STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092233	A. BUILDING: _____ B. WING _____	R-C 05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWNDALE MANOR	601 LAKESIDE DRIVE GARNER, NC 27529

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Wake County Department of Social Services conducted a follow-up survey and complaint investigation on 05/05/26 - 05/07/26.	D 000		
D 066	10A NCAC 13F .0305 (h)(3) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (3) all exit door locks shall operate from the inside at all times by a single hand motion without keys, tools or special knowledge; and This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure all exit door locks were easily operable by a single hand motion from the inside without keys including the front entrance doors and the double exit doors in the theater room. The findings are: Review of the facility's census report provided on 05/05/26 revealed there were 41 residents currently residing in the facility. Observation of the theater room on 05/05/26 at 10:36am revealed: -There was an exit to the outside with double doors. -The two metal rods connected to the push bars used to open the doors were bent. -The metal push bar used to open the door on the left was missing.	D 066		

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D 066	Continued From page 1 -The doors could not be pushed open with one hand. -The door on the left with the broken push bar opened when both hands and some force was applied to the door. Second observation of the theater room on 05/06/26 at 9:15am revealed: -The exit door was cracked open without anyone near it. -Upon closing the exit door on 05/06/26 at 9:17am, the exit doors were pushed but would not open. Observation of the front entrance doors on 05/07/26 at 1:11pm revealed: -There was a sign on the left side of the double doors from the outside that read, please use other door. -When the surveyor attempted to open the door from the outside it opened although the lock was turned on. -When facing the front door from the inside of the facility, there was a sign on the right side of the double door that read, please use other door. Review of a contracting corporation proposal company invoice dated 04/02/26 revealed: -The work description for the estimate included removing and replacing two exterior double doors. -The front entry and theater room double doors were listed in the work description as part of the estimate. Review of a maintenance company invoice dated 04/21/26 revealed: -The form was an estimate for the facility. -There was pricing provided for a front door, back door, push bars (front door), handicap door	D 066		

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D 066	Continued From page 2 operator, and door stops. Interview with the Administrator on 05/05/26 at 9:08am revealed: -The doors in the theater room would open if pushed hard. -The area leading out of the theater room was the area where residents used to smoke. -Residents did not leave out of the doors in the theater room. -The exit doors in the theater room were not safe for the residents to open, therefore, she asked them not to go out of those doors. -Residents could not open the exit doors in the theater room because they were too heavy to open. -New doors were ordered for the theater room but she was not sure when they would be delivered and installed. Interviews with the Regional Director of Operations (RDO) on 05/05/26 at 4:15pm and 05/07/26 at 12:22pm revealed: -During the previous survey in February 2026, there was a plastic rubber piece wedged between the bars on the doors in the theater room to prevent the doors from opening because they were malfunctioning. -The doors in the theater room would not close. -The front door was broken. -The front door's release bar was not working properly; the doors would open without pushing in the release bar. -The front door could not be locked. -The doors had been broken since the last survey in February 2026 and they had gotten some estimates. -There had been a delay in replacing the doors because of waiting for the corporate office to approve ordering the doors.	D 066		

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D 066	Continued From page 3 -New exit doors had been ordered and should be delivered to the facility by the end of this week on Friday, 05/08/26. -The new exit doors would be installed on Saturday, 05/09/26.	D 066		
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 and interviews, the facility failed to ensure 2 of 2 sampled common bathrooms on the 200 hall used by residents, two resident rooms on the 200 Hall, and the floors in the common hallways were maintained in a clean and orderly manner. The findings are: Observation of resident room 204 on 05/06/26 at 10:00am revealed: -There were brownish stains and black mold in	D 079		

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the toilet.
-There was a spill on the floor in reddish color.
-There was trash and dirt under the beds.
-There was trash on the floor in the bathroom.

Interview with the resident's family member on 05/06/26 at 9:55am revealed:
-The room was the "nastiest thing I have ever seen."
-There was trash under the bed that had been there for 3 weeks.
-The room had not been cleaned.

Observation of the 200 Hall common bathroom beside room 210 on 05/05/26 at 9:59am revealed:
-There was dirt and debris scattered on the floor.
-There was a hoyer lift pad lying under the sink on the floor with dirt and debris scattered around it.
-There was dirt and debris and a dead bug in the bathtub.
-There were rust stains around the drain in the bathtub.
-There was dirt and debris on the shower floor and a buildup of white soap scum on the shower drain.
-There was a brown stain on the yellow shower curtain.
-There were brownish, gray stains on the floor around the base of the toilet.
-There was a pair of used rubber gloves on a wooden shelf on the wall in the bathroom.

