Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034118	A. BUILDING: _____ B. WING _____	R 03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITT-PLACE WINSTON SALEM	2500 POLO RIDGE COURT WINSTON SALEM, NC 27106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on March 24-26, 2026.	D 000		
D 079	10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the facility was free from hazards as evidenced by unsecured oxygen cylinders stored in a resident's room (#1). The findings are: 1. Review of Resident #1's current FL2 dated 09/15/25 revealed: -Diagnoses included vascular dementia, primary hypertension, loss of appetite, and hyperlipidemia. -She was ambulatory.	D 079	•The Executive Director, or designee will ensure oxygen in Resident #1room is removed or properly stored in a metal rack off the floor. The Executive Director, or designee, will do 100% unit audit to ensure no other oxygen is stored incorrectly. Any issues identified will be corrected immediately. •The Director of Health and Wellness will do a weekly unit audits to ensure all oxygen is stored properly. The audits will be reviewed monthly by the Executive Director. •The date of correction for this deficiency will not exceed May 1, 2026.	5/1

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D 079	Continued From page 1 -She was continent of bowel and incontinent of bladder. Review of Resident #1's Resident Register revealed she was admitted to the facility on 04/17/20. Observation of the room where Resident #1 resided during the initial tour on 03/24/26 from 10:00am to 10:15am revealed: -To the right side of the entry hallway, there were 4 oxygen cylinders (one large and 3 small) placed on the floor inside the entry the door. -The oxygen cylinders were not secured in a storage rack. -The large oxygen cylinder had a valve and gauge assembly attached to the tank outlet. Review of Resident #1's Primary Care Provider's (PCP) encounter notes dated 02/18/26 revealed an order for supplemental oxygen at 2 liters via nasal cannula as needed for shortness of breath and/or oxygen saturation below 92%. Review of Resident #1's PCP's encounter notes dated 02/20/26 revealed documentation the PCP had sent an order for Resident #1's oxygen to the durable medical equipment agency. Interview with Resident #1 on 03/24/26 at 10:05am revealed: -She only used oxygen when needed. -She did not know how long the oxygen tanks had been in her room. Interview with a medication aide (MA) on 03/26/26 at 3:10pm revealed: -Residents who were on oxygen stored their oxygen cylinders in their rooms. -The oxygen cylinders should be stored in a rack	D 079		

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D 079		D 079		
	Continued From page 2 or crate. -Oxygen cylinders should never be stored on the floor and should always be in a rack. -She was unsure why Resident #1's oxygen cylinders were on the floor and not stored in a rack. -Sometimes the oxygen providers delivered oxygen to residents' rooms and did not place the oxygen cylinders in a rack. -She informed the Resident Care Coordinator (RCC) that Resident #1 had unsecured oxygen tanks to the Resident Care Coordinator but she was not sure when. Interview with a second MA on 03/26/26 at 3:20pm revealed: -Residents with oxygen cylinders in their room should have the oxygen stored in metal cylinder racks. -There was a storage room for overstock oxygen cylinders on the third floor. -If the DME provider delivered oxygen tanks, the tanks were routinely delivered to the third-floor nursing office for storage by the facility nurse. -Occasionally the DME provider delivered oxygen tanks to a resident's room. -The tanks should be relocated to the third-floor storage room if not in use. -The facility nurse routinely coordinated the removal of excess oxygen cylinders to the third floor storage. Interview with the Director of Health and Wellness (DHW) on 03/26/26 at 3:05pm revealed: -She was the facility's nurse. -Resident #1's oxygen was to be discontinued due to the resident refusing to wear oxygen and no signs of shortness of breath. -She moved Resident #1's extra oxygen tanks to the storage on 03/25/26 until the DME agency			

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D 079	Continued From page 3 picked up the supplies. -She did not know Resident #1 had unsecured oxygen cylinders in her room until 03/24/26 when she was informed by the survey team. -Routinely, any oxygen cylinders in residents rooms should be securely stored in a metal rack to prevent the tank from easily being tipped over creating a hazard. Interview with the Administrator on 03/26/26 at 3:22pm revealed: -Residents who used oxygen stored their oxygen cylinders in their rooms. -Oxygen cylinders should never be stored on the floor, and always in a storage rack. -If there was not a rack in the resident's room for oxygen cylinders, the staff should have contacted the resident's oxygen vendor and requested a rack for storage. -The DHW was responsible to assure oxygen	D 079		
D 259	cylinders were properly stored. 10A NCAC 13F .0802 (a) (c) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (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,	D 259	The Executive Director will ensure that the care plans for Resident #1, #3, #4, and #5 will be signed by the PCP •The Director of Health and Wellness will do a 100% audit of care plans to ensure they have PCP signatures in place along with all resident orders (medication/parameters)and LHPS's are all completed within a 30 day time frame or within the compliance timeframe.•	5/1

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D 259	Continued From page 4 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 Medicaid. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure that 4 of 5 sampled residents (#1, #3, #4, and #5) had a care plan completed within 30 days of admission and at	D 259	The Executive Director will review the monthly audit. •The date of correction for this deficiency will not exceed May 1, 2026.	

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D 259	Continued From page 5 least annually thereafter, including assuring the Primary Care Provider approved and signed care plan. The findings are: 1. Review of Resident #1's current FL2 dated 09/15/25 revealed: -Diagnoses included vascular dementia, primary hypertension, loss of appetite, and hyperlipidemia. -She was ambulatory. -She was continent of bowel and incontinent of bladder. Review of Resident #1's signed care plan dated 04/18/24 revealed: -Resident #1 required supervision with eating, toileting, ambulation, grooming and transfers activities of daily living (ADLs). -Resident #1 required limited assistance with bathing and dressing ADLs. Review of Resident #1's facility assessment and care plan dated 06/08/25 revealed: -The resident was assessed for assistance in ADLs of bathing, grooming, dressing, toileting, eating (nutrition), ambulation, and mobility and transfers. -The care plan was not signed by the PCP. -There was no subsequent care plan available for review. Based on observations, interviews and record review, it was determined Resident #1 was not interviewable. Refer to the interview with the Resident Care Coordinator (RCC) on 03/26/26 at 2:00pm.	D 259		

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D 259	Continued From page 6 Refer to the interview with the Director of Health Services (DHS) on 03/26/26 at 2:44pm. Refer to the interview with the Administrator on 03/26/26 at 3:15pm. 2. Review of Resident #4's current FL2 dated 09/15/25 revealed: -Diagnoses included venous thrombosis, hyperlipidemia, transit ischemic, muscle weakness, diabetes type 2, polyneuropathy, pulmonary embolism, fracture of the spine and neck pain. -Resident #4 was semi-ambulatory. -Resident #4 used a wheelchair to assist with ambulation. -Resident #4 was continent of the bowel and bladder. Review of Resident #4's care plan dated 11/05/25 revealed: -Resident #4's care plan was not approved or signed by the Primary Care Provider (PCP). -Resident #4 required extensive assistance with bathing and dressing. -Resident #4 required supervision with ambulation, grooming and transfers. -There was no subsequent care plan available for review. Refer to the interview with the Resident Care Coordinator (RCC) on 03/26/26 at 2:00pm. Refer to the interview with the Director of Health Services (DHS) on 03/26/26 at 2:44pm. Refer to the interview with the Administrator on 03/26/26 at 3:15pm. 3. Review of Resident #5's current FL2 dated	D 259		

