STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019022	A. BUILDING: _____ B. WING _____	R 06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNMORE SENIOR LIVING OF SILER CITY	260 VILLAGE LAKE ROAD SILER CITY, NC 27344

(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 a follow up survey on 06/02/26.	{D 000}		
D 056	10A NCAC 13F .0305 (f)(5) Physical Environment 10A NCAC 13F .0305 Physical Environment (f) The requirements for storage rooms and closets are: (5) the requirements for housekeeping storage are: (A) a housekeeping closet, with mop sink or mop floor receptor, shall be provided at the rate of one per 60 residents or portion thereof. In multi-level facilities, each resident floor shall have a housekeeping closet; and (B) there shall be separate locked areas for storing cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled, or handled. Cleaning supplies shall be monitored while in use; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure substances that may be hazardous were kept in a separate locked area and not accessible to residents in the Special Care Unit (SCU). The findings are: Observation of an unlocked nutrition room on 06/02/26 at 8:22am revealed: -There was a bottle containing a blue liquid with disinfectant spray handwritten on the bottle. -There were no warnings on the spray bottle. -There was a bottle of cleaning powder.	D 056		

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D 056	Continued From page 1 -The warnings on the cleaning powder included causing serious eye irritation and mild skin irritation; do not ingest, inhale or get in the eyes. Observation of an unlocked janitor room on 06/02/26 at 8:29am revealed: -There was a keypad lock on the door. -The door was able to be opened without entering the code on the keypad lock. -There was a cleaning cart containing several spray bottles containing liquid and other cleaning products just inside the janitor room. Observation of the SCU on 06/02/26 at 8:30am revealed: -There was 1 staff member located in the dining room with 6 residents. -There was 1 resident walking down the hall wandering in and out of rooms. Interview with a medication aide (MA) on 06/02/26 at 8:50am revealed: -The janitor door was always locked. -The janitor door had a keypad lock with a code that needed to be entered to open the door. -She was not sure how the janitor door became unlocked. -She was not sure how long the janitor door was unlocked. -The nutrition room door was never locked. -She had not entered the nutrition room that morning. -She did not know there were cleaning products in the nutrition room. -The cleaning supplies should not have been in the nutrition room. -All cleaning supplies should be stored in a locked area. -A resident could enter the nutrition room and get into the cleaning products.	D 056		

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D 056	Continued From page 2 -There was a resident that wandered the SCU going into open and unopened doors. Observation of the Lead Housekeeper on 06/02/26 at 8:59am revealed: -She opened the door to the janitor room door without putting in the code on the keypad lock. -She turned the lock on the back of the door and shut the door. -She turned the handle but could not open the door. -She entered the code on the keypad lock and opened the door. Interviews with the Lead Housekeeper on 06/02/26 at 9:00am and 12:06pm revealed: -The disinfectant spray bottle in the nutrition room and the spray bottles on the cleaning cart were filled from large chemical containers located in the laundry room. -The janitor room was always supposed to be locked. -She had entered the janitor room several times that morning. -She did not realize the janitor room was unlocked because she entered the code like she would every time she entered the janitor room. -She was not sure how long the janitor door was unlocked. -The nutrition room was never locked. -She had seen cleaning supplies in the nutrition room before. -She had told staff not to keep cleaning supplies in the nutrition room but could not remember when. -She was concerned a resident could get into the cleaning supplies and get hurt or poisoned. Observation of the laundry room on 06/02/26 at 2:16pm revealed:	D 056		

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D 056	Continued From page 3 -The laundry room was located in the Assisted Living area of the facility and stored the bottles of cleaning solution that were on the cleaning cart in the SCU. -There were 4 large containers labeled for different cleaning areas. -There was a large container labeled as a rapid multi-surface disinfectant cleaner. -The warnings on the rapid multi-surface disinfectant cleaner included causing severe skin burns and eye damage, harmful if inhaled. -There was a large container labeled disinfecting acid bathroom cleaner. -The warning on the disinfecting acid bathroom cleaner included causing irreversible eye damage. -There was a large container labeled bio-enzymatic odor eliminator. -The warnings on the bio-enzymatic odor eliminator included causing serious eye damage. -There was a large container labeled no-rinse alkaline floor cleaner. -The warnings on the no-rinse alkaline floor cleaner included causing severe skin burns and eye damage. Observation of a cleaning cart on 06/02/26 at 2:18pm revealed: -The same cart had been observed in the unlocked janitor room at 8:29am and was now located outside the main SCU doors in a hallway. -There was a can of aerosol odor eliminator spray on the cleaning cart. -The warnings on the odor eliminator spray included do not swallow or get in eyes; if swallowed, call poison control immediately. -There was a can of aerosol glass cleaner on the cleaning cart. -The warnings on the glass cleaner included harmful if swallowed, if swallowed, rinse mouth	D 056		