Observation of the 200 Hall common bathroom beside the janitor's closet on 05/05/26 at 10:01am revealed:
-There was dirt and debris scattered on the floor.
-There were long, black streaks scattered across the bathroom floor.
-There was black debris and rust stains at the

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D 079	Continued From page 5	D 079		

base of the toilet.
-There were scattered brown stains inside of the toilet bowl.
-There were scattered brown stains on the floor around the toilet.
-The metal grab bar beside the toilet was rusted and stained.
-There was a white shelving cabinet on the wall with multiple brownish gray stains, a broken white plastic clothes hanger, and a partial roll of toilet paper lying on the top shelf.
-There was a piece of white wood lying on the second shelf of the wall cabinet.
-There was a toilet chair with no lid in the shower stall that had rust and a buildup of white soap scum on the metal areas of the toilet chair.
-There was a pinkish brown buildup in several areas on the shower floor and shower walls including the grout.
-There was dirt and debris scattered on the shower floor.
-There were two small yellow artificial flowers lying on the drain of the shower floor.
-The empty stall beside the shower stall had dirt and debris on the floor and a black seat cushion with a fuzzy gray film covering the top and sides of the cushion.
-There was a pair of green socks lying on top of the paper towel dispenser.
-The small trash can near the sink had a used incontinence brief and other trash inside.
-There was a large trash can near the door filled to the top with trash.
-There was a large trash bag on the floor near the large trash can that contained soiled linens.

Interview with a resident on 05/05/26 at 2:20pm revealed:
-The personal care aides (PCAs) showered her in the 200 Hall common bathrooms.

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D 079	Continued From page 6 -The 200 Hall common bathrooms had been dirty since April 2026. -The 200 Hall common bathrooms were so dirty, she often did not want to go into the bathrooms. -Pink soap scum build-up was on the floors of the showers. -Toilet paper and garbage littered the bathroom floors. -There used to be two housekeepers but now there was only one housekeeper. -She never saw the housekeeper go into the 200 Hall common bathrooms to clean. -The PCAs would sometimes clean the bathroom the best they could between residents' showers. -The trash cans in the bathrooms stayed full and over-flowing onto the floor. -The PCAs would sometimes have to take out the bathroom trash. Interview with a second resident on 05/05/26 at 2:45pm revealed: -The 200 Hall common bathrooms had been dirty "for a while" (unknown duration). -The floors, toilets, and shower chairs were dirty. -The bathrooms were so dirty, she did not like going into the bathrooms. Observation of the common hallways in the facility on 05/05/26 at 10:35am revealed: -The common hallways included the 100 Hall, 200 Hall, and the central common hallway that led to the activity room. -The floor tiles were dingy and had a thick gray buildup with black streaks scattered throughout the facility. -There was a thick brown buildup on the edges of the floor in the hallways near the baseboard and on the baseboard. -There was dirt, debris, and spill stains throughout the hallway floors.	D 079		

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D 079	Continued From page 7 -There were two missing tiles near the guest bathrooms on the central hallway. Second observation of the 200 Hall common bathroom beside room 210 on 05/05/26 at 3:19pm revealed the room had not been cleaned and it was in the same condition as noted on 05/05/26 at 9:59am. Second observation of the 200 Hall common bathroom beside the janitor's closet on 05/05/26 at 3:17pm revealed: -The room had not been cleaned and it was in the same condition as noted on 05/05/26 at 10:01am except the trash bag with linen and the large trash can had been removed. -The lid to the large trash can was lying upside down on the floor with scattered trash on the floor near it. -There was a large used white towel lying on the sink. Observation of a resident room on the 200 Hall across from a common hall bathroom on 05/07/26 at 1:43pm revealed: -There was a large, dark, dried, sticky substance on the floor in front of the resident's bed with trash and debris covering the floor. -There was a non-ambulatory resident in the room. Interview with a resident residing in the room on 05/07/26 at 1:43pm revealed: -The sticky, dried puddle in front of the bed and floor debris had been there for weeks. -She asked staff for help to clean the floor, but no one came to clean it. Interview with a PCA on 05/07/26 at 12:40pm revealed:	D 079		

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D 079	Continued From page 8 -The 200 Hall common bathrooms had been dirty since March 2026. -Prior to January 2026, three housekeepers kept the facility very clean. -Housekeeper positions were cut by the facility's corporate office in January/February 2026. -There was currently only one housekeeper for the facility. -The current housekeeper did not clean residents' rooms or common hall bathrooms. -She asked the housekeeper to clean the 200 Hall common bathrooms and a couple of residents' rooms several times. -The housekeeper would not clean residents' rooms or the 200 Hall common bathrooms because the housekeeper would socialize instead. -She had to sanitize the 200 Hall common bathroom shower chairs before showering residents. -She told the Administrator about the dirty 200 Hall common bathrooms this week. Interview with a medication aide (MA) on 05/05/26 at 3:59pm revealed: -She had worked at the facility for about a week. -She had never seen a housekeeper working on second shift. -She assumed the PCAs cleaned the facility. Interview with a second MA on 05/05/26 at 4:00pm revealed: -Staff and family members had complained to her about the cleanliness of the facility. -There was usually only one housekeeper on first shift who worked from 7:00am - 12:00pm. -The PCAs usually cleaned up in the bathrooms after they gave showers. -There was no deep cleaning at the facility because there was only one housekeeper.	D 079		

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-The housekeeper was not good at cleaning.
-She observed the housekeeper mop the 200 hallway floors yesterday but not the 100 hallway floors.
-The housekeeper was supposed to clean everything in the bathrooms but she had only seen him mop in the bathrooms.
-The common bathrooms were "disgusting" and they had been that way for about 3 weeks.

