's Care Plan dated 01/06/26 revealed: -Resident #5's memory was intact. -Resident #5 was considered a fall risk due to her balance and gait issues. -Resident #5 was considered independent with mobility and transfers. -Resident #5 required a hospital bed and an armchair to assist with mobility/transfers. -Resident #5 required a walker to assist with mobility/transfers. Review of Resident #5's Accident/Incident report dated 04/24/26 revealed: -The Resident Care Director (RCD) documented Resident #5 had an unwitnessed fall in her room. -Emergency Medical Services (EMS) were called and transported Resident #5 to a local Emergency Department (ED) for further evaluation due to left leg pain. -Resident #5's Power of Attorney (POA) notified at 7:10pm. -Resident #5 was diagnosed with a sprained left knee and returned to the facility.	D 118		

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-She was referred to her Primary Care Practitioner (PCP) for follow-up care on next rounds in the facility.

Review of Resident #5's progress note dated 04/23/26 at 8:08pm revealed Resident #5 was transported to the hospital for a fall.

Review of Resident #5's progress noted dated 04/24/26 at 2:54pm revealed:
-A Health and Wellness Nurse documented Resident #5 had a fall in her room on 04/23/26 at 5:00pm.
-There was documentation the fall resulted in a sprain to left knee.

Review of Resident #5's EMS report dated 04/23/26 revealed:
-EMS was notified at 7:29pm due to a fall: the crew was dispatched at 7:32pm.
-EMS arrived on scene at 7:47pm.
-She was transported to a local ED for evaluation.
Review of Resident #5's ED visit note dated 04/23/26 revealed:
-She arrived at the ED at 8:22pm.
-Her chief complaint was a fall and left knee pain.
-X-rays were completed on the left leg and knee.
-She was diagnosed with a left knee ligament sprain.
-She was given prescriptions for pain and to follow-up with primary care physician.
-She was discharged back to the facility on 04/23/26 at 9:44pm.

Review of Resident #5's Medication Administration Audit Report dated 04/23/26 revealed Resident #5 received her 7:00pm medications at 7:07pm.

Observation of Resident #5's room on 04/29/26 at

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D 118	Continued From page 3 10:21am revealed: -Resident #5 was approximately 80 feet around the corner and down to the end of the hall from the Case Manager and Resident Care Coordinator's (RCC) office. -There were no staff present on the hall or within close proximity. Interview with Resident #5 on 04/29/26 at 10:21am revealed: -On 04/23/26 at about 5:00pm she fell near her bed after getting tripped up with her cane. -She pressed the pendant on her lanyard two times, and after about two hours no one came so she used her cane to reach the pull cord next to her bed and still no one came. -She complained of severe pain in her left leg and knee. -Her leg felt "broken" because of how bad it hurt when she tried to move her left leg. -She could not move her leg without having pain. -When the MA brought her nighttime medications around 7:00pm, the MA found her on the floor. -The MA checked her out and she wanted to go to the emergency room because the pain was constant and so bad she thought she had "broken" her leg. -She did not know the call bell system was not working. -She was not given anything to call for help until the call bell system was fixed yesterday (04/29/26). -Staff did not check on her more frequently until yesterday (04/29/26). Telephone interview with Resident #5's responsible party on 04/29/26 at 1:40pm revealed: -She was called by staff at 7:33pm on 04/23/26 that Resident #5 had a fall and was transported to	D 118		

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the emergency room.
-She met Resident #5 in the emergency room.
-Resident #5 told her that she was never told the call bell system was not working.
-She was not notified about call bell system.
-She had not received an email before Friday (04/24/26) regarding the call bell system.

Telephone interview with a personal care aide (PCA) on 04/30/26 at 2:16pm revealed:
-On 04/23/26, the Resident Care Coordinator (RCC) informed her by text to check on the residents more frequently because the call bell system was down.
-She was assigned to Resident #5 and twelve other residents on the 2nd floor.
-She saw Resident #5 coming back from dinner around 5:30pm.
-There was no time frame to regularly check on residents, but she checked as often as possible.
-On 04/23/26, after she saw Resident #5, she handed out dinner trays, fed a resident, and provided care and services to other residents.
-She did not see Resident #5 again until she was notified that Resident #5 had fallen and was taken to the ED.
-Normally, when the call bell system was working, and a resident needed assistance, the resident would press their pendant or pull their emergency call bell cord in their bedroom or bathroom, and it would alert the phone of the PCA assigned to that resident.
-There would have been no way for her to know that the resident in room 265 fell, and she was not aware of anything given to the residents to call for help if residents fell or needed assistance.

Telephone interview with a MA on 04/29/26 at 3:08pm revealed:
-On 04/23/26, she was the MA providing

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medications to Resident #5.
-On 04/23/23 at about 7:00pm she went to Resident #5's room to administer the 7:00pm medications and found Resident #5 on the floor beside her bed complaining of left knee pain.
-She called 911.
-Resident #5 stated that she fell after returning from dinner around 5:00pm and was unable to use her pendant to call for help.
-She did not know the call bell system was not working.
-She did not receive report from the first shift MA related to the call bell systems not working.

Refer to interview with a housekeeper on 04/28/26

Refer to interview with a PCA on 04/29/26 at 4:02pm.

Refer to interview with MA on 04/29/26 at 10:40am.

Refer to interview with a Wellness Nurse on 04/30/26.

Refer to interview with the RCC on 04/60/26 at 10:24am.

Refer to interview with the RCD on 04/30/26 at 11:49am.

Refer to interview with the Administrator on 04/28/26 at 11:38am.

Refer to interview with the Administrator on 04/30/26 at 2:49pm.

2. Review of Resident #7's FL2 dated 03/28/26 revealed:

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-Diagnoses included a history of urinary tract infections.
-She was semi-ambulatory.
-The recommended level of care was AL.

Review of Resident #7's care plan dated 05/13/25 revealed:
-Resident #7 was independent with eating, bathing, dressing and grooming.
-Resident #7 required assistance with a mobility aid for transfers and toileting.
-Resident #7 required assistance with ambulation.

Observation of Resident #7's room on 04/29/26 at 10:30am revealed:
-Room 265 was approximately 160 feet around the corner, down to the end of the hall, around another corner and at the end of the hall on the left from the Case Manager and RCC office.
-There were no staff present on the hall or within close proximity.

Observation of a Resident #7 on 04/29/26 at 10:30am revealed:
-After knocking on the door, a faint sound was heard but no one answered the door.
-Upon opening the door, no one was observed in the main area of the room.
-Another faint sound came from behind the bathroom door.
-Resident #7 slightly opened the door of the bathroom and was standing in the doorway requesting help in the bathroom.