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D 259	Continued From page 7 09/13/25 revealed: -Diagnoses included hypertension, Alzheimer's disease, osteoarthritis, anxiety, gout and vitamin D deficiency. -Resident #5 was semi-ambulatory. -Resident #5 used a wheelchair to assist with ambulation. -Resident #5 was constantly disoriented. -Resident #5 was incontinent of the bowel and bladder. Review of Resident #5's signed care plan dated 01/23/24 revealed: -Resident #1 required supervision with transferring -Resident #1 required limited assistance with bathing. Refer to the interview with the Resident Care Coordinator (RCC) on 03/26/26 at 2:00pm. Refer to the interview with the Director of Health Services (DHS) on 03/26/26 at 2:44pm. Refer to the interview with the Administrator on 03/26/26 at 3:15pm. 4. Review of Resident #2's current FL-2 dated 09/17/25 revealed diagnoses included muscle weakness, venous insufficiency, acute kidney failure, hypertension. Review of Resident #2's Resident Register revealed an admission date of 10/01/25. Review of Resident #2's care plan dated 10/02/25 revealed: -Resident #3 needed supervision from staff with eating, toileting, ambulation, bathing, grooming, and transferring. -Resident #3 needed limited assistance from staff	D 259		

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D 259	Continued From page 8 with bathing and dressing. -The care plan was not signed by the Primary Care Provider (PCP). 5. Review of Resident #3's current FL2 dated 03/26/25 revealed: -Diagnoses included asthma, osteoporosis, chronic kidney disease, hypothyroidism. - The resident was ambulatory. Review of Resident #3's Resident Register revealed an admission date of 02/29/24. Review of Resident #3's care plan dated 10/02/25 revealed: -Resident #3 needed supervision from staff with eating, toileting, ambulation, bathing, grooming, and transferring. -Resident #3 needed limited assistance from staff with bathing and dressing. -The care plan was not signed by the Primary Care Provider (PCP). Refer to the interview with the Resident Care Coordinator (RCC) on 03/26/26 at 2:00pm. Refer to the interview with the Director of Health Services (DHS) on 03/26/26 at 2:44pm. Refer to the interview with the Administrator on 03/26/26 at 3:15pm. Interview with the Resident Care Coordinator (RCC) on 03/26/26 at 2:00pm revealed: -She was aware the care plans had not been signed by the PCP. -She had not been assigned any care plan responsibilities. -It was the responsibility of the Director of Health and Wellness (DHW) to ensure the care plan was	D 259		

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D 259	Continued From page 9 signed by the PCP. Interview with the Director of Health Services (DHS) on 03/26/26 at 2:44pm revealed: -It was her responsibility to ensure the care plans were completed. -She did not realize the care plan needed to be signed by the PCP. Interview with the Administrator on 03/26/26 at 3:15pm revealed. -She was not aware the care plans were not signed by the PCP. -She expected the care plan to be completed and signed by the PCP.	D 259		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to implement orders from the primary care provider (PCP) for 1 of 5 sampled residents (#2) who had an order for daily blood pressure and pulse checks. The findings are:	D 276	•The Director of Health and Wellness will ensure Resident #2 order will be updated to include parameters •The Director of Health and Wellness will review all resident orders for accuracy and correct any errors identified and submit the changes to the pharmacy. •The Director of Health and Wellness will complete daily audits to review and confirm all new orders. The audits will be reviewed weekly by the Executive Director. •The date of correction for this deficiency will not exceed May 1, 2026.	5/1

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D 276	Continued From page 10 Review of Resident #2's current FL2 dated 09/17/25 revealed diagnoses included hypertension, muscle weakness, venous insufficiency, and acute kidney failure. Review of Resident #2's signed physician orders dated 12/03/25 revealed: -There was an order for metoprolol (a medication used to treat high blood pressure) 25mg give once daily; hold metoprolol if the systolic blood pressure (SBP) was less than 110 or the pulse was less than 55 beats per minute (BPM). Review of Resident #2's January 2026, February 2026, and March 2026 from 03/01/26 through 03/24/26 electronic medication administration records (eMARs) revealed: -There was an entry for metoprolol 25mg give once daily; hold metoprolol if the SBP was less than 110 or the pulse was less than 55 BPM. -There was no documentation that Resident #2's SBP and pulse were checked prior to administering the metoprolol. Review of Resident #2's Vital Signs Log from 10/06/25 - 03/25/26 revealed there was no documentation Resident #2's SBP and pulse were checked from January 2026-March 25th, 2026. Interview with a representative from the facility's contracted pharmacy on 03/25/26 at 9:09am revealed: -The pharmacy entered all new orders for the facility into a pending state on the eMAR. -The facility then needed to review the orders to ensure they were accurate prior to approving. -After the facility approved the order, it would then be displayed on the eMAR for administration. -They did not enter any parameters associated	D 276		

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D 276	Continued From page 11 with new orders. -The facility was responsible for entering the parameters into the eMAR. Interview with Resident #2 on 03/26/26 at 11:20am revealed: -The staff did not check her SBP or pulse every day. -She did not complain of dizziness. Interview with a medication aide (MA) on 03/26/26 at 10:57am revealed: -She did not take Resident #2's SBP or pulse before administering the metoprolol. -She did not notice that the order included parameters to hold the metoprolol if Resident #2's SBP was less than 110 or pulse less than 55 BPM. -Resident #2 did not complain to her of dizziness after being administered the metoprolol. Interview with a second MA on 03/26/26 at 11:05am revealed: -She tried to take Resident #2's SBP and pulse prior to administering the metoprolol but the resident would refuse. -She did not document the refusal because she did not know where to document it. -She did not notify management or the PCP regarding Resident #2 refusing for her to check her SBP and pulse. -Resident #2 did not complain of dizziness to her. Interview with the Resident Care Coordinator (RCC) on 03/26/26 at 2:00pm revealed: -The pharmacy staff entered orders into the eMAR system in a pending state awaiting approval. -She was not aware there was an order to hold Resident #2's metoprolol if her SBP was less than	D 276		

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D 276	Continued From page 12 110 or pulse less than 55 BPM. -She was not responsible for looking at orders. -She was responsible for printing the orders and ensuring they were filed in the resident's record. -The Director of Health Services (DHS) was responsible for reviewing the orders to ensure they were accurate on the eMAR. Interview with the DHS on 03/26/26 at 2:44pm revealed: -The pharmacy entered all new orders into the eMAR for them to be approved prior to administration. -She was not aware Resident #2 had an order to hold the metoprolol if her SBP was less than 110 or pulse less than 55 BPM. -She would be responsible for implementing new orders. -She was responsible for reviewing the orders and then approving them in the eMAR if they were accurate. -She was not reviewing the new orders prior to approving them in the eMAR. -She did not audit orders with parameters to ensure they were being completed. Interview with Resident #2's PCP on 03/26/26 at 3:27pm revealed: -The SBP and pulse should be taken prior to administering the metoprolol because if Resident #2's SBP and pulse were already too low the metoprolol would drop it even lower resulting in possible falls. -She expected the MA's to follow the order as written. Interview with the Administrator on 03/26/26 at 3:45pm. -It was the DHS's responsibility to review and implement the orders to be entered onto the	D 276		

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D 276	Continued From page 13 eMAR. -She expected the DHS to review the orders for accuracy prior to approving them.	D 276		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure quarterly Licensed Professional Health Support evaluations (LHPS) were completed by an LHPS nurse for 3	D 280	•The Executive Director, or designee will ensure a Licensed Health Professional Support (LHPS) evaluation is completed on Resident #1, #4, and #5. •The Executive Director, or designee will complete a 100% audit on all residents to ensure they have an LHPS evaluation. Any LHPS evaluations that are identified as missing will be completed. •The Executive Director will do a monthly audit to ensure all residents have an LHPS evaluation. The audit will review all new admissions to ensure they are completed in the 30-day time frame. •The date of correction for this deficiency will not exceed May 1, 2026.	5/1