Interview with the Administrator on 05/05/26 at 3:38pm revealed:
-The facility used to have two housekeepers, but the corporate office cut back housekeeping hours about a month ago.
-The facility currently only had one housekeeper who worked Monday - Friday from 7:00am to 12:00pm or 12:30pm.
-There was no housekeeper at the facility after 12:00pm or 12:30pm during the week and no housekeepers on the weekends.
-The PCAs cleaned on the weekends but it was difficult because the PCAs were busy providing care to residents.
-The PCAs should clean up behind themselves and get up any dirty linen after they gave showers.
-Their current housekeeper quit earlier today, 05/05/26, and he was not available for interview.
-The current housekeeper quit because other staff were saying he was not doing his job.
-The cleanliness of the common bathrooms was a problem, and the common bathrooms should be clean.
-The housekeeper was supposed to clean all common bathrooms and bathrooms in residents' rooms everyday including the floors, showers, toilets, sinks, and taking out the trash.
-The housekeeper was supposed to clean resident rooms and the floors in the hallways

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D 079	Continued From page 10 every day. -The hallway floor needed cleaning and buffing. -There were not enough housekeeping hours allotted to have enough time to do any deep cleaning. -She tried to do a walk-through of the facility each day she was there, but she was out of the facility 3 times a week for marketing tasks. -Most mornings, she was unable to do a facility walk-through to check for cleanliness because she was bombarded with staff and residents when she came into work. -She had not done a walk-through this morning, 05/05/26 and was not aware of the condition of the common bathrooms on the 200 Hall.	D 079		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents' rights were maintained as related to staff not responding in a timely manner to call bells. The findings are: Review of the facility's Call Light Response Policy dated 05/06/26 revealed: -The purpose of the policy was to ensure that all residents received timely, appropriate, and respectful responses to call light requests in order to maintain safety, dignity, and quality of care.	D 338		

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D 338	Continued From page 11 -All call light alerts must be responded to promptly by facility staff. -No call light should be ignored. -Staff were responsible for ensuring that resident needs were addressed in a timely manner or communicated to the appropriate personnel for follow-up. -Call lights must be acknowledged immediately upon activation. -Staff were expected to respond in person within 5 minutes whenever possible. -Requests involving potential emergencies, including but not limited to falls, difficulty breathing, chest pain, or acute distress, should be addressed without delay. -All staff, including nursing personnel, personal care aides, and support staff, shared responsibility for responding to call lights. -Response was not limited to assigned staff. Observation of a resident in their room on the 100 Hall on 05/05/26 at 9:20am revealed: -The resident rang a hand bell. -There was a personal care aide (PCA) walking up and down the hall, trying to locate the ringing hand bell. -The PCA eventually located the resident after 10 minutes. Interview with a resident on 05/05/26 at 9:35am revealed: -She had a hand bell, but it took staff 30 to 60 minutes to respond; sometimes hours. -She recently had to wait 1 hour for help after ringing for toileting assistance. Interview with a second resident on 05/05/26 at 10:00am revealed: -He had end-stage cancer and received palliative care.	D 338		

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D 338	Continued From page 12 -He required a wheelchair to ambulate and needed toileting and transfer assistance. -He had a hand bell to call for help. -Staff's responses to calls were delayed since staff could not locate which resident rang their hand bell. Interview with a third resident on 05/05/26 at 10:20am revealed: -He required a walker for ambulation. -He had a hand bell to call for help. -Staff's responses were delayed since staff had trouble locating where the ring came from. -Sometimes it took 30 to 60 minutes or longer to get help. Observation of resident room 112 and the nurses' station on 05/05/26 from 9:23am - 9:55am revealed: -At 9:23am, the state surveyor pulled the call bell and the light on the wall started to blink off and on in room 112. -At 9:30am, the call bell light on the wall was still blinking. -At 9:49am, the call bell system at the nurses' station announced room 112; there were no staff at the nurses' station, and the announcement could not be heard unless you were near the nurses' station. -At 9:55am, a medication aide (MA) was at the nurses' station and checked the call bell system; she asked the state surveyor, "did you go into room 112?". -The MA then left the nurses' station and went into resident room 112. Observation of resident room 212 and the nurses' station on 05/05/26 from 9:14am - 9:24am revealed: -At 9:14am, the surveyor pressed the button on	D 338		

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the resident's call pendant that was lying on the resident's bedside table; a red light lit up on the pendant; an audible alarm could be heard from the nurses' station down the hall.
-At 9:16am, the surveyor pulled the call bell cord on the wall near the resident's bed; a red light came on the wall panel for the call bell; and an audible alarm could be heard down from the nurses' station down the hall.
-At 9:17am, the surveyor pulled the call bell cord on the wall in the resident's bathroom; a red light flashed on the wall panel for the call bell cord in the bathroom; and an audible alarm could still be heard from the nurses' station down the hall.
-The call bell light on the ceiling in the hallway outside the resident's room did not turn on when either of the call bells were activated.
-No staff responded to the call bells.
-At 9:19am, the call bell system was still sounding at the nurses' station and was announcing room 212 and announcing the resident's name in room 212.
-A housekeeper went to the nurses' station and turned off a door alarm switch that was also alarming.
-At 9:22am, the call bell system was still sounding and announcing room 212 and the resident's name.
-At 9:24am, a MA came to resident room 212 to respond to the call bells.