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D 056	Continued From page 4	D 056		

with water, drink large amount of water or milk, call a physician or poison control immediately.
-There was an aerosol furniture polish on the cleaning cart.
-The warnings on the furniture polish included may be fatal if swallowed and enters airways, causes serious eye irritation.
-There was a bottle of toilet bowl cleaner on the cleaning cart.
-The warnings on the toilet bowl cleaner included causing irreversible eye damage and skin burns; if swallowed, call poison control or a doctor immediately.
-There was a container of disinfectant wipes on the cleaning cart.
-The warnings on the disinfectant wipes included causing moderate eye irritation, hazardous to humans, harmful if inhaled.

Interview with a personal care aide (PCA) on 06/02/26 at 2:24pm revealed:
-The janitor door was always locked.
-The nutrition room was never locked.
-He noticed the cleaning products in the nutrition room that morning.
-He did not remove the cleaning products from the nutrition room or tell management.
-Usually when he saw the cleaning products in the nutrition room, he would dump them out or put the cleaning products in the janitor room away from the residents.
-He was not sure why he did not dump or put the cleaning products in the janitor room that morning.
-He knew cleaning products should be stored in a locked area.
-A resident wandered into rooms in the SCU.

Interview with the Special Care Unit Coordinator (SCC) on 06/02/26 at 2:34pm revealed:

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D 056	Continued From page 5 -The janitor room door should have been locked. -She did not know the janitor room door was not locked that morning. -She was not sure why a staff member would unlock the janitor door. -She was not aware there were cleaning supplies in the nutrition room. -She had not entered the nutrition room today, 06/02/26. -SCU staff would use the cleaning supplies to clean up after meals. -All chemicals including cleaning supplies should be stored behind a locked door. -She was concerned that a resident could accidentally ingest a cleaning product, get it on their skin or eyes and become seriously injured. -She expected all cleaning products to be stored behind a locked door. Interview with the Resident Care Coordinator (RCC) on 06/02/26 at 2:50pm revealed: -The janitor room door was always supposed to be locked. -She was not sure how the janitor room door became unlocked. -The nutrition room was never locked. -The cleaning supplies should not be stored in the nutrition room. -She was concerned a resident could get into the cleaning products and injure themselves. -She expected staff to store all cleaning products in a locked room. Interview with the Administrator on 06/02/26 at 3:20pm revealed: -She was not aware there were cleaning products left out where a resident could get to them. -She was concerned a resident could become injured if they were to get into the cleaning products	D 056		

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D 056	Continued From page 6 -She expected all cleaning supplies to be locked away from the residents. Telephone interview with the facility's contracted primary care provider (PCP) on 06/02/26 at 4:40pm revealed: -Cleaning products could cause serious harm to a resident if ingested. -If a resident were to get a cleaning product on their skin it could cause burns to the skin. -He expected all cleaning products to be locked away and not accessible to the residents in the SCU.	D 056		
D 067	10A NCAC 13F .0305 (h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) in facilities with at least one resident who is determined by a physician or is otherwise observed by staff to be disoriented or exhibits wandering behavior, a continuously sounding device that is activated when the door is opened shall be located on each exit door that opens to the outside. The sound shall be audible in the facility. If a central system of remote sounding devices is provided, the control panel shall be powered by the facility's electrical system, and be in a location accessible by staff to operate the control panel. Notwithstanding the requirements of Rule .0301, the requirements of this Paragraph shall apply to new and existing facilities.	D 067		