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PRUITT-PLACE WINSTON SALEM	2500 POLO RIDGE COURT WINSTON SALEM, NC 27106

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D 280	Continued From page 14 of 5 sampled residents (#1, #4, #5) related to evaluating tasks including ambulation using a wheelchair, oxygen, and physical/occupational therapy (#1), obtaining finger stick blood sugar (FSBS) and anti-thrombotic (TED) hose (#4), and obtaining FSBS (#5). The findings are: 1. Review of Resident #1's current FL2 dated 09/15/25 revealed: -Diagnoses included vascular dementia, primary hypertension, loss of appetite, and hyperlipidemia. -She was ambulatory. -She was continent of bowel and incontinent of bladder. Review of Resident #1's Resident Register revealed she was admitted to the facility on 04/17/20. Observation of Resident #1 during the initial facility tour on 03/24/26 at 10:00am revealed: -Resident #1 was seated on her bed with a wheel chair close to the bed. -Resident #1 had 4 oxygen storage tanks in the entrance foyer of her room. Review of Resident #1's provider's notes revealed Resident #1 had physical therapy and occupational therapy notes documenting encounters from 02/02/26 to 03/24/26. Review of Resident #1's LHPS evaluations revealed there were no quarterly LHPS evaluations available for review. Review of Resident #1's primary care provider's (PCP) encounter notes dated 02/18/26 revealed	D 280		

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D 280	Continued From page 15 an order for supplemental oxygen at 2 liters via nasal cannula as needed for shortness of breath and/or oxygen saturation below 92%. Interview with the contracted Physical Therapy Coordinator (PTC) on 03/26/26 at 11:30am revealed Resident #1 was currently seen by physical therapy 3 to 4 times a week for strengthening and gait therapy. Based on observations, interviews and record review, it was determined Resident #1 was not interviewable. Refer to the interview with the Director of Health Services (DHS) on 03/25/26 at 10:00am. Refer to the interview with the Resident Care Coordinator (RCC) on 03/26/26 at 2:00pm. Refer to the interview with the Administrator on 03/26/26 at 4:00pm. 2. Review of Resident #4's current FL2 dated 09/15/25 revealed: -Diagnoses included venous thrombosis, hyperlipidemia, transit ischemic, muscle weakness, diabetes type 2, polyneuropathy, pulmonary embolism, fracture of the spine and neck pain. -He was semi-ambulatory. -He was continent of the bowel and bladder. -There was an order for FSBS three times a day. -There was an order to apply anti-thrombotic (TED) hose in the morning and remove in the evening. Review of Resident #4's Resident Register revealed he was admitted to the facility on 09/12/24.	D 280		

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D 280	Continued From page 16 Review of Resident #4's record revealed there were no quarterly LHPS evaluations available for review. Review of Resident #4's January 2026 eMAR revealed: -There was an entry on the eMAR to check FSBS three times a day. -There were FSBS values documented on the eMAR from 01/01/26 through 01/31/26. -There was an entry on the eMAR to apply ted hose in the morning and remove in the evening -There was documentation on the eMAR from 01/01/26 through 01/31/26 that TED hose were applied and removed. Review of Resident #4's February 2026 eMAR revealed: -There was an entry on the eMAR to check FSBS three times a day. -There were FSBS values documented on the eMAR from 02/01/26 through 02/28/26. -There was an entry on the eMAR to apply ted hose in the morning and remove in the evening - There was documentation on the eMAR from 02/01/26 through 02/28/26 that ted hose were applied and removed. Review of Resident #4's March 2026 eMAR revealed: -There was an entry on the eMAR to check FSBS three times a day. -There were FSBS values documented on the eMAR from 03/01/26 through 03/31/26. -There was an entry on the eMAR to apply ted hose in the morning and remove in the evening - There was documentation on the eMAR from 03/01/26 through 03/31/26 that ted hose were applied and removed.	D 280		

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D 280	Continued From page 17 Refer to the interview with the Director of Health Services (DHS) on 03/25/26 at 10:00am. Refer to the interview with the Resident Care Coordinator (RCC) on 03/26/26 at 2:00pm. Refer to the interview with the Administrator on 03/26/26 at 4:00pm. 3. Review of Resident #5's current FL2 dated 09/13/25 revealed: -Diagnoses included hypertension, Alzheimer's disease, osteoarthritis, anxiety, gout and vitamin D deficiency. -He was semi-ambulatory. -He was constantly disoriented. -He was incontinent of the bowel and bladder. -There was an order for FSBS one time a day. Review of Resident #5's Resident Register revealed he was admitted to the facility on 01/31/23. Review of Resident #5's record revealed there were no quarterly LHPS evaluations available for review. Review of Resident #5's January 2026 eMAR revealed: -There was an entry on the eMAR to check FSBS three times a day. -There were FSBS values documented on the eMAR from 01/01/26 through 01/31/26. Review of Resident #5's February 2026 eMAR revealed: -There was an entry on the eMAR to check FSBS three times a day. -There were FSBS values documented on the	D 280		

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D 280	Continued From page 18 eMAR from 02/01/26 through 02/28/26. Review of Resident #5's March 2026 eMAR revealed: -There was an entry on the eMAR to check FSBS three times a day. -There were FSBS values documented on the eMAR from 03/01/26 through 03/31/26. Refer to the interview with the Director of Health Services (DHS) on 03/25/26 at 10:00am. Refer to the interview with the Resident Care Coordinator (RCC) on 03/26/26 at 2:00pm. Refer to the interview with the Administrator on 03/26/26 at 4:00pm. _____ Interview with the Director of Health Services (DHS) on 03/25/26 at 10:00am revealed: -She was responsible for ensuring resident LHPS reviews were completed quarterly. -She was aware some residents did not have a quarterly LHPS. -She was responsible for chart audits to ensure LHPS reviews were completed and signed. -She had been in the -She had not been completing LHPS reviews until March of 2026. Interview with the Resident Care Coordinator (RCC) on 03/26/26 at 2:00pm revealed: -She did not complete residents' LHPS evaluations. -The DHS was responsible for completing the LHPS. Interview with the Administrator on 03/26/26 at 4:00pm revealed: -She was not aware the LHPS were not	D 280		

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D 280	Continued From page 19 completed. -It was the responsibility of the DHS to complete the LHPS. -She expected the LHPS to be completed quarterly.	D 280		

D 299	10A NCAC 13F .0904(d)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall be based on the U.S. Department of Agriculture Dietary guidelines for Americans 2020-2025, which are hereby incorporated by reference including subsequent amendments and editions. These guidelines can be found at https://dietaryguidelines.gov/sites/default/files/202 1-03/Dietary_Guidelines_for_Americans-2020-2025.pdf for no cost. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that 8 ounces of milk or other equivalent dairy products were served three times daily to 22 residents in the Special Care Unit (SCU). The findings are: Review of the facility's daily menu for 03/24/26 revealed 8 ounces of 2 percent milk or equivalent dairy products listed on the menu to be served on 03/24/26.	D 299	• All residents in the Special Care Unit meals will include 8 ounces of dairy three times a day. All residents will be offered and served milk or approved alternative per dietary guidelines at every meal in the Special Care Unit. • 100% of trays on the Special Care Unit will be audited daily to ensure 8 ounces of dairy are present. Any issues identified will be corrected immediately. • The Executive Director will do a monthly audit to ensure all meals on the Special Care Unit are served with eight ounces of dairy. • All dietary staff will be educated on the requirement to serve dairy or an approved alternative at each meal. • The date of correction for this deficiency will not exceed May 1, 2026.	5/1