Observation of the hallway for rooms 260 to 267 on 04/29/26 from 10:35am to 10:55am revealed:
-At 10:35am, a maintenance staff member was in laundry room with the door closed, located at the top of the hallway in the first room on the right.

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-At 10:42am, a resident entered room 260.
-At 10:43am, the physical therapy staff entered their work room located at the top of the hallway and the first room on the left.
-At 10:44am, two staff members entered room 264.
-At 10:45am, the PCA entered room 261 to let the resident know the call bell system was back up and working and then she left the hall without informing the rest of the residents on the hall.

Interview with Resident #7 on 04/29/26 at 10:30am and 10:55am revealed:
-At 10:30am she was in the bathroom alone giving herself a bird bath and could not receive visitors.
-At 10:55am she explained that she was given hand bells last night, 04/28/26, to call for help.
-This morning, 04/29/26 after breakfast, she rang the hand bells for assistance with her bath, and no one came so she did a "bird bath" instead and had a hard time with it.
-About four days ago (04/25/26), on Saturday, she pressed her pendant to get assistance with getting her downstairs in her wheelchair for lunch and no one came to get her.
-Around 3:00pm, she saw someone in the hall and let them know she did not receive lunch and that staff member told her that the call bell system was not working.
-That staff member got a sandwich for her.
-She was not told about the call bell system wasn't working for a few days.
-She called her son and let him know the call bell system was not working and that she had no way to call for help.
-The call bell on her lanyard was the only way to really call for help in case she fell because she would not be able to get to the emergency pull cords in the bedroom and bathroom or even to

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the phone.
-She felt helpless and worried about needing help and no way to call for help.
-On 04/26/26, she began having diarrhea after breakfast.
-She had about five episodes of bad diarrhea and because she could not get to the bathroom fast enough, she soiled her clothes.
-There was no way to call for help because the staff said the call bell system did not work and no one checked on her, so she had to clean herself up and rinse out her soiled clothes herself.
-She slipped on the feces in the bathroom and fell up against the edge of the sink.
-She did not tell anyone because the staff did not respond to the use of her pendant all day until the MA came around 9:00pm to take off her pain patch.

Observation of Resident #7 on 04/29/26 at 11:10am revealed:
-At 11:10am, the resident pressed the pendant on her lanyard.
-The pendant lit up green.
-At 11:14am, a PCA entered the room and asked what the resident needed.
-She told the PCA that she was told the call bell system was down and did not know it was working.
-The PCA stated the call bell system was back up and running this morning.

Telephone interview with Resident #7's POA on 04/29/26 at 4:38pm revealed:
-On 04/25/26, in the morning, the resident called him and let him know that she was unable to get assistance from the staff when she pressed her pendant.
-The resident called him again around 3:00pm stating that she did not get assistance with taking

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her to lunch in her wheelchair after pressing the pendant.
-The resident now used a wheelchair and cannot propel herself on the carpet.
-She used the pendant to call for help.
-He was very concerned and anxious about the resident's safety because the pendant was the only way to call for help if she fell because there was no way for her to reach the emergency call bell cords or her telephone sitting on the table.
-No one would be able to hear the resident if she yelled for help because her room was far away from the nurse station and her door was closed all of the time.
-This had given the family member anxiety about not being able to call for help.

Refer to interview with a housekeeper on 04/28/26

Refer to interview with a PCA on 04/29/26 at 4:02pm.

Refer to interview with MA on 04/29/26 at 10:40am.

Refer to interview with a Wellness Nurse on 04/30/26.

Refer to interview with the Resident Care Coordinator (RCC) on 04/60/26 at 10:24am.

Refer to interview with the RCD on 04/30/26 at 11:49am.

Refer to interview with the Administrator on 04/28/26 at 11:38am.

Refer to interview with the Administrator on 04/30/26 at 2:49pm.

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D 118	Continued From page 10 3. Review of Resident #3's FL2 dated 10/28/25 revealed: -Diagnoses included cerebral palsy and muscle spasms. -Resident #3 was orientated. -Resident #3 was non-ambulatory. Review of Resident #3's Resident Register revealed an admission date of 10/31/21. Review of Resident #3's care plan dated 04/27/26 revealed: -Resident #3 memory and cognition was intact. -Resident #3 was at risk for falls due to cerebral palsy. -Resident #3 required assistance with bed and wheelchair mobility/transfers. -Resident #3 required one-person assistance with toileting, bathing, dressing and grooming. Interview with Resident #3 on 04/28/26 at 10:18am revealed: -The call bell system had stopped working the morning of 04/21/26. -She informed the facility that the call bell system was not working the morning of 04/21/26. -The morning of 04/24/26, she sat in the bathroom for 55 minutes, needing assistance with toileting before a housekeeper found her. -The facility did not provide her with any type of sounding device for when she needed assistance. -The facility was supposed to check on her more frequently but did not until after the bathroom incident on 04/24/26. -The call bell system started working on Saturday (04/25/26). -The call light system was still down for residents located on the second floor.	D 118		

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D 118	Continued From page 11 Interview with the Resident Wellness Nurse on 04/30/26 at 11:03am revealed: -She worked on 04/21/26 through 04/24/26. -She was notified on 04/24/26 that the call bell system was down. -She could not recall or remember if anyone had told her the call bell system was down prior to Friday (04/24/26). -There was no communication from the Administrator about staff increasing supervision until Friday (04/24/26). -The residents were not given any type of sounding devices to use if the resident's needed assistance. -Resident #3 did notify her on 04/24/26 at 10:00am of the bathroom incident that happened on the same day. -She did not know if residents were told about the call bell system being down. Interview with the Administrator on 04/29/26 at 1:55pm revealed: -She knew that Resident #3 had sat in her bathroom for 55 minutes waiting on assistance. -She did not know that the residents had not been provided with some type of sounding device. -She was told by the previous Administrator that the facility was to obtain sounding devices for the residents. -She had instructed the previous Administrator to have staff provide additional supervision of the residents. -Staff should have been rounding on the residents every 30 minutes and the residents were supposed to be provided with handheld sounding devices. Refer to interview with a housekeeper on 04/28/26	D 118		

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D 118	Continued From page 12 Refer to interview with a PCA on 04/29/26 at 4:02pm. Refer to interview with MA on 04/29/26 at 10:40am. Refer to interview with a Wellness Nurse on 04/30/26. Refer to interview with the RCC on 04/60/26 at 10:24am. Refer to interview with the RCD on 04/30/26 at 11:49am. Refer to interview with the Administrator on 04/28/26 at 11:38am. Refer to interview with the Administrator on 04/30/26 at 2:49pm. 4. Review of Resident #1's current FL2 dated 01/26/26 revealed: -Diagnoses included dementia, diabetes mellitus type 1 and urinary retention with urinary catheter. -Resident #1 was intermittently disoriented. -Resident #1 was semi-ambulatory. -Resident #1's recommended level of care was AL. Review of Resident #1 Resident Register revealed an admission date of 02/02/26. Review of Resident #1's care plan dated 04/30/26 revealed: -Resident #1's memory and cognition were moderately impaired. -Resident #1 required assistance with urinary catheter care. -Resident #1 required one-person assistance with	D 118		

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toileting, bathing, dressing and grooming.
-Resident #1 was at risk for falls due to his physical condition and had falls since his admission.