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D 067	Continued From page 7 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 3 exterior exit doors was equipped with a continuous sounding device that was audible throughout the facility when the door was opened and accessible to 2 of 2 sampled residents residing in the Special Care Unit (SCU) who had diagnoses of dementia, were constantly disoriented, and were known to wander. The findings are: Observation of the SCU on 06/02/26 at 8:29am revealed: -There was a resident wandering in and out of rooms in the SCU. -There was an interior door labeled janitor/sprinkler room. -The janitor/sprinkler room door had a keycode lock on the outside of the door. -The janitor/sprinkler room door was unlocked and able to be opened without entering a keycode. -The janitor/sprinkler room door did not alarm when opened. -Inside the room was an unlocked exit door that led to the parking lot of the facility that did not alarm when opened. -The parking lot did not have a secure fence surrounding it and was next to a busy 2 lane road. Observation of the Lead Housekeeper on 06/02/26 at 8:59am revealed: -She opened the janitor/sprinkler room door without putting in the code on the keypad lock. -She turned the lock on the back of the janitor/sprinkler room door and shut the door.	D 067		

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D 067	Continued From page 8	D 067		

-She turned the handle but could not open the janitor/sprinkler room door.
-She entered the code on the keypad lock and opened the janitor/sprinkler room door.

1. Review of Resident #2's FL2 dated 05/04/26 revealed:
-Diagnoses included dementia.
-Resident #2 was constantly disoriented.
-Resident #2 had wandering behavior.

Telephone interview with Resident #2's primary care provider (PCP) on 06/02/26 at 4:40pm revealed:
-He was concerned Resident #2 could exit through the unlocked door without staff knowledge.
-He expected all exit doors to be alarmed to alert staff if a resident exited the SCU.

Attempted telephone interview with Resident #2's power of attorney (POA) on 06/02/26 at 10:42am was unsuccessful.

Refer to interview with a medication aide (MA) on 06/02/26 at 8:50am.

Refer to interview with the Lead Housekeeper on 06/02/26 at 9:00am.

Refer to interview with a personal care aide (PCA) on 06/02/26 at 2:24pm.

Refer to interview with the Resident Care Coordinator (RCC) on 06/02/26 at 2:50pm.

Refer to interview with the Administrator on 06/02/26 at 3:20pm.

2. Review of Resident #4's FL2 dated 05/04/26

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D 067	Continued From page 9	D 067		

revealed:
-Diagnoses included moderate dementia with mood disturbance.
-Resident #4 was constantly disoriented.
-Resident #4 had wandering behavior.

Review of Resident #4's current care plan dated 02/18/26 revealed:
-Resident #4 had significant memory loss.
-Resident #4 was independent with ambulation and transferring.
-Resident #4 wandered most of the day in the halls, going into other residents' rooms.

Interview with a medication aide (MA) on 06/02/26 at 8:50am revealed:
-Resident #4 wandered the SCU going into open and unopened doors.
-She had not seen Resident #4 attempt to open the janitor/sprinkler room door.

Interview with a personal care aide (PCA) on 06/02/26 at 2:24pm revealed Resident #4 wandered into rooms.

Interview with the Resident Care Coordinator (RCC) on 06/02/26 at 2:50pm revealed:
-Resident #4 wandered through the SCU.
-She was concerned Resident #4 could enter through the unlocked door in the janitor/sprinkler room and go outside.

Interview with the Administrator on 06/02/26 at 3:20pm revealed Resident #4 wandered a lot and she was concerned Resident #4 could exit the facility and elope if the exit doors were not alarmed.

Telephone interview with Resident #4's Primary Care Provider (PCP) on 06/02/26 at 4:40pm

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D 067	Continued From page 10 revealed: -He was concerned Resident #4 could exit through the unlocked door without staff knowledge. -He expected all exit doors to be alarmed to alert staff if a resident exited the SCU. Attempted telephone interview with Resident #4's power of attorney (POA) on 06/02/26 at 10:44am was unsuccessful. Refer to interview with a MA on 06/02/26 at 8:50am. Refer to interview with the Lead Housekeeper on 06/02/26 at 9:00am. Refer to interview with a PCA on 06/02/26 at 2:24pm. Refer to interview with the RCC on 06/02/26 at 2:50pm. Refer to interview with the Administrator on 06/02/26 at 3:20pm. _____ Interview with a medication aide (MA) on 06/02/26 at 8:50am revealed: -The janitor/sprinkler room door should always be locked. -The janitor/sprinkler room door had a keypad lock with a code that needed to be entered to open the door. -She was not sure how the janitor door became unlocked. -She was not sure how long the janitor door was unlocked. Interview with the Lead Housekeeper on 06/02/26 at 9:00am revealed:	D 067		

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-She had entered the janitor/sprinkler room several times that morning.
-She did not realize the janitor/sprinkler room was unlocked because she entered the code like she would every time she entered the room.
-She was not sure how long the janitor/sprinkler door was unlocked.
-She was concerned a resident could exit through the unlocked door and get lost.