Interview with the MA on 05/05/26 at 9:24am revealed:
-The call bell lights on the ceiling outside of the residents' rooms did not work because they were used with the previous call bell system.
-This made it more difficult for staff because they could not always hear the call bells sounding at the nurses' station if they were in a resident room with the door closed.

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-The call bells with cords in the resident's rooms had to be turned off at the wall switch in the residents' rooms.
-The call pendants could be turned off at the nurses' station or by using the pendant.

Observation of the nurses' station on 05/06/26 from 9:06am - 9:46am revealed:
-At 9:06am, the state surveyor was at the nurses' station.
-At 9:06am, 9:18am, 9:42am and 9:49am, the call bell system announced resident room 107's pendant.
-The announcement from the call bell system could only be heard at the nurses' station.

Observation of the facility's call bell system on 05/06/26 at 1:43pm revealed:
-A resident's call bell was activated and flashed green.
-The resident's call alerted on the call system screen and audibly alerted the resident's room number at the nurse's station.
-Staff did not respond to the call bell by 2:03pm.

Interview with the Resident Care Director (RCD) on 05/07/26 at 6:43pm revealed:
-Staff should answer call bells as soon as possible at least within a few minutes.
-There was one resident in the facility who screamed out when she needed help because the resident complained that staff could not hear the call bell ring.

Interview with the Regional Director of Operations (RDO) on 05/07/26 at 6:32pm revealed:
-The facility's standard was to answer call bells in 5 minutes or less but as soon as possible was the best option.
-He thought it would help if the alarm was louder

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D 338	Continued From page 15 so staff could hear it better. -Residents should never have to wait long periods of time for staff to respond to call bells. -He was planning to in-service staff on the new call light response policy effective 05/06/26.	D 338		
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: FOLLOW-UP TO TYPE A1 VIOLATION. The Type A1 Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 3 residents (#2, #4) observed during the medication passes including errors with a nasal spray for seasonal allergies (#4) and an eye drop for glaucoma (#2) and for 1 of 5 residents (#3) sampled for record review including errors with medications for heart/blood pressure and acid reflux. The findings are: 1. The medication error rate was 6% as evidenced by 2 errors out of 32 opportunities	D 358		

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D 358	Continued From page 16 during the 7:00am - 9:00am medication pass and the 2:00pm medication pass on 05/06/26. a. Review of Resident #4's current FL-2 dated 09/19/25 revealed diagnoses included diabetes mellitus type 2, chronic pain syndrome, depression, peripheral neuropathy, insomnia, and right above knee amputation. Review of Resident #4's primary care provider (PCP) order dated 03/10/26 revealed an order for Flonase 0.05% Nasal Spray, use 2 sprays in each nostril every day for allergies. (Flonase is used to treat seasonal allergy symptoms.) Observation of the 8:00am medication pass on 05/06/26 revealed: -The medication aide (MA) retrieved Resident #4's Flonase Nasal Spray bottle from the medication cart. -The MA handed the Flonase Nasal Spray bottle to Resident #4. -Resident #4 used 1 spray in each nostril at 8:00am instead of 2 sprays in each nostril as ordered. -The MA did not instruct or prompt Resident #4 to use 2 sprays in each nostril. Review of Resident #4's May 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Flonase 0.05% Nasal Spray use 2 sprays in each nostril every day for allergies scheduled at 8:00am. -Flonase Nasal Spray, 2 sprays in each nostril was documented as administered every day from 05/01/26 - 05/06/26. Observation of Resident #4's medications on hand on 05/06/26 at 1:44pm revealed:	D 358		

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D 358	Continued From page 17 -There was one bottle of Flonase 0.05% Nasal Spray dispensed on 03/10/26. -The instructions were to use 2 sprays in each nostril every day for allergies. Interview with Resident #4 on 05/06/26 at 2:01pm revealed: -She used Flonase Nasal Spray, 1 spray in each nostril each day. -She only used 1 spray in each nostril because the MAs had told her in the past that she could only use 1 spray in each nostril. -She thought she was supposed to be getting 2 sprays in each nostril. -Flonase usually helped with her allergy symptoms. Interview with the Resident Care Director (RCD) on 05/06/26 at 2:23pm revealed: -The MAs had been trained to read and follow instructions on the eMAR and medication label. -Resident #4 should have received 2 sprays in each nostril of Flonase Nasal Spray. Interview with the Administrator on 05/06/26 at 2:36pm revealed: -The MA who administered medications to Resident #4 during the 8:00am medication pass today, 05/06/26, was unavailable because the MA had left work early because she was feeling sick. -The MAs were supposed to check the eMARs 3 times and follow the instructions. -The MA should have instructed Resident #4 to use 2 sprays of the Flonase Nasal Spray in each nostril. Interview with Resident #4's PCP on 05/07/26 at 11:32am revealed: -It was less than ideal for Resident #4 to receive 1 spray in each nostril of Flonase Nasal Spray	D 358		

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instead of 2 sprays in each nostril.
-Not getting the full dosage of Flonase Nasal Spray could worsen Resident #4's chronic rhinitis (inflammation that causes nasal congestion, runny nose, sneezing, and itching).

b. Review of Resident #2's current FL-2 dated 05/20/25 revealed diagnoses included hypertension, hyperglycemia, and major depressive disorder without psychosis.