Review of Resident #1's accident/incident report dated 04/24/26 revealed:
-Resident #1 was observed laying on the floor next to his bed on 04/24/26 at 3:00am.
-Resident #1 stated he had a bad dream and fell out of bed.
-Emergency medical services (EMS) was called and Resident #1 was transported to the emergency department (ED) due to bleeding from his head.

Review of Resident #1's ED discharge summary dated 04/24/26 revealed:
-Resident #1 presented to the ED for evaluation after a fall.
-Resident #1 called out for help after the fall.
-Resident #1 called 911 himself.
-Resident #1 had a small laceration to the top of his head and spinal tenderness.
-Resident #1's laceration was repaired with tissue adhesive, and he was discharged back to the facility.

Interview with Resident #1 on 04/28/26 at 3:15pm revealed he did not remember having a fall recently.

Telephone interview with Resident #1's family member on 04/29/26 at 2:21pm revealed:
-She could not remember the date, but she received an email from the facility informing her the call light system was down for a day.
-The call light system was down at the time Resident #1 had the fall on 04/24/26 at 3:00am.
-Resident #1 had short term memory loss and

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D 118	Continued From page 14 she was glad he was cognitively aware enough at the time of the fall on 04/24/26 to call EMS for himself. Refer to interview with a housekeeper on 04/28/26 Refer to interview with a PCA on 04/29/26 at 4:02pm. Refer to interview with MA on 04/29/26 at 10:40am. Refer to interview with a Wellness Nurse on 04/30/26. Refer to interview with the RCC on 04/60/26 at 10:24am. Refer to interview with the RCD on 04/30/26 at 11:49am. Refer to interview with the Administrator on 04/28/26 at 11:38am. Refer to interview with the Administrator on 04/30/26 at 2:49pm. 5. Review of Resident #8's current FL2 dated 08/11/25 revealed: -Diagnoses included chronic obstructive pulmonary disease and acute respiratory failure with hypoxia (low blood oxygen levels). -Resident #8 was ambulatory. -Resident #8 was continent of bowel and had an indwelling urinary catheter. -Resident #8's recommended level of care was for AL. Review of Resident #8 Resident Register	D 118		

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D 118	Continued From page 15 revealed an admission date of 04/08/24. Review of Resident #8's care plan dated 03/24/26 revealed: -Resident #8's memory was intact. -Resident #8 was independent with dining/eating. -Resident #8 was at risk for falls and had fallen. -In an emergency, Resident #8 had no mobility needs and could evacuate independently. -There was no documentation indicating Resident #8's required assistance, if any, with his toileting, bathing, dressing and grooming needs. Interview with Resident #8 on 04/28/26 at 10:00am and 1:00pm revealed: -The call light system was down for three days in the past week. -He thought the call light system was down from 04/25/26 to 04/27/26. -No facility staff informed him the call light system was not working. -He had rung his call light on 04/24/26 at 11:00pm to get his water bottle filled. -The call light was not answered and he fell asleep. -He did not know how much time elapsed from him pushing his call light and falling asleep. -Staff did not check on him more frequently when the call light system was not functioning. -He found out from another resident at breakfast on 04/25/26, he thought, after his call light was not answered on 04/24/26 at about 11:00pm. -If he had known the call light system was down, he would have made his daughter aware. Refer to interview with a housekeeper on 04/28/26 Refer to interview with a PCA on 04/29/26 at 4:02pm.	D 118		

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D 118	Continued From page 16 Refer to interview with MA on 04/29/26 at 10:40am. Refer to interview with a Wellness Nurse on 04/30/26. Refer to interview with the RCC on 04/60/26 at 10:24am. Refer to interview with the RCD on 04/30/26 at 11:49am. Refer to interview with the Administrator on 04/28/26 at 11:38am. Refer to interview with the Administrator on 04/30/26 at 2:49pm. 6. Review of Resident #9's FL2 dated 03/10/26 revealed: -Diagnoses included unspecified systolic congestive heart failure, pulmonary fibrosis, abnormal weight loss, and history of falling. -She was semi-ambulatory. -She was continent of bowel and bladder. Review of Resident #9's undated care plan revealed she was independent with eating, toileting, ambulation, bathing, dressing, grooming and transfers. Review of Resident #9's Accident/Incident Report dated 04/24/26 at 10:00am revealed: -The Resident Care Director (RCD) documented Resident #9 had an unwitnessed fall in her room. -Resident #9 was bleeding from the top of her head. -Resident #9 was transported to the hospital via ambulance.	D 118		

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-Resident #9's power of attorney (POA) was notified on 04/24/26 at 10:25pm.
-Resident #9's primary care physician (PCP) was notified on 04/25/26 at 6:05am.

Review of Resident #9's ED visit note dated 04/25/26 revealed:
-Resident #9 arrived at the ED at 10:00am.
-Resident #9's chief complaint was a fall and bleeding from her head.
-Resident #9 was diagnosed with a superficial wound to her head.
-Resident #9 was released back to facility on 04/25/26.
Review of Resident #9's progress notes dated 04/25/26 revealed:
-The Health and Wellness Nurse documented Resident #9 had an unwitnessed fall in her room.
-Resident #9 had visible bleeding from the top her head.

Telephone interview with Resident #9's POA on 04/29/26 at 5:25pm revealed:
-She had a camera in her room so she could see Resident #9 on the camera.
-Resident #9 fell while getting out of the shower on 04/24/26.
-Resident #9 crawled from the bathroom to the bedroom.
-Resident #9 called her and she encouraged her to press her pendant to alert the staff.
-She did not know if she pressed her pendant and Resident #9 threw the pendant across the room.
-Resident #9 slammed her door and staff came in after that.
-She thought Resident #9 was in her room after the fall for around 30 minutes before staff came into her room.