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D 299	Continued From page 20 Observation of the kitchen on 03/24/26 at 9:20am revealed 6 gallons of 2 percent in the refrigerator. Observation of the lunch meal service on 03/24/26 between 12:00pm and 12:30pm revealed: -There were 22 residents present in the dining room. -There were 22 place settings prepared for residents with 2 cups at each place setting pre-filled with water and juice. -There were 22 residents who were not served milk and there were no other dairy products served to the residents. Interview with a resident on 03/24/26 at 12:35pm revealed: -She did not like milk, so the staff knew not to give it to her. -They did not serve milk with all the meals. Interview with a medication aid (MA) on 03/24/26 at 12:40pm revealed: -She was aware milk should be served to all residents three times a day. -The facility always served milk three times a day until the new owners took over last summer. -She asked the administrator about serving milk three times a day and was told to only serve milk at breakfast and dinner. Interview with a kitchen staff member on 03/25/26 at 4:00pm revealed: -She was aware residents in the SCU should be served milk three times a day. -She was not aware residents were not offered milk during the lunch meal on 03/24/26. -She does not send milk to the SCU because it is kept in a refrigerator in their unit to be used as needed.	D 299		

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D 299	Continued From page 21 Interview with the Special Care Unit Coordinator (SCUC) on 03/25/26 at 4:15pm revealed: -She was not aware residents in the SCU should be served milk three times a day. -She thought staff only had to serve milk to the residents twice a day during the breakfast and dinner meal service. Interview with the Administrator on 03/25/26 at 4:25pm revealed: -She was not aware milk should be served during each meal service three times a day. -She thought milk only had to be served with two meals each day. -Her expectation would be to serve milk to all residents in the SCU three times a day.	D 299		
D 306	10A NCAC 13F .0904(d)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (4) Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure water was served at each meal for 27 of 32 assisted living (AL) residents in addition to other beverages.	D 306	All meals in the Assisted living will include 8 ounces of water three times a day. All residents will be offered and served water. •100% of trays in Assisted Living will be audited daily to ensure 8 ounces of water are present. Any issues identified will be corrected immediately. •The Executive Director will do a monthly audit to ensure all meals in the Assisted Living are served with eight ounces of water. •Al dietary staff will be educated on the requirement to serve water at each meal. •The date of correction for this deficiency will not exceed May 1, 2026.	

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D 306	Continued From page 22 The findings are: Observation of the lunch meal service for the AL dining room on 03/24/26 between 12:00pm and 12:25pm revealed: -There were 32 residents present for the lunch service. -Beverages available included milk, tea, lemonade, and water. -The beverages were served by the dietary staff. -Five residents were served water in addition to the other beverages. -No other residents were served water. Interview with a resident on 03/24/26 at 4:00pm revealed: -Water was not served to every resident with every meal. -The staff would give her water if she requested it. -She had never requested water from the staff. -She might drink the water if it was placed on the table. Attempted interview with the Kitchen Manager (KM) on 03/25/26 at 8:30am revealed he was out on medical leave. Interview with a kitchen staff member on 03/25/26 at 3:00pm revealed: -She was aware water was supposed to be served to all residents at each meal service. -She was not aware that only five out of 32 residents were served water during the lunch meal service. -The staff should serve water to all residents at each meal three times a day. Interview with the Director of Health Services (DHS) on 03/25/26 at 3:10pm revealed:	D 306		

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D 306	Continued From page 23 -She was not aware water should be served to residents on the AL side three times a day. -She thought water only had to be offered to residents on the AL unit and served to residents in the Special Care Unit (SCU). Interview with the Resident Care Coordinator (RCC) on 03/25/26 at 4:10pm revealed: -She was aware all residents on the AL unit and SCU side were supposed to be served water with each meal service. -She was not aware all residents on the AL unit were not served water during the lunch meal service. -She would expect staff to serve all residents water three times a day during each meal service. Interview with the Administrator on 07/30/25 at 4:20pm revealed: -She was aware water should be served three times a day to all residents in the facility with each meal. -She was not aware that only five out of 32 residents on the AL unit were served water during	D 306		

D 310	the lunch meal service. -She would expect the kitchen staff to serve water to all residents during every meal service. 10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.	D 310	• Resident #8 diet order will be reviewed for accuracy and diet board will be updated. •100% of residents have been reviewed against their diet orders to diet board. A weekly audit will be conducted to verify all new dietary orders to diet board. Any issues identified will be corrected immediately.	

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D 310	Continued From page 24	D 310		

	This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to serve therapeutic diets as ordered by the provider for 1 of 6 sampled residents (#8) with therapeutic diet order for a mechanical soft (MS) diet. The findings are: Review of Resident #8's current FL2 dated 01/09/26 revealed a diagnosis of cholecystectomy, hypertension, hyperlipidemia, and non-traumatic intracerebral hemorrhage and benign prostate hyperplasia. Review of Resident #8's diet order form dated 01/12/26 revealed an order for a MS diet. Review of the therapeutic diet list revealed Resident #8 was to be served a MS diet. Observation of the Resident #8's lunch meal service on 03/24/26 between 12:00pm and 12:48pm revealed: -Resident was served a regular diet menu of shrimp scampi, rice pilaf, squash, a roll and Jello. -Resident ate 100 percent of the shrimp scampi, rice pilaf and Jello with no difficulty. -Resident ate 50 percent of the roll and drank 100 percent of beverage with no difficulty. Review of the MS menu for the lunch meal service on 03/24/26 revealed Resident #8 was to be served a ground shrimp and noodles, squash, a roll and Jello. Observation of Resident #8's lunch meal service on 03/25/26 between 12:00pm and 12:45pm revealed: -Resident was served a regular diet menu of		The Executive Director will review the audits monthly to ensure all tray cards match current diet orders. •The date of correction for this deficiency will not exceed May 1, 2026.	5/1

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D 310	Continued From page 25 Italian meatballs, rice, green beans and cake. - Resident #8 ate 100 percent of his meatballs, rice, green beans and cake and drank 75 percent of his beverages without difficulty. Review of the MS menu for the lunch meal service on 03/25/26 revealed Resident #8 was to be served ground meatballs with sauce, rice, green beans and cake. Review of Resident # 8's progress note dated 01/03/26 revealed: -Resident was evaluated by speech therapy for a diet texture analysis and swallowing safety. - Resident was given a trail chopped diet of chopped ham to assess him for a potential diet upgrade. -Resident consumed the textured meat with no signs of aspiration noted. -Resident was educated on swallowing strategies of alternating small bites with sips of beverages and verbalized and demonstrated understanding. -The plan was to continue the MS diet until the next analysis. -There were no follow-up notes available. Interview with Resident # 8 on 03/25/26 at 2:00pm revealed: -He thought he was on a regular diet. -He knew how to cut up his food into small pieces and eat it. -He is 90 years old and should be able to eat what he likes. -He did not like the flavor of ground meats. -He would ask his doctor to change his diet order during his upcoming appointment later this month. Interview with a kitchen staff member on 03/25/26 at 3:00pm revealed:	D 310		