Review of Resident #2's primary care provider (PCP) order dated 01/16/26 revealed an order for Brimonidine 0.2% eye drops, instill 1 drop into both eyes 3 times a day for glaucoma. (Brimonidine is used for glaucoma, an eye condition that damages the optic nerve and can lead to vision loss or blindness.)

Observation of the 2:00pm medication pass on 05/06/26 revealed:
-The medication aide (MA) put on gloves and retrieved Resident #2's Brimonidine 0.2% eye drops from the medication cart.
-Resident #2 was in his room and laid back on the bed while using his own hands to pull open the top and lower lids of both his eyes.
-At 2:18pm, the MA touched the tip of the Brimonidine eye drop bottle inside the corner of the resident's left eye and squeezed causing a stream of eye drops to spill out of the resident's eye and run down his face.
-The MA then touched the tip of the Brimonidine eye drop bottle inside the corner of the resident's right eye and squeezed causing a stream of eye drops to spill out of the resident's eye and run down his face.
-Resident #4 was not administered 1 drop of Brimonidine 0.2% into each eye as ordered.

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Review of Resident #2's May 2026 electronic medication administration records (eMARs) revealed:
-There was an entry for Brimonidine 0.2% eye drops, instill 1 drop into both eyes 3 times a day for glaucoma scheduled at 7:00am, 2:00pm, and 6:00pm.
-Brimonidine 0.2% was documented as administered from 05/01/26 - 05/06/26.

Observation of Resident #2's medications on hand on 05/06/26 at 2:20pm revealed:
-There was a 10ml bottle of Brimonidine 0.2% eye drops dispensed on 04/13/26.
-The instructions were to instill 1 drop into both eyes 3 times a day.

Interview with Resident #2 on 05/07/26 at 8:00am revealed:
-The MAs always put the eye drop bottle in the corner of his eyes and squeezed and the drops always ran down his face.
-"It's wasteful" and he was concerned that he was not getting enough medication in his eyes to help with his glaucoma.
-He could only see silhouettes and his vision had been that way for "a while" (could not give specific timeframe).
-He would like the MAs to put the eye drops in his eyes correctly.

Interview with the MA on 05/06/26 at 2:19pm revealed:
-She did not recall specifically how she was trained to administer eye drops.
-She usually pulled up on the upper eyelid and put the drops in the corner of the resident's eye.
-It was difficult to get just one drop in the resident's eyes.

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Interview with the Resident Care Director (RCD) on 05/06/26 at 2:30pm revealed:
-She did an in-service with the MAs about 2 ½ weeks ago on the proper way to instill eye drops because Resident #2 complained about the way the MAs administered his eye drops.
-She instructed the MAs to pull the lower eye lid down to make a pocket and then instill the eye drops in the pocket according to the order.

Interview with the Administrator on 05/06/26 at 2:36pm revealed:
-The MAs had been trained by a registered nurse (RN) on the proper technique for instilling eye drops when they completed their 15-hour state medication administration training course.
-The MAs should use proper technique when instilling eye drops, including not touching with the dropper.

Interview with Resident #2's PCP on 05/06/26 at 11:32am revealed:
-The MAs should use proper technique when administering eye drops and use the proper amount of eye drops to ensure efficacy.
-Putting too many eye drops in the resident's eyes was wasteful and touching the tip of the dropper in the resident's eye could potentially cause contamination.

2. Review of Resident #3's current FL-2 dated 01/16/26 revealed diagnoses included uncontrolled diabetes mellitus, history of hypertension, cognitive impairment, complicated urinary tract infection, chronic pain syndrome, and paroxysmal atrial fibrillation.

a. Review of Resident #3's current FL-2 dated 01/16/26 revealed there was an order for Pantoprazole 40mg 1 tablet twice daily.

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D 358	Continued From page 21 (Pantoprazole is used to treat acid reflux.) Review of Resident #3's March 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Pantoprazole 40mg 1 tablet twice daily but was scheduled for 8:00am only. -Pantoprazole was documented as administered once daily at 8:00am from 03/01/26-03/31/26, except from 03/17/26-03/19/26 when the resident was in the hospital. Review of Resident #3's April 2026 eMAR revealed: -There was an entry for Pantoprazole 40mg 1 tablet twice daily but was scheduled for 8:00am only. -Pantoprazole was documented as administered once daily at 8:00am from 04/01/26-04/30/26. Review of Resident #3's May 2026 eMAR revealed: -There was an entry for Pantoprazole 40mg 1 tablet twice daily but was scheduled for 8:00am only. -Pantoprazole was documented as administered once daily at 8:00am from 05/01/26-05/07/26. Observation of Resident #3's medications on hand on 05/07/26 at 5:49pm revealed: -There was a supply of 60 Pantoprazole 40mg tablets dispensed on 04/08/26 with instructions to take 1 tablet twice a day. -There were 7 of 60 tablets remaining. Interview with Resident #3 on 05/07/26 at 6:41pm revealed: -She thought she only received Pantoprazole 40mg once a day.	D 358		

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-She had never been given Pantoprazole 40mg with her nighttime medication.
-She denied any increase on current symptoms of acid reflux, heartburn, or difficulty swallowing.