Interview with the RCD on 04/30/26 at 11:49am

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revealed:
-She was aware of Resident #9 falling on 04/24/26 but did not know specifics about the fall.
-Resident #9 required constant reminding that she had a button to push and cords to pull when she needed assistance.
-She expected staff to check on Resident #9 every 30 minutes while the call system was not working.
-She was not aware if staff checked on Resident #9 that often.

Interview with the Administrator on 04/30/26 at 2:49pm revealed:
-She knew about Resident #9 falling on 04/24/26.
-She was not notified of any interventions that were not working.
-She expected staff to check on all residents constantly while the call system was down.

Based on observations, interviews, and record review, it was determined that Resident #9 was not interviewable.

Refer to interview with a housekeeper on 04/28/26

Refer to interview with a PCA on 04/29/26 at 4:02pm.

Refer to interview with MA on 04/29/26 at 10:40am.

Refer to interview with a Wellness Nurse on 04/30/26.

Refer to interview with the RCC on 04/60/26 at 10:24am.

Refer to interview with the RCD on 04/30/26 at

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D 118	Continued From page 19 11:49am. Refer to interview with the Administrator on 04/28/26 at 11:38am. Refer to interview with the Administrator on 04/30/26 at 2:49pm. 7. Review of Resident #2's current FL2 dated 09/30/25 revealed: -Diagnoses included other sequelae following nontraumatic subarachnoid hemorrhage (cognitive deficits, speech impairment, hemiparesis/paralysis, and mental health conditions like depression, or post-traumatic stress disorder), muscle weakness, multiple sclerosis, trigeminal neuralgia (sudden, severe, and brief episodes of stabbing, electric shock-like facial pain, typically affecting one side of the jaw, cheek, or lips), diabetes type 2, dysphagia, hypertension, hyperlipidemia, depression. -Resident #2 had an indwelling catheter. Review of Resident #2's Resident Register revealed an admission date of 10/03/25. Review of Resident #2's Care Plan dated 10/07/25 revealed: -Resident #2 required extensive assistance with toileting, ambulation, bathing, dressing, and transfers. -Resident #2 had a hoyer lift for transfers. Interview with Resident #2 on 04/29/26 at 10:18am revealed: -She did not know the call bell system was broken until yesterday (04/28/26) sometime after dinner. -Staff gave her a drum stick to hit her side table on 04/29/26. -Staff told her to bang the drumstick on the side	D 118		

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D 118	Continued From page 20 table and staff would be walking through every 30 minutes and someone would hear her. -She had not had to use the drumstick for help after it was given to her. . Observation of hallway for rooms 242-251 on 04/29/26 at 10:33am until 10:45am revealed: -The surveyor asked resident who resided in room 242 to hit her drumstick on her side table while surveyor stepped outside the room and went to end of the hallway to see if she could hear the drumstick. -The surveyor went to other end of hallway from room 242 and could hear the resident in room 242 hit the drum stick on her side table. -No staff were visible in the hallway, and no staff came to her room while she hit her drumstick between 10:33am to 10:45am. Refer to interview with a housekeeper on 04/28/26 Refer to interview with a PCA on 04/29/26 at 4:02pm. Refer to interview with MA on 04/29/26 at 10:40am. Refer to interview with a Wellness Nurse on 04/30/26. Refer to interview with the RCC on 04/60/26 at 10:24am. Refer to interview with the RCD on 04/30/26 at 11:49am. Refer to interview with the Administrator on 04/28/26 at 11:38am.	D 118		

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D 118	Continued From page 21 Refer to interview with the Administrator on 04/30/26 at 2:49pm. _____ Interview with a housekeeper on 04/28/26 at 12:07pm revealed: -She knew the call bell system had been down but was unsure of the date. -She had not seen any hand bells, whistles or any type of sounding devices in any of the residents' rooms. Interview with a PCA on 04/29/26 at 4:02pm revealed: -She worked on 04/22/26 and 04/23/26 when the call system was broken. -She heard the call bell system was broken from a 1st shift staff person when she came onto her shift. -They were told to check on residents every 30 minutes instead of every 1-2 hours like usual. -She did not remember anyone falling on her shift during the time she worked those 2 days. -She did not know if residents were alerted that the call bell system was broken or if they were given anything to alert staff they needed help. Interview with MA on 04/29/26 at 10:40am revealed: -She usually worked first shift. -She returned to work on Friday, 04/24/26 and she was told the call bell system was down. -She was instructed to check on the residents more often during her shift. -She ensured their doors were left ajar, which enabled her to better hear the residents, in the event of a resident needed something. -She parked her medication cart closer to the residents. -She did not know of any bells or whistles given to the residents.	D 118		

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D 118	Continued From page 22 -She saw a notice regarding the call bell system, placed downstairs at the concierge desk. -She did not know how the residents were informed about the call bells system not working by management. -She was doubtful staff would hear bells or whistles from some of the rooms, especially if the doors were closed. Interview with a Wellness Nurse on 04/30/26 at 11:03am revealed: -She noticed a sign at the front desk about the call system not working but was unsure what date the sign was posted. -She could not recall the date she found out the pendant system was down, but she did know by Friday (04/24/26). -She heard complaints from residents about the call system not working so she checked on one of the residents more often who had complained to her. -She did not know what measures were put into place once the call bell system was not working. -She did not know if increased supervision was put into place, but she would expect staff to initiate that. -She was "kept out of the loop" a lot of times because she was not part of the email system. -She did not know how shifts communicated with each other. -She had told a PCA to check on residents more often. -On 04/24/26, she had heard hand bells were on the way, but she never saw them arrive to the facility. -She expected hand bells or whistles to be given to residents when the call system was down. Interview with the Resident Care Coordinator RCC on 04/30/26 at 10:24am revealed:	D 118		

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D 118	Continued From page 23 -The previous Administrator asked her to add an additional PCA on 3rd shift only, starting on Thursday, 04/23/26 to round on all AL residents every 30 minutes due to the call bell system being down. -Residents were not provided with any type of sounding devices until yesterday (04/29/26). -She posted a notice about call bells not working at the concierge desk in the front lobby but did not go room to room to notify the residents who did not go downstairs to the front lobby. Interview with the RCD on 04/30/26 at 11:49am revealed: -She was aware a receiver had failed and that caused the call bell system to go down. -Parts had to be ordered for the call bell system and would not be readily available at the facility until the weekend. -Hand bells finally arrived on 04/29/26 and the system was fully operational by the time the bells arrived. -On 04/21/26, 30-minute checks were initiated. -There were drumsticks given to residents yesterday (04/29/26) to alert staff they needed help. -She thought additional checks and increased staffing were initiated. -She did not know if families were notified. -She was not told to notify anyone. Interview with the acting Administrator on 04/28/26 at 11:38am revealed: -She had been the acting Administrator starting on 04/24/26. -The previous Administrators last day was on 04/24/26. -She was notified by the previous Administrator of the call bell system not working on Tuesday, 04/21/26 at 5:58pm.	D 118		