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D 310	Continued From page 26 -She was aware Resident #8 was on a MS diet, and his meat should be ground. -She was not aware he was served a regular diet for lunch meal service on 03/24/26 and 03/25/26. -She only worked during the dinner service and on the weekends. Interview with the Director of Health Services (DHS) on 03/25/26 at 3:15pm revealed: -She was not aware Resident # 8 was served a regular diet instead of a MS diet. -It is her responsibility to ensure the kitchen gets any new diet orders. -She expected all diets to be served as ordered. Interview with the Primary Care Provider (PCP) on 03/26/26 at 3:00pm revealed: -She was aware Resident #8 was on a MS diet and had a swallowing analysis. -She expected Resident # 8 to remain on a MS diet until she could reevaluate him to see if he could tolerate a chopped or regular diet. -She expected Resident #8's diet to be served as order until he is reevaluated. Interview with the Administrator on 03/26/26 at 4:00pm revealed: -She was not aware Resident #8 was served a regular diet instead of his MS diet order for the lunch meal service on 03/24/26 and 03/25/26. -She would expect all meals to be served as ordered for all residents three times a day.	D 310		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications,	D 358		

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	HAL034118	A. BUILDING: _____ B. WING _____	R 03/26/2026

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D 358	Continued From page 27 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 ensure medications were administered as ordered and in accordance with policies and procedures for 2 of 5 residents (#9, and #10) observed during the medication pass including errors with medications for pain (#9) and gout prevention (#10); and for 1 of 5 residents (#3) sampled for record review related to administering a blood pressure medication with administration parameters. The findings are: 1. The medication error rate was 5% as evidenced by 2 errors out of 39 opportunities during the 8:00am medication pass on 03/25/26. a. Review of Resident #10's current FL2 dated 02/18/26 revealed: -Diagnoses included coronary artery disease, obstructive sleep apnea, arthritis of the lumbar spine, and hypertension. -There was an order for allopurinol 100mg daily on the second page of the FL2. (Allopurinol is used to prevent gout attacks). Observation of the 8:00am medication pass on 03/25/26 revealed: -At 7:55am, the medication aide (MA) consulted the electronic medication administration record (eMAR) display to prepare 9 oral medications and one nasal spray for Resident #10.	D 358	•The Director of Health and Wellness will review all resident orders for accuracy and correct any errors identified and submit the changes to the pharmacy. •The Director of Health and Wellness will complete daily audits to review and confirm all new orders. The audits will be reviewed weekly by the Executive Director. •The date of correction for this deficiency will not exceed May 1, 2026.	5/1

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D 358	Continued From page 28 -Allopurinol 100mg tablet was not included in the medications prepared for Resident #10. -The MA administered the medications to Resident #10 at the third-floor medication cart and documented administration on the electronic medication administration record (eMAR). Review of Resident #10's March 2026 eMAR revealed: -There was no entry for allopurinol 100mg daily scheduled on the eMAR. -Allopurinol 100mg was not documented as administered on 03/25/26 at 8:00am. Observation of Resident #10's medications on hand on 03/25/26 at 7:55am revealed: -Resident #10's medications were pre-packaged by the contracted pharmacy weekly in continuous medication strips with each medication sealed in an individual package. -The resident's medications were packaged by day of the week and date on a continuous strip with each day's medication continuing into the next day's medication. -Allopurinol 100mg was not included in medications scheduled at 8:00am or any other scheduled time for administration on 03/25/26. Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/26/26 at 9:00am revealed: -The facility was responsible for sending all medications orders to the pharmacy. -The contracted pharmacy did not generate the facility's eMARs. -The contracted pharmacy had documentation for receipt of one page of the FL2 dated 02/18/26. If there was a page 2 of the FL2, the pharmacy had not record of receipt of a page 2 for a FL2 dated 02/18/26.	D 358		

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D 358	Continued From page 29 -There was no additional documentation of the Resident #10's allopurinol 100mg order dated 02/18/26. Interview with the Director of Health Services (DHS) on 03/26/26 at 10:40am revealed: -She was responsible for oversight of the MAs on a daily basis. -She or her assistant DHS were responsible for entering orders onto the eMAR and discontinuing order medications on the eMAR. -Medications that were scheduled for administration once daily were routinely entered on the eMAR and scheduled for administration at 8:00am daily unless the physician's order specified another time. -The contracted pharmacy dispensed medications according to the physician's orders the pharmacy had on file. -MAs could fax FL2 and any other medication orders to the contracted pharmacy. -The second page of Resident #10's FL2 with the order for allopurinol 100mg should have been faxed to the pharmacy along with page one of the FL2. -She did not know why the second page of Resident #2's FL2 was not received by the contracted pharmacy, or allopurinol 100mg overlooked for entry on the eMAR. -Allopurinol 100mg would have been scheduled for administration at 8:00am for Resident #10. -She did not currently have a system in place to routinely audit residents' physician orders compared to the current orders on the eMAR. Interview with the third-floor MA on 03/26/26 at 1:45pm revealed: -She administered medications according to the computer eMAR screen. -She did not enter orders into the eMAR system.	D 358		

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D 358	Continued From page 30 -The contracted pharmacy prepacked medication for residents one week at a time with individual medications labeled for the day and time of administration. -She checked the medications available for administration and the eMAR to match when preparing medications for administration. -Medication orders were entered into the eMAR system by the DHS. -If a medication was not on the eMAR or included in the pre-packaged medications, she would not have known to administer the medication. -She had not administered Resident #10's allopurinol at 7:55am on 03/25/26. Interview with Resident #10 on 03/26/26 at 1:50pm revealed: -He used to take allopurinol for prevention of gout. -He received a lot of medications in the morning and did not know all his medications. -He did not know if allopurinol 100mg had been discontinued. -He had been avoiding the foods and beverages that used to cause gout flare-ups. -He had not had a flare-up of gout in several months. Interview with Resident #10's Primary Care Provider (PCP) on 03/26/26 at 3:32pm revealed: -She had reviewed Resident #10's medications since his admission in February 2026. -She had not discontinued allopurinol 100mg for Resident #10. -If Resident #10 did not receive allopurinol 100mg for got prevention, he could experience a gouty attack of a joint. -All medications ordered on the FL-2 should be administered as ordered unless discontinued.	D 358		

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D 358	Continued From page 31 Interview with the Administrator on 03/26/26 at 4:00pm revealed: -The DHS was responsible for ensuring medications were administered as ordered. -All medication orders should be faxed to the contracted pharmacy and entered on the facility eMAR system by the DHS or designated staff. -Discontinued medications should be discontinued. -She did not know residents had medications not administered as ordered. b. Review of Resident #9's current FL2 dated 09/12/25 and physician order dated 12/03/25 revealed: -Diagnoses included insomnia and dementia. -There was an order for Tylenol (acetaminophen is the generic name) 500mg one tablet twice a day. (Acetaminophen is used to treat mild pain.) Review of Resident #9's physician's triage note dated 01/05/26 revealed there was an order to discontinue acetaminophen 500mg twice a day for pain. Observation of the 8:00am medication pass on 03/25/26 revealed: -The medication aide (MA) consulted the electronic medication administration record (eMAR) display to prepare 3 oral medications for Resident #9. -One acetaminophen 500mg tablet was included in the medications prepared for Resident #9. -The MA administered the medications to Resident #9 sitting on the edge of her bed in her room. Review of Resident #9's March 2026 eMAR revealed: -There was an entry acetaminophen 500mg twice	D 358		