Interview with a medication aide (MA) on 05/07/26 at 2:40pm revealed:
-When the MAs administered medications, they were supposed to check the eMAR and medication label a total of 3 times to ensure that the medication and instructions matched.
-She did not recall noticing any discrepancies with Resident #3's Pantoprazole.
-Resident #3's order stated to administer Pantoprazole 40mg twice a day.
-She could only see the orders on the eMAR for the prescribed medications during first shift.

Interview with the Resident Care Director (RCD) on 5/07/26 at 3:45pm revealed:
-The pharmacy usually entered all orders into the eMAR system.
-She was responsible for reviewing all orders before approving them to become active in the eMAR system.
-She had only been employed by the facility for 2 weeks and had not had time to fully check every resident's medication orders in the eMAR system.
-The medication was on Resident #3's eMAR for only 8:00am and not 8:00pm and this was a computer error.
-Resident #3's Pantoprazole 40mg should have been administered twice daily.

Interview with the Regional Director of Operations on (RDO) 05/07/26 at 3:53pm revealed:
-The RCD was responsible for sending orders to the pharmacy.
-There were storage bins located in the RCD's office for new orders or hospital discharge orders

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to be stored for the RCD to review.
-The RCD was responsible for reviewing all orders from the bins daily to ensure that the orders were complete and accurate.
-The RCD was responsible for ensuring that all orders aligned with the resident's care plan and physician instructions.
-If there were any unclear orders, the RCD was responsible for seeking clarification immediately with the provider or hospital.
-The pharmacy usually entered orders into the eMAR system.
-The RCD had to approve orders for the orders to become active in the eMAR system.
-Resident #3's Pantoprazole 40mg should have been administered twice daily.
-He was unsure why this was not noticed sooner.

Attempted telephone interviews with Resident #3's primary care provider (PCP) on 05/07/26 at 5:53pm and 6:37pm were unsuccessful.

b. Review of Resident #3's hospital discharge summary dated 03/19/26 revealed there was an order for Carvedilol 12.5mg 1 tablet 2 times a day, hold for systolic blood pressure (SBP) less than (<) 100 or heart rate (HR) <60. (Carvedilol is used to lower blood pressure (BP) and HR.)

Review of Resident #3's March 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for Carvedilol 12.5mg take 1 tablet 2 times a day, hold for SBP<100 and HR<60.
-Carvedilol was scheduled at 8:00am and 8:00pm.
-Carvedilol was documented as administered twice daily from 03/01/26-03/31/26, except from 03/17/26-03/19/26 when the resident was in the

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hospital and 03/04/26 at 8:00pm, 03/12/26 at 8:00pm, 03/19/26 at 8:00pm and 03/24/26 at 8:00pm when the resident refused.
-There was no space for the BP or HR to be documented with the Carvedilol entry.
-There were entries in the "Vitals" section of the eMAR.
-The resident's BP ranged from 100/61-157/95 from 03/01/26-03/31/26.
-There were no HR checks documented for 8:00am or 8:00pm.

Review of Resident #3's April 2026 eMAR revealed:
-There was an entry for Carvedilol 12.5mg take 1 tablet 2 times a day, hold for SBP<100 or HR<60.
-Carvedilol was scheduled at 8:00am and 8:00pm.
-Carvedilol was documented as administered twice daily from 04/01/26-04/30/26 except for 04/03/26 at 8:00pm, 04/04/26 at 8:00pm, 04/15/26 8:00pm, 04/18/26 at 8:00pm, 04/24/26 at 8:00pm when Resident #3 refused and 04/19/26 at 8:00pm when Resident #3 was out of the facility.
-There was no space for the BP or HR to be documented with the Carvedilol entry.
-There were entries in the "Vitals" section of the eMAR for BP.
-The resident's blood pressure ranged from 91/56-189/98 from 04/01/26-04/30/26.
-The medication was not administered on the days the SBP was <100.
-There were no HR checks documented for 8:00am or 8:00pm.

Review of Resident #3's May 2026 eMAR revealed:
-There was an entry for Carvedilol 12.5mg take 1 tablet 2 times a day, hold for SBP<100 or HR<60.

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-Carvedilol was scheduled at 8:00am and 8:00pm.
-Carvedilol was documented as administered twice daily from 05/01/26-05/06/26 except for 05/01/26 when the medication was not available.
-There was no space for the BP or HR to be documented with the Carvedilol entry.
-There were entries in the "Vitals" section of the eMAR.
-The resident's BP ranged from 96/69-174/82 from 05/01/26-05/06/26.
-There were no HR checks documented for 8:00am or 8:00pm.