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D 118	Continued From page 24 -She instructed the previous Administrator to have staff increase supervision of the residents and notify the residents and their responsible parties. -The previous Administrator told her the facility was purchasing hand bells and/or whistles. -She did not know the residents never received any type of sounding devices until 04/28/26. -She did not know some of the residents had not been notified that the call bell system had not been working until today 04/28/26. -She knew there were some rooms on the second floor that did not have an operating call bell system. -She expected staff to initiate what she told them to do. _____ The facility failed to ensure residents had a sounding device to alert staff for assistance. There were residents who sustained falls with injuries and hospital visits, and a resident who required assistance with toileting and transferring that was left unassisted for an extensive amount of time. The failure of the facility to ensure there was an operating call bell system in place resulted in serious harm and neglect of the residents and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/28/26. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MAY 30, 2026.	D 118		
D 259	10A NCAC 13F .0802 (a) (c) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan	D 259		

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D 259	Continued From page 25 (a) The facility shall develop and implement a care plan for each resident based on the resident's assessment completed in accordance with Rule .0801 of this Section. The care plan shall be resident-centered and include the resident's preferences related to the provision of care and services. A copy of each resident's current care plan shall be maintained in a location in the facility where it can be accessed by facility staff who are responsible for the implementation of the care plan. (c) The care plan shall include the following: (1) a description of services, supervision, tasks, and level of assistance to be provided to address the resident's needs identified in the resident's assessment in Rule .0801 of this Section; (2) frequency of the services or tasks to be performed; (3) revisions of tasks and frequency based on reassessments in accordance with Rule .0801 of this Section; (4) licensed health professional tasks required according to Rule .0903 of this Subchapter; (5) a dated signature of the assessor upon completion; and (6) a dated signature of the resident's physician or physician extender as defined in Rule .0102 of this Subchapter within 15 days of completion of the care plan certifying the resident is under this physician's care and has a medical diagnosis with associated physical or mental limitations warranting the provision of the personal care services in the above care plan in accordance with G.S. 131D-2.15. This shall not apply to residents assessed through the Medicaid State Plan Personal Care Services Assessment for the portion of the assessment covering tasks needed for each activity of daily living of this Rule for which care planning and signing are directed by	D 259		

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D 259	Continued From page 26 Medicaid. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop a complete resident care plan for 1 of 7 sampled residents (#8) and have the care plan completed and signed by the Primary Care Practioner (PCP) for 2 of 2 sampled residents (#1 and #9) within 30 days following admission to the facility. The findings are: 1. Review of Resident #1's current FL2 dated 01/26/26 revealed: -Diagnoses included dementia, diabetes mellitus type 1 and urinary retention with urinary catheter. -Resident #1 was intermittently disoriented. -Resident #1 was semi-ambulatory. Review of Resident #1 Resident Register revealed an admission date of 02/02/26. Review of Resident #1's care plan dated 04/30/26 revealed: -Resident #1 memory and cognition were moderately impaired. -Resident #1 required assistance with urinary catheter care. -Resident #1 required one-person assistance with toileting, bathing, dressing and grooming. -The care plan was signed by Resident #1' Primary Care Provider (PCP) on 04/30/26.	D 259		

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D 259	Continued From page 27 Review of Resident #1's record revealed there were no other care plans for Resident #1. Interview with the Resident Care Coordinator (RCC) on 04/30/26 at 10:01am revealed: -The facility nurses were required to complete the physical assessment part of the resident's care plan. -She was responsible to complete the resident's life and wellness portions of the care plan. -After the care plan was completed, it was her responsibility to print the care plan and have the appropriate people sign it, including the resident's PCP. -Resident #1's care plan was completed and available to staff but was not yet signed by the resident's PCP. Refer to the interview with the Administrator on 04/30/26 at 2:49pm. 2. Review of Resident #8's current FL2 dated 08/11/25 revealed: -Diagnoses included chronic obstructive pulmonary disease and acute respiratory failure with hypoxia (low blood oxygen levels). -Resident #8 was ambulatory. -Resident #8 was continent of bowel and had an indwelling urinary catheter. Review of Resident #8 Resident Register revealed an admission date of 04/08/24. Review of Resident #8's care plan dated 03/24/26 revealed: -Resident #8's memory was intact. -Resident #8 was independent with dining/eating. -Resident #8 was at risk for falls and had fallen. -In an emergency, Resident #8 had no mobility	D 259		

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needs and could evacuate independently.
-There was no documentation indicating Resident #8's required assistance, if any, with his toileting, bathing, dressing and grooming needs.

Interview with the RCC on 04/30/26 at 10:01am revealed:
-The facility nurses were required to complete the physical assessment part of the resident's care plan.
-She was not aware Resident #8's care plan did not address all care needs.

Interview with the Resident Care Director (RCD) on 04/30/26 at 11:49am revealed:
-She was responsible for completing the physical assessment for resident care plans and entering it into the electronic system.
-She was not aware Resident #8's care plan did not address all his activities of daily living (ADL) care needs.
-If Resident #8 was independent with an ADL, the care plan should indicate he was independent.

Refer to the interview with the Administrator on 04/30/26 at 2:49pm.
3. Review of Resident #9's FL2 dated 03/10/26 revealed:
-Diagnoses included unspecified systolic congestive heart failure, pulmonary fibrosis, abnormal weight loss, and history of falling.
-Resident #9 was intermittently disoriented.
-Resident #9 was semi-ambulatory.

Review of Resident #9's Resident Register revealed an admission date of 03/09/26.

Review of Resident #9's care plan dated 04/29/26 revealed:
-Resident #9's memory and cognition were intact.

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-Resident #9 was independent with toileting, bathing, dressing, and grooming.
-Resident #9's care plan was not signed by the primary care physician (PCP).

Review of Resident #9's record revealed there were no other care plans for Resident #9.

Interview with a personal care aide (PCA) on 04/29/26 at 4:02pm revealed:
-There was a care plan initiated for Resident #9 that she could refer to on their online program that all the staff had access to.
-She attempted to login to show the care plan for Resident #9, but she was unable to log in to the system now.
-The nurses knew the level of care prior to their admission, and they posted the level of care on a billboard.
-The sheets were removed from the billboard after their admission, and it was entered into the online system for staff to view.