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D 358	Continued From page 32 daily for pain scheduled at 8:00am and 8:00pm. - Acetaminophen 500mg was documented as administered on 03/25/26 at 8:00am. Observation of Resident #9's medications on hand on 03/25/26 at 8:22am revealed: -Resident #9's medications were pre-packaged by the contracted pharmacy weekly in continuous medication strips with each medication sealed in an individual package. -The resident's medications were packaged by day of the week and date on a continuous strip with each day's medication continuing into the next day's medication. -Acetaminophen 500mg was labeled for administration at 8:00am on 03/25/26. Interview with Resident #9 on 03/25/26 at 8:25am revealed: -She usually took her medications in her room every morning. -She did not take many medications. -The medication staff prepared her medications, but she did not know the names of all her medications. Interview with the MA on 03/25/26 at 2:45pm revealed: -She administered medications according to the computer eMAR screen. -She did not enter orders into the eMAR system. -The contracted pharmacy pre-packed medication for residents one week at a time with individual medications labeled for the day and time of administration. -She checked the medications available for administration and the eMAR to match when preparing medications for administration. - Medication orders were entered into the eMAR system by the Director of Health Services (DHS).	D 358		

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D 358	Continued From page 33	D 358		
	Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/26/26 at 9:00am revealed: -The facility was responsible for sending all medications orders to the pharmacy. -The contracted pharmacy did not generate the facility's eMARs. -There was no documentation Resident #9's acetaminophen order to discontinue the medication dated 01/05/26 was received by the pharmacy. Interview with the DHS on 03/26/26 at 10:40am revealed: -She was responsible for oversight of the MAs on a daily basis. -She or her assistant DHS were responsible for entering orders onto the eMAR and discontinuing order medications on the eMAR. -The contracted pharmacy dispensed medications according to the physician's orders the pharmacy had on file. -She did not currently have a system in place to routinely audit residents' physician orders compared to the current orders on the eMAR. -The order to discontinue acetaminophen 500mg for Resident #9 must have been overlooked and not sent to the contracted pharmacy as well as not discontinued on Resident #9's eMAR. Interview with Resident #9's Primary Care Provider (PCP) on 03/26/26 at 3:32pm revealed: -She expected the facility to discontinue medications according to orders. -Resident #9's acetaminophen 500mg should not be administered twice a day, routinely. -There would be no adverse effects for Resident #9 receiving acetaminophen 500mg after it was discontinued.			

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D 358	Continued From page 34 Interview with the Administrator on 03/26/26 at 4:00pm revealed: -The DHS was responsible for ensuring medications were administered as ordered. -All medication orders should be faxed to the contracted pharmacy and entered on the facility eMAR system. -Discontinued medications should be discontinued. -She did not know residents had medications not administered as ordered. 2. Review of Resident #2's current FL2 dated 09/17/25 revealed diagnoses included muscle weakness, hypertension, and venous insufficiency. Review of Resident #2's signed physician order dated 12/03/25 revealed an order for metoprolol 25mg (a medication used to treat high blood pressure) 1 tablet daily; hold if systolic blood pressure (SPB) was less than 110 or the heart rate (HR) was less than 55 beats per minute (BPM). Review of Resident #2's January 2026 electronic medication administration record (eMAR) revealed: -There was an entry for metoprolol 25mg give once daily; hold metoprolol if the SBP was less than 110 or the pulse was less than 55 BPM. -Metoprolol was documented as administered from 01/01/26 through 01/28/26; there was no documentation to review for 01/29/26-01/31/26. -There was no documentation that Resident #2's SBP and pulse were checked prior to administering the metoprolol. -It was unable to be determined if Resident #2's metoprolol was administered as ordered due to	D 358		

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D 358	Continued From page 35 no documentation of BP and HR values. Review of Resident #2's February 2026 eMAR revealed: -There was an entry for metoprolol 25mg give once daily; hold metoprolol if the SBP was less than 110 or the pulse was less than 55 BPM. - Metoprolol was documented as administered 28 of 28 opportunities. -There was no documentation that Resident #2's SBP and HR were checked prior to administering the metoprolol. -It was unable to be determined if Resident #2's metoprolol was administered as ordered due to no documentation of SBP and HR values. Review of Resident #2's March 2026 eMAR from 03/01/26 - 03/24/26 revealed: -There was an entry for metoprolol 25mg give once daily; hold metoprolol if the SBP was less than 110 or the pulse was less than 55 BPM. - Metoprolol was documented as administered 24 of 24 opportunities. -There was no documentation that Resident #2's SBP and pulse were checked prior to administering the metoprolol. -It was unable to be determined if Resident #2's metoprolol was administered as ordered due to no documentation of BP and HR values. Review of Resident #2's Vital Signs Log from 10/06/25 to 03/25/26 revealed there was no documentation Resident #2's SBP HR were checked from 01/01/26 through 03/24/26. Interview with Resident #2 on 02/24/26 at 3:40pm revealed: -The medication aides (MA) did not take her SBP or HR before administering her metoprolol. -She denied refusing to let the MAs take her SBP	D 358		

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D 358	Continued From page 36	D 358		

or HR.
-She denied any current issues with low blood pressure levels or having experienced symptoms of dizziness.

Interview with an MA on 03/26/26 at 10:57am revealed:
-She administered medications to Resident #2, and she followed the medication orders in the eMAR system when administering medications to residents.
-She did not notice there was a parameter to hold Resident #2's metoprolol if her SBP was less than 110 or her HR was less than 55bpm.
-Resident #2 did not complain of dizziness or headache to her.

Interview with a second MA on 03/26/26 at 11:32am revealed:
-She administered medications to Resident #2, and she followed the medication orders in the eMAR system when administering medications to residents.
-She knew there was a parameter to hold Resident #2's metoprolol if her SBP was less than 110 or HR was less than 55bpm.
-Resident #2 refused to allow her to check her SBP or HR.
-She did not notify management or Resident #2's Primary Care Provider (PCP) regarding the refusals.
-She did not know why she did not notify management or the PCP.
-Resident #2 did not complain of dizziness to her.

Interview with the Resident Care Coordinator (RCC) on 03/26/26 at 2:00pm revealed:
-She was not aware there was an order to hold Resident #2's metoprolol if her SBP was less than 110 or pulse less than 55 BPM.

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D 358	Continued From page 37 -The Director of Health Service (DHS) was responsible for reviewing orders with parameters to ensure they were accurate on the eMAR. Interview with the DHS on 03/26/26 at 2:44pm revealed: -She was not aware Resident #2 had an order to hold the metoprolol if her SBP was less than 110 or pulse less than 55 BPM. -She did not audit orders with parameters to ensure they were being completed. Interview with Resident #2's PCP on 03/26/26 at 3:27pm revealed: -The SBP and pulse should be taken prior to administering the metoprolol because if Resident #2's SBP and pulse were already too low the metoprolol would drop it even lower resulting in possible falls. -She expected the MA's to follow the order as written. Interview with the Administrator on 03/26/26 at 3:45pm. -It was the DHS's responsibility to review medications with parameters to ensure they were correctly administered. -She expected the DHS to review any orders with parameters for accuracy.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the	D 366		

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D 366	Continued From page 38 medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medication staff who administered medications observed a resident (#1) taking their medications prior to documenting administration on the electronic medication administration record. The findings are: Review of the facility's undated medication administration policy revealed staff will provide documentation on the medication administration record after observing the residents taking medications and before administration to another resident. Review of Resident #1's current FL2 dated 09/15/25 revealed: -Diagnoses included vascular dementia, primary hypertension, loss of appetite, and hyperlipidemia. -She was ambulatory. -She was continent of bowel and incontinent of bladder. Review of Resident #1's Resident Register revealed she was admitted to the facility on 04/17/20. Review of Resident #2's primary care provider's (PCP) orders dated 12/01/25 revealed: -There was an order for carvedilol (used to lower	D 366	•The Director of Health and Wellness will review all resident orders for accuracy and correct any errors identified and submit the changes to the pharmacy. •The Director of Health and Wellness will complete daily audits to review and confirm all new orders. The audits will be reviewed weekly by the Executive Director. •The date of correction for this deficiency will not exceed May 1, 2026.	5/1