Observation of Resident #3's medications on hand on 05/07/26 at 5:49pm revealed:
-There was a supply of 60 Carvedilol 12.5mg tablets dispensed on 04/08/26 with instructions to take 1 tablet by mouth twice a day for hypertension, hold for SBP<100 or HR<60.
-There were 7 of 60 tablets remaining.

Interview with Resident #3 on 05/07/26 at 6:41pm revealed:
-The MAs checked her BP every morning and at night.
-The MAs had never checked her HR.
-She denied any current symptoms of high or low BP.

Interview with a medication aide (MA) on 05/07/26 at 2:40pm revealed:
-She checked Resident #3's BP before administering Carvedilol every morning.
-Resident #3's BP was documented in the eMAR system.
-There was not a place to document HR in the eMAR system.
-She did not know there was a place to document the HR in the eMAR system.

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D 358	Continued From page 26 -She thought that checking the BP was enough. Interview with the Resident Care Director (RCD) on 05/07/26 at 3:45pm revealed: -She could not locate any HRs on the eMAR for Resident #3's Carvedilol. -She was responsible for checking orders and approving them in the eMAR system. -She had not noticed any problems with Resident #3's Carvedilol parameter not being followed. -She believed that the word "or" in the order may have confused the MA. -The MA checked the BP twice a day but not the HR because the MA did not see a place to document HR. Interview with the Regional Director of Operations (RDO) on 05/07/26 at 3:53pm revealed: -The RCD was responsible for sending orders to the pharmacy. -There were storage bins located in the RCD's office for new orders or hospital discharge orders to be stored for the RCD to review. -The RCD was responsible for reviewing all orders from the bins daily to ensure that the orders were complete and accurate. -The RCD was responsible for ensuring that all orders aligned with the resident's care plan and physician instructions. -If there were any unclear orders, the RCD was responsible for seeking clarification immediately with the provider or hospital. -The pharmacy usually entered orders into the eMAR system. -The RCD had to approve orders for the orders to become active in the eMAR system. -Resident #3's Carvedilol 12.5mg orders were not followed as directed by the eMAR. -Resident #3's HR should have been checked and documented.	D 358		

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D 358	Continued From page 27 Attempted telephone interviews with Resident #3's primary care provider (PCP) on 05/07/26 at 5:53pm and 6:37pm were unsuccessful.	D 358		
D 371	10A NCAC 13F .1004 (n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION. The Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record review, the facility failed to ensure infection control measures were implemented during the morning medication pass on 05/06/26 by 2 of 2 medication aides observed who failed to wash or sanitize their hands prior to preparing and after administering multiple oral medications, insulins, nasal sprays, applying topical patches, and performing fingerstick blood sugar checks. The findings are: Review of the facility's Infection Prevention and Control Policy for Medication Administration revised on 05/06/26 revealed:	D 371		

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D 371	Continued From page 28 -The purpose of the policy was to establish standardized infection prevention and control procedures during medication administration to reduce the risk of transmission of infectious organisms, protect residents and staff, and ensure compliance with North Carolina (NC) licensing requirements and Centers for Disease Control (CDC)-based infection prevention standards. -The facility should ensure that all medication administration was performed in a manner that prevented cross-contamination and the spread of infection. -All staff responsible for medication administration should adhere to standard precautions and infection control practices consistent with the CDC guidelines and NC Division of Health Services Regulation (DHSR) expectations for assisted living facilities. -Staff should perform hand hygiene before and after each resident during the medication pass. -Hand hygiene should be performed between residents and after any contact with potentially contaminated surfaces. -Alcohol-based hand sanitizer may be used when hands were not visibly soiled. -Soap and water must be used when hands were visibly soiled or following exposure to bodily fluids. -Gloves should be worn when there was potential contact with bodily fluids, mucous membranes, or non-intact skin, including administration of topical, ophthalmic, otic, or injectable medications if applicable. -Gloves should be removed immediately after use and disposed of appropriately, followed by hand hygiene. 1. Observation of a medication aide (MA) administering medications on the 100 Hall during	D 371		

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D 371	Continued From page 29 the 8:00am medication pass on 05/06/26 from 7:50am - 8:17am revealed: -There was a bottle of hand sanitizer on top of the medication cart. -At 7:50am, the MA was on the 100 Hall administering medications to the residents. -At 7:52am, the MA opened the drawer to one of the medication carts to retrieve medications for a resident. -The MA did not sanitize or wash her hands prior to preparing medications for the resident. -The MA administered 9 different oral medications to the resident in the resident's room at 7:57am. -At 8:00am, the MA handed a nasal spray to the same resident for the resident to spray in the resident's nostrils. -At 8:02am, the MA used gloves to apply a topical patch to the same resident's upper right arm. -The MA went back to the medication cart and retrieved the same resident's glucometer and used gloves to check the resident's blood sugar at 8:06am. -The MA then went back to the medication cart and retrieved two insulin pens for the same resident. -At 8:10am and 8:11am, the MA used gloves to administer the two insulins to the same resident. -The MA then returned to the medication cart and prepared an oral controlled substance for the same resident. -At 8:15am, the MA administered the oral controlled substance to the same resident. -The MA returned to the medication cart and used her hands to enter documentation into the computer system and to handwrite information in the controlled substance log notebook. -The MA did not sanitize or wash her hands. -At 8:17am, the MA pushed the medication cart down the hall and proceeded to start preparing	D 371		

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medications for a second resident.
-The MA did not wash or sanitize her hands prior to preparing medications for the next resident.