Interview with the RCC on 04/30/26 at 10:01am revealed:
-She had been employed a little over two months.
-The initial care plan for Resident #9 was completed in the system, but the PCP did not sign it.
-She was not sure why the PCP did not sign the care plan.
-She was responsible for printing it and getting the physician to sign the care plan.
-The care plan could have gotten missed because she does not get an alert that the 30-day care plan needs to be printed and signed.

Interview with the RCD on 04/30/26 at 11:49am revealed:
-She was responsible for completing the physical

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D 259	Continued From page 30 assessment for resident care plans and entering it into the electronic system. -She was not aware Resident #9's PCP did not sign her care plan within 30 days of admission. Refer to the interview with the Administrator on 04/30/26 at 2:49pm. _____ Interview with the Administrator on 04/30/26 at 2:49pm revealed: -The RCC and the Nurse were responsible for completing care plans. -Care givers had the care plans on their tablets to refer to immediately. -The RCC should print the care plan and have the PCP sign. -She thought the RCC did not know to give it to the PCP to sign.	D 259		
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: Based on interviews and record reviews, the facility failed to ensure referral and follow-up to meet the routine healthcare needs for 2 of 5 sampled residents (#1 and # 2) related to notifying the Primary Care Practioner (PCP) of finger stick blood sugars (FSBS) below 130 (#1), and failure to implement a referral to urology (#2). The findings are: 1. Review of Resident #1's current FL2 dated	D 273		

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D 273	Continued From page 31 01/26/26 revealed diagnoses included dementia and diabetes mellitus type 1. Review of Resident #1 Resident Register revealed an admission date of 02/02/26. Review of Resident #1's facility's move in record revealed an admission date of 02/10/26. Review of Resident #1's Nurse Practitioner's (NP) orders dated 01/28/26 revealed there was an order for lispro insulin (a medication to lower blood sugar levels) inject per sliding scale (administer in addition to scheduled mealtime insulin): 201-250=2 units, 251-300=3 units, 301-350=4 units, 351-400=5 units, greater that 400 administer 6 units and notify the resident's primary care provider (PCP). Review of Resident #1's NP's order dated 02/19/26 revealed there was an order for lispro insulin) inject per sliding scale (administer in addition to scheduled mealtime insulin); 201-250=2 units, 251-300=3 units, 301-350=4 units, 351-400=5 units, greater than 400 administer 6 units and notify the resident's PCP. Review of Resident #1's February 2026 electronic medication administration record (eMAR) revealed: -There was an entry for lispro insulin inject per sliding scale with meals, scheduled at 7:30am, 11:30am and 4:30pm. -The entry was to check Resident #1's FSBS and inject lispro insulin per sliding scale FSBS: 201-250=2 units, 251-300=3 units, 301-350=4 units, 351-400=5 units, greater than 400 administer 6 units and notify the resident's PCP. -There were 6 of 55 opportunities when Resident #1's FSBS was greater than 400 and no	D 273		

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documentation his PCP was notified.
-For example, on 02/26/26 at 11:30am, Resident #1's FSBS was 504.
-There was no documentation Resident #1's PCP was notified.

Review of Resident #1 March 2026 eMAR revealed:
-There was an entry for lispro insulin inject per sliding scale with meals, scheduled at 7:30am, 11:30am and 4:30pm.
-The entry was to check Resident #1's FSBS and inject lispro insulin per sliding scale FSBS: 201-250=2 units, 251-300=3 units, 301-350=4 units, 351-400=5 units, greater than 400 administer 6 units and notify the resident's PCP.
-There were 26 of 93 opportunities when Resident #1's FSBS was greater than 400 and no documentation his PCP was notified.
-For example, on 03/23/26 at 4:30pm, Resident #1's FSBS was 592.
-There was no documentation Resident #1's PCP was notified.

Review of Resident #1 April 2026 eMAR revealed:
-There was an entry for lispro insulin inject per sliding scale with meals, scheduled at 7:30am, 11:30am and 4:30pm.
-The entry was to check Resident #1's FSBS and inject lispro insulin per sliding scale FSBS: 201-250=2 units, 251-300=3 units, 301-350=4 units, 351-400=5 units, greater than 400 administer 6 units and notify the resident's PCP.
-There were 18 of 80 opportunities when Resident #1's FSBS was greater than 400 between 04/01/26 and 04/28/26 at 11:30am and no documentation his PCP was notified.
-For example, on 04/21/26 and 04/22/26 at 4:30pm, Resident #1's FSBS was 592.

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D 273	Continued From page 33 -There was no documentation Resident #1's PCP was notified. Review of Resident #1's record revealed there was no documentation his PCP was notified when his FSBS was greater than 400 for six opportunities in February 2026, 26 opportunities in March 2026 and 18 opportunities in April 2026. Interview with Resident #1 on 04/28/26 at 3:15pm revealed he did not know when his PCP was to be notified regarding his FSBS readings. Interview with Resident #1's PCP on 04/30/26 at 8:57am revealed: -He received many notifications of Resident #1's FSBS being greater than 400. -He did not know the dates and times of the notifications. -He expected the MAs to follow the order and notify him each time Resident #1's FSBS were greater than 400. Interview with a medication aide (MA) on 04/29/26 at 2:54pm revealed: -Resident #1's PCP was to be notified if the resident's FSBS reading was greater than 400. -She usually told the Resident Care Director (RCD) if Resident #1's FSBS was greater than 400 and the RCD contacted his PCP. -She did not know when, but she had notified Resident #1's PCP of FSBS over 400 in the past. -She did not document when she notified Resident #1's PCP of FSBS over 400 because she was not instructed to. Interview with the RCD on 04/30/26 at 11:49am revealed: -The MAs were responsible to notify Resident #1's PCP for FSBS over 400.	D 273		

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-She and the Wellness Nurses could help the MAs and notify Resident #1's PCP of FSBS greater than 400 if they were in the building.
-The MAs were responsible to make notes in the eMAR system when a resident's PCP was notified of Resident #1's FSBS greater than 400.
-When she notified Resident #1's PCP of FSBS greater than 400, she made a note in Resident #1' eMAR.
-She did not remember when, but she had discussions with some MAs reminding them to make a note in the resident's record when a PCP was contacted.

Interview with a Wellness Nurse on 04/30/26 and 11:05am revealed:
-The MAs were responsible to notify Resident #1's PCP when his FSBS were greater than 400 as indicated on his order.
-The MAs were responsible to document if they contacted Resident #1's PCP.

Interview with the Administrator on 04/30/26 at 2:49pm revealed:
-She expected the MAs to follow-up with Resident #1's PCP as indicated in the order for FSBS greater than 400.
-The MA contacting the PCP was responsible to document a note in the electronic eMAR system each time the PCP was contacted.