Interview with a PCA on 06/02/26 at 2:24pm revealed:
-He was not sure how long the janitor/sprinkler room door could have been unlocked.
-He was concerned a resident could enter the janitor/sprinkler room door and exit the SCU.

Interview with the Special Care Unit Coordinator (SCC) on 06/02/26 at 2:34pm revealed:
-A code must be entered to open the janitor/sprinkler room door.
-She did not know the janitor/sprinkler room door was unlocked.
-She was not sure how the janitor/sprinkler room door became unlocked.
-She was not sure how long the janitor/sprinkler room door had been unlocked.
-She was concerned a resident could exit the SCU without staff knowledge.

Interview with the Resident Care Coordinator (RCC) on 06/02/26 at 2:50pm revealed:
-The janitor/sprinkler room door should always be locked and a code entered to open the door.
-She was not sure how the janitor/sprinkler room door became unlocked.
-The exit door in the janitor/sprinkler room did not have an alarm because the interior door was always locked.

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D 067	Continued From page 12 Interview with the Administrator on 06/02/26 at 3:20pm revealed: -She was not aware the janitor/sprinkler room door was unlocked. -The janitor/sprinkler room door should be always locked. -There was no reason why the janitor/sprinkler room door should have been unlocked. -She knew that it had been no more than 1 week since the janitor/sprinkler room door could have been unlocked because she had a team working on equipment located in the janitor/sprinkler room 1 week prior. -She expected the janitor/sprinkler room door to always be locked. _____ The facility failed to ensure 1 of 3 exterior exit doors in the Special Care Unit (SCU) was equipped with a continuous sounding device that alerted staff when activated for residents who were identified by their physician to be constantly disoriented and wandered (#2 and #4) and being accessible to a resident (#4) who was known to wander throughout the SCU. The exterior exit door led to the facility parking lot located near a busy road. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/02/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 17, 2026.	D 067		
{D 273}	10A NCAC 13F .0902(b) Health Care	{D 273}		

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{D 273}	Continued From page 13 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was abated. Non-compliance continues. Based on interviews and record reviews, the facility failed to ensure referral and follow-up to meet the health care needs for 2 of 3 sampled residents (#1 and #2), including a resident (#1) whose blood pressure (BP) readings were outside the ordered parameter, and the primary care provider (PCP) was not notified, and a resident (#2) that had an order to schedule a follow-up appointment with a cardiologist provider. The findings are: 1. Review of Resident #2's FL2 dated 05/04/26 revealed diagnoses included persistent atrial fibrillation (an irregular heartbeat), chronic systolic congestive heart failure (the heart cannot pump blood effectively), and hypertension (high blood pressure). Review of Resident #2's PCP's visit note dated 04/06/26 revealed there was an order to arrange a follow-up appointment with Resident #2's cardiologist related to recent septal MI (damage to the septum - the thick wall of muscle that separates the heart's two lower chambers) and management of heart failure.	{D 273}		

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{D 273}	Continued From page 14 Review of Resident #2's record revealed there was no after visit summary from a cardiologist available fore review. Interview with the Resident Care Coordinator (RCC) on 06/02/26 at 2:50pm revealed: -She was aware of the order to arrange a follow-up appointment with Resident #2's cardiologist. -She discussed the follow-up appointment with Resident #2's PCP on 04/06/26 and the PCP was supposed to contact Resident #2's family member to schedule the appointment. -She did not follow-up to ensure the family member was contacted and made Resident #2's cardiology appointment. Interview with Resident #2's PCP on 06/02/26 at 4:40pm revealed: -He ordered the follow-up cardiology appointment for Resident #2 because of the different heart-related diagnoses Resident #2 had. -There was a note in his computer system documenting that he contacted Resident #2's family member around 04/06/26 but there were no notes of what was discussed. -He expected the facility to follow-up to ensure Resident #2 had a scheduled cardiology appointment made. Interview with the Administrator on 06/02/26 at 3:20pm revealed: -It was the responsibility of the RCC to ensure follow-up appointments were made. -She expected the RCC to follow up with Resident #2's family member to ensure that the cardiologist appointment was made. Based on observations, interviews, and record reviews, it was determined Resident #2 was not	{D 273}		