Interview with the Administrator on 05/06/26 at 2:36pm revealed the MA who administered medications on the 100 Hall during the 8:00am medication pass today, 05/06/26, was unavailable for interview because the MA had left work early because she was feeling sick.

Refer to interview with the Resident Care Director (RCD) on 05/06/26 at 2:30pm.

Refer to interview with the Administrator on 05/06/26 at 2:36pm.

Refer to interview with the facility's contracted primary care provider (PCP) on 05/07/26 at 11:32am.

2. Observation of a medication aide (MA) administering medications on the 200 Hall during the 8:00am/9:00am medication pass on 05/06/26 from 8:35am - 9:47am revealed:
-There was a bottle of hand sanitizer on top of the medication cart.
-At 8:35am, the MA was on the 200 Hall preparing to administer medications to a resident.
-The MA did not sanitize or wash her hands prior to preparing medications for the resident.
-At 8:38am, the MA used gloves to check the resident's blood sugar.
-The MA removed the gloves and then started preparing oral medications for the same resident.
-At 8:51am, the MA administered 15 different oral medications to the resident in the resident's room.
-The MA went back to the medication cart and retrieved an oral inhaler for the same resident.
-At 9:00am, the MA prepared the oral inhaler and

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handed it to the resident to use and then gave the resident a cup of water to rinse and spit, then the MA took the cup back from the resident.
-At 9:03am, the MA used gloves to remove an old topical patch from the same resident's lower back and apply a new topical patch to the resident's lower back.
-At 9:07am, the MA used gloves to apply a different topical patch on the same resident's right upper arm.
-At 9:14am, the MA used her hands to search the medication cart for a nasal spray for the same resident but was unable to locate it.
-The MA then used her hands to enter documentation into the computer system.
-The MA did not sanitize or wash her hands.
-At 9:15am, the MA pushed the medication cart to another resident's room, put on gloves then removed the gloves and retrieved a blood pressure machine from the medication cart.
-Someone from an outside agency came to the medication cart and asked the MA a question.
-The MA used her bare hands to type on the computer to get the needed information, then walked down the hall with agency staff and knocked on a resident door with her bare hands to show a resident to the agency staff.
-At 9:20am, the MA returned to the medication cart but did not wash or sanitize her hands.
-The MA put on gloves and took the blood pressure machine into the second resident's room to check the resident's blood pressure.
-At 9:24am, the MA came out of the resident's room and had to go down the hall to retrieve another blood pressure machine.
-At 9:26am, the MA returned to the resident's room still wearing gloves and went inside with a different blood pressure machine and checked the resident's blood pressure and used a glucometer to check the resident's blood sugar.

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D 371	Continued From page 32 -At 9:30am, the MA returned to the medication cart, removed gloves, and retrieved an insulin pen. -The MA used her bare hands to type information into the computer system and then started putting oral medications into a cup and using the touch screen on the laptop computer. -The MA used an ink pen to handwrite information in the controlled substance log notebook and put the notebook back in the medication cart. -The MA locked the medication cart, put on gloves, poured water in a cup and went into the resident's room to administer medications at 9:42am. -At 9:43am, the MA returned to the medication cart, removed her gloves, and scratched her head with her bare hands. -The MA did not wash or sanitize her hands. -The MA then prepared an oral medication in a cup for a third resident and entered information into the computer using the touch screen. -The MA then poured a cup of water, went into the third resident's room and administered the medication. -At 9:47am, the MA returned to the medication cart, did not wash or sanitize her hands, then walked away from the medication cart. Interview with the MA on 05/06/26 at 2:07pm revealed: -She usually sanitized her hands between each resident during the medication pass if her hands were soiled. -She sometimes washed her hands with soap and water if her hands were soiled. -She forgot to sanitize her hands during the medication pass that morning (05/06/26). Refer to interview with the Resident Care Director (RCD) on 05/06/26 at 2:30pm.	D 371		

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D 371	Continued From page 33 Refer to interview with the Administrator on 05/06/26 at 2:36pm. Refer to interview with the facility's contracted primary care provider (PCP) on 05/07/26 at 11:32am. _____ Interview with the Resident Care Director (RCD) on 05/06/26 at 2:30pm revealed: -The medication aides (MAs) had hand sanitizer and wipes available for use on the medication carts. -The MAs should use hand sanitizer between each resident during the medication pass and wash with soap and water after every fifth resident. Interview with the Administrator on 05/06/26 at 2:36pm revealed: -Hand sanitizer was available on the medication carts. -The MAs should use hand sanitizer between each resident during the medication pass and wash with soap and water after every third resident. Interview with the facility's contracted primary care provider (PCP) on 05/07/26 at 11:32am revealed: -The MAs should sanitize or wash their hands during the medication pass. -Not washing or sanitizing hands during the medication pass could potentially cause contamination and spread germs.	D 371		