2. Review of Resident #2's current FL2 dated 09/30/25 revealed:
-Diagnoses included other sequelae following nontraumatic subarachnoid hemorrhage (cognitive deficits, speech impairment, hemiparesis/paralysis, and mental health conditions like depression, or post-traumatic stress disorder), muscle weakness, multiple sclerosis, trigeminal neuralgia (sudden, severe,

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and brief episodes of stabbing, electric shock-like facial pain, typically affecting one side of the jaw, cheek, or lips), diabetes type 2, dysphagia, hypertension, hyperlipidemia, depression.
-Resident #2 had an indwelling catheter.

Review of Resident #2's Resident Register revealed an admission date of 10/03/25.

Review of Resident #2's Care Plan dated 10/07/25 revealed:
-Resident #2 required extensive assistance with toileting, ambulation, bathing, dressing, and transfers.
-Resident #2 had a hoyer lift for transfers.

Review of Resident #2's signed Primary Care Physician (PCP) order dated 01/22/26 revealed a referral to urology for multiple urinary tract infections (UTI's).

Review of Resident #2's signed PCP note dated 01/06/26 revealed Resident #2 was seen for an acute care follow-up visit for urine analysis results indicating a UTI.

Review of Resident #2's signed PCP note dated 02/05/26 revealed Resident #2 was seen for an acute care follow-up visit for urine analysis results indicating a UTI.

Review of Resident #2's progress note dated 02/04/26 revealed she was positive for a UTI.

Review of Resident #2's progress note dated 02/16/26 revealed a Wellness Nurse contacted a urology office for Resident #2 to be seen and they were waiting for an authorization and the office would call back for an appointment.

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D 273	Continued From page 36 Interview with Resident #2 on 04/29/26 at 10:18am revealed she thought she had been seeing a urologist but could not remember when her last visit was. Telephone interview with Resident #2's Power of Attorney (POA) on 04/30/26 at 8:35am revealed: -Resident #2 had a catheter and had multiple UTI's. -Resident #2 had not been going to see a Urologist because during her last visit, they were unable to assess her due to not being able to transfer her from her wheelchair to the exam table and the office did not have a hoyer lift. -She had not been seen since February 2026 and told the Health and Wellness Nurse about the issue but was not sure of exact date. -She had been unable to find a Urologist for Resident #2 due to being sick for about a month. -She was unaware if the facility had been making phone calls for her to be seen by a Urologist. Interview with Resident #2's PCP on 04/30/26 at 8:56am revealed: -He found out today that Resident #2 had not seen a Urologist due to not being able to be transferred to the exam table. -He expected her to be seen by a Urologist for multiple UTI's. -Resident #2 had 2 to 3 UTI's in the past 3 months. -He was not concerned about her care there but hoped to produce a plan for her to be seen by a Urologist even if someone could come to the facility to see her. -He expected staff to make appointments. Interview with the Resident Care Coordinator (RCC) on 04/30/26 at 10:01am revealed: -She thought the front desk scheduled	D 273		

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appointments for residents.
-She never scheduled any appointments.

Interview with the Wellness Nurse on 04/30/26 at 11:03am revealed:
-She had spoken to the POA yesterday and became aware that Resident #2 went to an appointment but could not be examined due to not being able to be transferred.
-She had called in February 2026 about a Urology appointment for Resident #2 and they were waiting for authorization.
-She had called urology offices yesterday but has not been able to find one that will see Resident #2.

Interview with the Resident Care Director (RCD) on 04/30/26 at 11:49am revealed:
-She was aware that Resident #2 had gone to a urology appointment and could not be assessed due to the inability to transfer her to the exam table.
-She thought the sister (POA) wanted to schedule her appointments.
-She thought staff had been helping make phone calls since February 2026 to get Resident #2 into see a Urologist.
-She expected the staff to assist in getting appointments made.

Interview with the Administrator on 04/30/26 at 2:49pm revealed:
-She had no documentation of calls made notifying the doctor or calls made for Urology appointments.
-She expected staff to notify the PCP if Resident #2 were unable to see a Urologist so they could produce a plan so she could see a Urologist.

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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: The facility failed to administer medications and treatments as ordered for 2 of 7 sampled resident (#1 & #2) related to a medication for elevated blood sugar levels (#1) and blood sugar checks and insulin (#2). The findings are: 1. Review of Resident #1's current FL2 dated 01/26/26 revealed: -Diagnoses included dementia and diabetes mellitus type 1. -Resident #1 was intermittently disoriented. Review of Resident #1 resident register revealed an admission date of 02/02/26. Review of Resident #1's facility's move in record revealed an admission date of 02/10/26. Review of Resident #1's Nurse Practitioner's (NP) orders dated 01/28/26 revealed: -There was an order for lispro insulin (a medication to lower blood sugar levels) inject 5 units daily with breakfast. -Resident #1's lispro insulin 5 units daily with	D 358		

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breakfast was to be held for finger stick blood sugars (FSBS) less than 130.

Review of Resident #1's NP's orders dated 02/19/29 revealed:
-There was an order for lispro insulin inject 5 units daily with breakfast.
-Resident #1's lispro insulin 5 units daily with breakfast was to be held for FSBS less than 130.

Review of Resident #1's February 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for lispro insulin, inject 5 units daily with breakfast, scheduled at 7:30am, and hold for FSBS less than 130.
-There were 4 of 18 opportunities lispro insulin 5 units were documented administered to Resident #1 when his FSBS was less than 130.
-On 02/14/26 at 7:30am Resident #1 FSBS was 121 and lispro insulin 5 units was documented administered to the resident.
-On 02/15/26 at 7:30am Resident #1 FSBS was 111 and lispro insulin 5 units was documented administered to the resident.
-On 02/21/26 at 7:30am Resident #1 FSBS was 110 and lispro insulin 5 units was documented administered to the resident.
-On 02/22/26 at 7:30am Resident #1 FSBS was 105 and lispro insulin 5 units was documented administered to the resident.

Observation of medications on hand for Resident #1 on 04/29/26 at 2:50pm revealed there was a lispro insulin pen labeled with the resident's name and open date available for administration.

Interview with Resident #1 on 04/28/26 at 3:15pm revealed:
-He did not know how much or how often he was

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administered insulin.
-He did not know the names of the medications staff brought to him.

Interview with a medication aide (MA) on 04/29/26 at 2:54pm revealed:
-The MAs were responsible for reading the order on the eMAR system and administering medications as ordered.
-The MAs were responsible to hold Resident #1's insulin as indicated on the order in the eMAR system.