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{D 273}	Continued From page 15 interviewable. Attempted telephone interview with Resident #2's family member on 06/02/26 at 10:42am was unsuccessful. 2. Review of Resident #1's current FL2 dated 04/06/26 revealed diagnoses included hypertension, chronic diastolic congestive heart failure, atrial fibrillation, and Alzheimer's disease. Review of Resident #1's signed PCP orders dated 04/06/26 revealed an order to monitor and record BP twice daily for 14 days. Call PCP if systolic BP was greater than 140 or less than 100, or heart rate greater than 120 or less than 55. Review of Resident #3's March 2026 electronic medication administration record (eMAR) revealed: -There was an entry to check Resident #1's BP and heart rate twice daily, scheduled at 8:00am and 8:00pm; call the PCP if the systolic BP was greater than 140 or less than 100 or heart rate greater than 120 or less than 55. -Resident #1's systolic BP was 96 on 03/28/26 at 2:00pm and 94 at 8:00pm. -Resident #1's systolic BP was 98 on 03/29/26 at 8:00am and 96 at 8:00pm. -Resident #1's systolic BP was 96 on 03/31/26 at 8:00pm. -There was no documentation the PCP was notified of the systolic BP readings less than 100. Review of Resident #1's April 2026 eMAR revealed: -There was an entry to check Resident #1's BP and heart rate twice daily, scheduled at 8:00am and 8:00pm; call the PCP if the systolic BP was	{D 273}		

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greater than 140 or less than 100 or heart rate greater than 120 or less than 55.
-Resident #1's systolic BP was 96 on 04/01/26 at 8:00pm.
-Resident #1's systolic BP was 94 on 04/02/26 at 8:00pm.
-Resident #1's systolic BP was 92 on 04/03/26 at 8:00am.
-Resident #1's systolic BP was 90 on 04/06/26 at 8:00am and 92 at 8:00pm.
-Resident #1's systolic BP was 98 on 04/07/26 at 8:00pm.
-There was no documentation the PCP was notified of the systolic BP readings less than 100.

Review of Resident #1's progress notes revealed no documentation that the PCP had been notified that the systolic BP was less than 100.

Interview with Resident #1 on 06/02/26 at 2:58pm revealed:
-The MA took her BP, and the physical therapist (PT) also took her BP.
-She knew when her BP was low because she would be dizzy.
-She complained to the PT about an hour ago that she was dizzy, but the PT took her BP, and it was fine.
-She did not recall at other times when her BP was low; it just happened off and on.

Interview with a medication aide (MA) on 06/02/26 at 3:08pm revealed:
-MAs were responsible for checking resident BPs.
-If a resident had a BP with parameters, she would notify the Resident Care Coordinator (RCC); the RCC called the PCP.
-If the RCC was not at the facility, she would contact the PCP, and she would document the

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{D 273}	Continued From page 17 notification on the resident's progress note. Interview with the RCC on 06/02/26 at 4:16pm revealed: -Any residents with BP readings that were outside of the PCP parameters, the PCP would be notified, and the notification would be documented in the residents' progress notes. -The MAs usually told her the BP results, and she notified the PCP, but the MAs should notify the PCP and document if she was not made aware. -She was not aware that Resident #1 had systolic BP readings that were less than 100. -She had not had a chance to audit Resident #1's MARs to have seen the BP readings. Telephone interview with Resident #1's PCP on 06/02/26 at 5:04pm revealed: -He was monitoring Resident #1's BP because her systolic BP was running low. -The order was to notify him when her systolic BP was less than 100. -Resident #1 was having issues with her heart rate being elevated, and the medication being administered was then causing her BP to drop, so they were trying to adjust her medications accordingly based on her BP readings. -If he had been notified, he would have been concerned if Resident #1's BP was too low and she was symptomatic. -Resident #1 knew that when she felt dizzy, she should sit down, so he was not concerned at this point because the resident had not had any falls or other outcomes. -He felt Resident #1's BPs had since improved. Interview with the Administrator on 06/02/26 at 4:40pm revealed: -She expected the MA or the RCC to notify the PCP when Resident #1's BP readings were	{D 273}		