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D 366	Continued From page 39 blood pressure) 6.25mg one tablet twice a day. -There was an order for clopidogrel (used to prevent blood clots)75mg once daily. -There was an order for cyanocobalamin (a vitamin supplement) 1000mcg daily. -There was an order for gabapentin (used to treat nerve pain) 300mg twice a day. -There was an order for lisinopril (used to treat high blood pressure) 2.5mg daily. -There was an order for memantine (used to treat vascular dementia) 10mg twice daily. -There was an order for potassium chloride (used to treat or prevent potassium deficiency) 20mEq every day. -There was an order for sertraline (used to treat depression) 75mg daily. -There was an order for cholecalciferol (used to supplement vitamin D) 25mcg daily. Review of Resident #2's March 2025 electronic medication administration record (eMAR) revealed: -There was an entry for carvedilol 6.25mg twice a day scheduled for administration at 9:00am and 9:00pm. -There was an entry for clopidogrel 75mg once daily scheduled for administration at 9:00am. -There was an entry for cyanocobalamin 1000mcg daily scheduled for administration at 9:00am. -There was an entry for gabapentin 300mg twice a day scheduled for administration at 9:00am and 9:00pm. -There was an entry for lisinopril 2.5mg daily scheduled for administration at 9:00am. -There was an entry for memantine 10mg twice a day scheduled for administration at 9:00am and 9:00pm. -There was an order for potassium chloride 20mEq one tablet every day scheduled for	D 366		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 366	Continued From page 40 administration at 9:00am. -There was an order for sertraline 75mg daily scheduled for administration at 9:00am. -There was an order for cholecalciferol 25mcg daily scheduled for administration at 9:00am. -There was documentation for administration of carvedilol 6.25mg, clopidogrel 75mg, cyanocobalamin 1000mcg, gabapentin 300mg, lisinopril 2.5mg, memantine 10mg, potassium chloride 20mEq, sertraline 75mg and cholecalciferol 25mcg at 9:00am on 03/24/26. Observation of Resident #1 on 03/24/26 at 12:30pm revealed: -Resident #1 was sitting alone at a corner table in the dining room. -Resident #1 had a cup of water and a plastic medication soufflé cup with multiple tablets in the cup sitting on the table in front of her. -The resident was staring at the pills and holding the water cup. Interview with Resident #1 on 03/24/26 at 12:30pm revealed: -The medication aides (MAs) usually brought her medications to her room in the mornings. -She resided on the second floor. -The medications in the cup on the table were her morning medications. -She liked to take her medications with food. -She did not answer if her medications were left in her room today or before. -The resident did not provide additional information. Interview with the morning medication aide (MA) on 03/24/26 at 12:45pm revealed: -When she administered residents' medications, she followed the instructions on the residents' eMARs.	D 366		

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D 366	Continued From page 41 -When she administered residents' medications, she took the medications in the residents' rooms and observed the residents taking the medications. -She did not leave the medications in the residents' rooms. -There were some residents she asked to open their mouth to ensure the resident had taken the medications. -Resident #1 was not a resident that she was familiar with for holding medications in their mouth (also called cheeking) and taking the medication later. -She said she took Resident #1's morning medications into her room this morning (03/24/26) and felt certain she watched the resident put the medications in her mouth. -Resident #1 did not have medications for administration at 12:00pm. -She did not know Resident #1 had medications in the dining room at lunch (12:35pm). Interview with the DHS on 03/26/26 at 1:40pm revealed: -She was responsible for oversight of the MAs on a daily basis. -MAs should administer medications to residents and observe each resident take the medication, even ask resident to open mouth for remaining tablets, prior to documenting medications were administered. -Resident #1 was not a resident with previous history of cheeking medications. -If a resident refused to take medications when administered, the MA should document the refused medications and dispose of the medications per policy. -No medications should be left in a resident's room for later administration.	D 366		

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D 366	Continued From page 42 Interview with Resident #1's primary care provider (PCP) on 03/26/26 at 3:32pm revealed: -Facility staff should not be leaving medications for residents to take on their own. -She was not aware Resident #1 had medications at the dining room table on 03/24/26 at 12:35pm with no staff observing administration. Interview with the Administrator on 03/26/26 at 4:00pm revealed: -The DHS was responsible for ensuring medications were administered as ordered. - Only residents with self-administration orders should take medications without MA observation of the resident actually taking the medication. - No medications were to be left in residents' rooms for later administration. -Medications should be documented on the eMAR after observed administration by the MA preparing and administering the medication.	D 366		
D 376	10A NCAC 13F .1005 (b) Self-Administration Of Medications 10A NCAC 13F .1005 Self-Administration Of Medications (b) When there is a change in the resident's mental or physical ability to self-administer or resident non-compliance with the physician's orders or the facility's medication policies and procedures, the facility shall notify the physician. A resident's right to refuse medications does not imply the inability of the resident to self-administer medications.	D 376	The Director of Health and Wellness will review all resident records to ensure any resident with an order to self-administer medication also has an evaluation in place. Any resident identified as unable to self-administer medication will have the order discontinued. •The Director of Health and Wellness will complete a monthly audit to determine if any new orders for self-administration have been written and that all evaluations are present and updated semi-annually. The Executive Director will review this audit monthly. •The date of correction for this deficiency will not exceed May 1, 2026.	5/1

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D 376	Continued From page 43 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 5 sampled residents (#3) was in compliance with the facility's self-administration of medication policy. The findings are: Review of the facility's self-administration of medication policy, dated 06/20/25, revealed: - Residents who desired to self-administer medication should be permitted to do so if any applicable requirements were met. -An evaluation would monitor the resident's ability to self-administer medication via semi-annual evaluations and would be documented in the resident's record. -If the facility had reason to believe the resident was no longer capable of self-administration of medications, the primary care physician (PCP) should be notified. Review of Resident #3's FL2 dated 03/26/25 revealed diagnoses included osteoporosis, asthma, chronic kidney disease, hypothyroidism, restless leg syndrome. Review of Resident #3's Resident Register revealed an admission date of 02/29/24. Review of Resident #3's signed physicians orders dated 12/03/25 revealed an order that she could self-administer all medications. Review of Resident #3's record revealed there was no self-administer medications evaluation available for review.	D 376		

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D 376	Continued From page 44 Interview with Resident #3 on 03/26/26 at 10:26am revealed: -She had self-administered her medications since she moved into the facility. -She did not remember having an evaluation done before she started to self-administer her medications. -She did not remember having an evaluation done since she started to self-administer her medications. Interview with the Resident Care Coordinator (RCC) on 03/26/26 at 2:00pm revealed: -Any resident that wanted to self-administer medications needed to have an initial evaluation done first. -She thought any evaluation completed after the initial evaluation was done as needed or when staff saw a change in the resident's mental or physical ability to self-administer her medications. -She had not read the facility's self-administration of medication policy. -She was not aware the facility's policy stated the resident would be evaluated semi-annually and would notify the resident's PCP if there was concern the resident no longer could self-administer their medications. -Director of Health Services (DHS) was responsible for completing the self-administration of medication evaluations with Resident #3. Interview with the DHS on 03/26/26 at 2:44pm revealed: -She had not completed at self-administration of medications evaluation for Resident #3. -She had read the facility's self-administration of medication policy but did not remember what it said. -She was not aware the facility's policy stated the resident would be evaluated semi-annually and	D 376		