Telephone interview with a Pharmacist with the facility's contracted pharmacy on 04/30/26 at 1:43pm revealed:
-Resident #1 had an order dated 02/09/26 for lispro insulin, 5 units with breakfast, 7 units with lunch and dinner and to hold the lispro insulin if the resident's FSBS was less than 130.
-If lispro insulin was administered when Resident #1's FSBS was less than 130, the resident could experience an even lower blood sugar level.
-Resident #1 could experience shakiness, sweating or loss of consciousness if his blood sugar level dropped too low.

Interview with Resident #1's NP on 04/30/26 at 8:57am revealed:
-He expected the MAs to administer Resident #1's insulin as ordered.
-If the MAs administered lispro insulin when the resident's FSBS was less than 130, the resident's blood sugar could drop lower.
-Resident #1 could experience lethargy (unusual lack of energy and mental alertness) and sweating if his blood sugar level was too low.

Interview with the Resident Care Director (RCD) on 04/30/26 at 11:49am revealed:

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-The MAs were responsible for accurately administering resident medications as ordered and for following parameters.
-She was not aware Resident #1 was administered lispro insulin when his FSBS was less than 130 and the lispro insulin should have been held.
-There were no formal eMAR audits performed checking the eMARs for accuracy.

Interview with a Wellness Nurse on 04/30/26 at 11:05 am revealed:
-The MAs were to administer medications as ordered and to hold Resident #1's insulin when outside of parameters.
-She was unsure if there were any eMAR audits to verify Resident #1's insulin was being administered as ordered.

Interview with the Administrator on 04/30/26 at 2:49pm revealed:
-The MAs were responsible for administering medications as ordered by the PCP.
-If an order had parameters, she expected the MAs to administer medications according to the ordered parameters.
-The nurses were responsible to review resident eMARs monthly for accuracy.

2. Review of Resident #2's current FL2 dated 09/30/25 revealed diagnoses included other sequelae following nontraumatic subarachnoid hemorrhage (cognitive deficits, speech impairment, hemiparesis/paralysis, and mental health conditions like depression, or post-traumatic stress disorder), muscle weakness, multiple sclerosis, trigeminal neuralgia (sudden, severe, and brief episodes of stabbing, electric shock-like facial pain, typically affecting one side of the jaw, cheek, or lips), diabetes type

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D 358	Continued From page 42 2, dysphagia, hypertension, hyperlipidemia, depression. Review of a signed physician's order dated 02/17/26 revealed: -There was an order for finger stick blood sugars (FSBS) to be checked after each meal and at night before bed. -There was an order for Lispro (a rapid acting synthetic insulin analog used to manage high blood sugar levels) with a sliding scale for FSBS: 0-50- no units; 151-250- 2 units; 251-300-4 units; 301-350- 6 units; 351-400-8 units; 401- 10 units; and to notify physician for reading less than 70 or greater than 401. Review of Resident #2's February, March & April 2026 electronic medication administration record (eMAR) revealed: -There was no entry to check blood sugars four times daily. -There was no entry for Lispro. -There was no documentation Resident #2 was administered Lispro or her FSBS were were checked. Interview with Resident #2 on 04/29/26 at 2:28pm revealed: -She had not had her blood sugar checked in awhile until this morning on 04/29/26. -She had not been feeling like her blood sugars were too high or too low, but she did not know what they were because staff were not checking them daily. Telephone interview with Resident #2's Power of Attorney (POA) on 04/30/26 at 8:35am revealed: -She was aware that Resident #2's blood sugars were not getting checked. -She was not sure if Resident #2 was having any	D 358		

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D 358	Continued From page 43 issues with blood sugar since they were not being checked. Telephone interview with the facility's contracted pharmacy on 04/28/26 at 4:27pm revealed: -Blood sugar checks four times a day was an an active order. -Lispro was an active order. -The pharmacy keyed in orders. -On 10/03/25, the order was changed from a medication order to pharmacy profile only and "no documentation was required undefined." -She was not sure why the order changed, but that was why it was not showing up on the eMAR. -A staff member from the facility confirmed the order. Interview with the Primary Care Physician (PCP) on 04/30/26 at 8:56am revealed: -Lispro was an active order for Resident #2. -Resident #2 also had an active order for blood sugars to be checked four times daily. -He was not sure why the order got removed from the eMAR. -He expected orders to be followed as written. -He was not concerned about her not getting her blood sugar checked if she was not exhibiting symptoms of high or low blood sugars. -He felt she was being managed well on metformin, so he was not concerned about Resident #2. Interview with a medication aide (MA) on 04/29/26 at 8:36am revealed: -She had stopped checking blood sugars on Resident #2 when the order was no longer on the eMAR. -She could not remember exactly when it was taken off the eMAR. -She had never checked with anyone about	D 358		

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medications that got removed from the eMAR.
-The Health and Wellness nurses take care of medications on the eMAR and remove medications on the eMAR.
-She had not checked Resident #9's blood sugars or given insulin since November 2025.
-She had never remembered Resident #9 ever needing insulin when she used to check her blood sugars because it was always within the normal range.

Interview with the Wellness Nurse on 04/29/26 at 9:00am revealed:
-She did not know anything about Resident #9's insulin or blood sugar checks.
-She confirmed orders from the pharmacy.
-If something were added or removed from the eMAR, she would confirm it.
-The only time she had ever heard of changing from pharmacy order to no documentation required would be for services like physical therapy (PT) or occupational therapy (OT).
-She had never heard of that happening with insulin.
-Documentation should always be required on insulin if it was an active order.
-She was not sure how that happened.

Interview with the Regional Registered Nurse on 04/28/26 at 4:15pm revealed:
-They have not had the order for blood sugar checks or insulin on the eMAR for Resident #2 because she has not had any issues with blood sugar that required any insulin.
-The staff have not been checking Resident #2's blood sugar since November 2025.
-She was not sure why the physician did not discontinue the medication.
-Active orders should be on the eMAR and staff should have been checking blood sugar.

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D 358	Continued From page 45 -She felt it was an error when it was taken off the eMAR. -She was not sure why that happened. Interview with the Resident Care Director (RCD) on 04/30/26 at 11:49am revealed: -She was not aware Resident #2 had an order for blood sugar checks and insulin administration. -She was not sure why it did not populate on the eMAR. -There was currently no one auditing active orders. -They complete physician orders every 6 months and have physicians sign them. -They had a new provider come in when it was taken off the eMAR and staff changes could have contributed to the error. Interview with the Administrator on 04/30/26 at 2:49pm revealed: -One nurse puts the orders into the system, and another nurse confirms the order. -She was not aware that orders were not being followed for Resident #2. -She expected the nurses to audit orders monthly.	D 358		