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D 376	Continued From page 45 would notify the resident's PCP if there was concern they no longer could self-administer their medications. -She knew that an assessment needed to be completed prior to a resident starting to self-administer their medications, but never reviewed Resident #3's record to ensure it was completed. Interview with Resident #3's PCP on 03/26/26 at 3:27pm revealed: -She wrote the order for Resident #3 to self-administer her medications. -She was not aware of the facility's self-administration of medication policy. -She expected the facility to follow their policies. Interview with the Administrator on 03/26/26 at 3:45pm revealed: -The DHS should complete a self-administration of medications evaluation on residents who wanted to self-administer their own medications. -An evaluation should be done semi-annually to ensure the resident was still mentally and physically able to continue to self-administer their medications. -She expected the self-administration of medication evaluations to be completed semi-annually by the DHS.	D 376		

D 378	10A NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration.	D 378		

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D 378	Continued From page 46 This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure that medications were stored safely and securely for 2 of 2 residents (#2, #6) including a resident who had prescription eye drops sitting on a stand next to her chair (#2) and a resident who had a cream medication sitting on a stand next to his chair (#6). The findings are: Review of the facility's Medication Services policy dated 12/05/25 revealed all medications for residents who received assistance with their medications would be stored in a designated medication storage area. 1. Review of Resident #2's current FL2 dated 09/17/25 revealed diagnoses included muscle weakness, hypertension, and venous insufficiency. Observation of Resident #2's room on 03/24/26 at 9:12am revealed: -Resident #2 was sitting in a chair in her room. -There were 3 bottles of eye drops located on the top of a bedside stand next to her chair. Review of Resident #2's signed physician orders dated 12/03/25 revealed: -There was an order for refresh tear drops 0.5% (a medication used to treat dry eyes) instill 1 drop in each eye daily at 2:00pm.	D 378	•The Executive Director will complete a room audit to ensure no medication is at bedside. Any identified medications will be stored properly. •The Director of Health and Wellness will complete weekly room audits to determine if any medications are left at bedside. The Executive Director will review the audits monthly. •The date of correction for this deficiency will not exceed May 1, 2026.	5/1

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D 378	Continued From page 47 -There was an order for brimonidine solution 0.2% (a medication used to lower pressure in the eye) instill 1 drop into each eye twice daily. -There was an order for latanoprost solution 0.005% (a medication used to lower pressure in the eye) instill 1 drop into each eye at bedtime. Interview with Resident #2 on 03/26/26 at 11:20am revealed: -Some of the medication aides (MA) left her eye drops with her to self-administer. -She did not ask them to leave the eye drops. -She was not sure who left the eye drops with her. -She could not remember how long the eye drops had been there. Interview with an MA on 03/26/26 at 10:57am revealed: -She was not aware Resident #2 had her eye drops in the room with her. -Resident #2 would ask her to leave the eye drops so she could self-administer them later. -She never left the eye drops with Resident #2. -Resident #2 administered her own eye drops but she would always stay with her and make sure she did. -She would take the eye drops with her to put back on the cart when Resident #2 was finished administering them. Interview with a second MA on 03/26/26 at 11:32am revealed: -Resident #2 would ask her to leave the eye drops with her to self-administer. -She never left the eye drops with Resident #2. -Resident #2 wanted to administer the eye drops herself. -She would always stay with her and remove the medication when she was finished.	D 378		

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D 378	Continued From page 48 -She was not sure who left the eye drops with Resident #2. Interviews with the Resident Care Coordinator (RCC) on 03/26/26 at 2:00pm revealed: -She was aware Resident #2 had her refresh eye drops in her room. -She was told by the Director of Health Services (DHS) that it was okay since they could be purchased over the counter. -She was not aware the latanoprost or brimonidine eye drops were in her room. -Resident #2 did not have an order to self-administer her eye drops. -Residents were not permitted to keep medications in their rooms unless they had an order for self-administration. Interview with the DHS on 03/26/26 at 3:27pm revealed: -Residents were not allowed to have medications in their rooms without a self-administration of medication order. -Resident #2 did not have a self-administration order. -She was not aware Resident #2 had her eye drops in the room. -She expected the MA's not to leave the eye drops in the room with Resident #2. Interview with the Administrator on 03/26/26 at 3:55pm revealed: -Medications were not to be stored in resident rooms without a self-administration order. -She was not aware Resident #2 had eye drops in her room. -She expected the MA's not to leave the eye drops with Resident #2. 2. Review of Resident #6's current FL2 dated	D 378		

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D 378	Continued From page 49 11/19/25 revealed diagnoses included bipolar disorder, hypertension and acid reflux disease. Review of Resident #6's resident register revealed an admission date of 08/18/22. Observation of Resident #6's room on 03/24/26 at 9:48am revealed there was a tube of prescription hydrocortisone cream located on a stand next to his chair that had a prescription label attached. Interview with Resident #6 on 03/24/26 at 9:49am revealed: -He had kept the hydrocortisone cream in his room since he moved in. -He was never told he could not keep medication in his room. -He used the hydrocortisone cream on his hands. Review with Resident #6's physician orders dated 12/01/25 revealed an order for hydrocortisone cream 2.5% apply topically to upper back and side of chest twice daily. Observation of Resident #6's room on 03/26/26 at 11:09am revealed there was a container of mentholatum topical analgesic rub (an over-the-counter medication used to treat muscle pain) sitting on the table next to his bed. Interview with Resident #6 on 03/26/26 at 11:10am revealed: -He used the rub inside his nose at night. -He purchased the rub at the store. -He was not told he could not have over-the-counter medication in his room. Interview with a medication aide (MA) on 03/26/26 at 10:57am revealed: -She was aware Resident #6 had hydrocortisone	D 378		

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D 378	Continued From page 50	D 378		

cream in his room.
-Resident #6 has always had hydrocortisone cream in his room.
-She was not aware if Resident #6 had an order to self-administer the hydrocortisone cream. -She was aware that Resident #6 needed an order to self-administer the hydrocortisone cream.
-She was not aware Resident #6 had an over-the-counter muscle rub in his room.

Interview with the Resident Care Coordinator (RCC) on 03/26/26 at 2:00pm revealed:
-She was aware Resident #6 had hydrocortisone cream in his room.
-She thought Resident #6 had an order to self-administer the hydrocortisone cream. -She was not aware Resident #6 had a container of muscle rub in his room.
-She was not sure if Resident #6 had been told he could not keep over-the-counter medications in his room.

Interview with the Director of Health Services (DHS) on 03/26/26 at 3:27pm revealed:
-Residents were not allowed to have medications in their rooms without a self-administration of medication order.
-She was aware Resident #6 had hydrocortisone cream in his room.
-She thought Resident #6 had an order to self-administer the hydrocortisone cream. -She was not aware Resident #6 had muscle rub in his room.
-She had not told Resident #6 he could not have over-the-counter medications in his room.
-She was not sure if Resident #6 had ever been told he could not have over-the-counter medications in his room.

STATE FORM

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D 378	Continued From page 51 Interview with the Administrator on 03/26/26 at 3:55pm revealed: -Medications were not to be stored in resident rooms without a self-administration order. - She was not aware Resident #6 had hydrocortisone cream and muscle rub in his room. -She expected the DHS to get a self-administration order for the hydrocortisone cream and muscle rub.	D 378		