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{D 273}	Continued From page 18 outside the ordered parameters. -There was a reason the BP parameters were ordered, and she expected the staff to follow through on the order.	{D 273}		
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 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 the medication aide (MA) observed 1 of 1 sampled resident take their medications that were left on a resident's table in their room (#5). The findings are: Review of the facility's medication guideline for the medication administration skills validation form revealed: -The MAs should observe a resident take their medications and ensure all medications had been swallowed. -This must be before documenting the administration of the medication.	D 366		

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Review of Resident #5's current FL2 dated 02/09/26 revealed:
-Diagnoses included atrial fibrillation, anxiety, memory loss, hypertensive heart disease, and chronic kidney disease.
-The resident was intermittently disoriented.

Review of Resident #5's signed primary care provider's (PCP) orders dated 04/23/26 revealed:
-There was an order for benazepril (used to treat high blood pressure) 40mg once daily.
-There was an order for diltiazem (used to treat high blood pressure) 300mg once daily.
-There was an order for Eliquis (a blood thinner) 2.5mg twice daily.
-There was an order for furosemide (used to treat fluid retention) 20mg, take ½ tablet every morning.
-There was an order for metoprolol succinate (used to treat high blood pressure) 200mg, once daily.
-There was an order for potassium chloride (a supplement) 40mg, take once daily.
-There was an order for sertraline (an antidepressant) 50mg, take one and ½ tablet once daily.
-There was an order for vitamin D3 (a supplement) 50mcg, once daily.

Observation of Resident #5's room on 06/02/26 at 8:28am revealed a medication cup, which contained 7 tablets, sitting on the table beside the resident's chair.

Interview with Resident #5 on 06/02/26 at 8:28am revealed:
-The MA did not leave her medications in the room when she first moved in (February 2025), but once the MA got to "know me," she knew "I would take them," so she felt comfortable leaving

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the medication in her room for her to take.
-The MA left the medications "not long ago".
-She had not taken any medications out of the cup yet, but she was getting ready to.

Second observation of Resident #5's room on 06/02/26 at 9:11am revealed there were no medications on Resident #5's table.

Review of Resident #5's June 2026 electronic medication administration record (eMAR) for 06/02/26 revealed:
-There was an entry for benazepril 40mg once daily with a scheduled administration time of 8:00am.
-There was documentation that benazepril 40mg was administered at 8:00am.
-There was an entry for diltiazem 300mg once daily with a scheduled administration time of 8:00am.
-There was documentation that diltiazem 300mg was administered at 8:00am.
-There was an entry for Eliquis 2.5mg with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation that Eliquis 2.5mg was administered at 8:00am.
-There was an entry for furosemide 20mg, take ½ tablet every morning with a scheduled administration time of 8:00am.
-There was documentation that furosemide 20mg, take ½ tablet, was administered at 8:00am.
-There was an entry for metoprolol succinate 200mg, once daily with a scheduled administration time of 8:00am.
-There was documentation that metoprolol succinate 200mg was administered at 8:00am.
-There was an entry for potassium chloride 40mg, take once daily with a scheduled administration

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time of 8:00am.
-There was documentation that potassium chloride 40mg was administered at 8:00am.
-There was an entry for sertraline 50mg, take one and ½ tablet once daily with a scheduled administration time of 8:00am.
-There was documentation that sertraline 50mg was administered at 8:00am.
-There was an entry for vitamin D3 50mcg, once daily with a scheduled administration time of 8:00am.
-There was documentation that vitamin D3 50mcg was administered at 8:00am.

Interview with the MA on 06/02/26 at 3:08pm revealed:
-She administered the 8:00am medications today, 06/02/26.
-She had administered Resident #5's medications today, 06/02/26, by 8:00am.
-Resident #5 was the last resident to have their medications administered because the resident did not like to go to breakfast.
-She watched Resident #5 take her medications today, 06/02/26.
-If there were medications in a cup in Resident #5's room, the medications must have been left by another MA.

Interview with Resident #5's family member on 06/02/26 at 4:07pm revealed:
-Resident #5 was forgetful.
-The MA administered Resident #5's medications.
-She thought Resident #5 "might" remember to take medications left in her room, but she was not sure.
-She had not seen any medications in Resident #5's room.

Telephone interview with Resident #5's PCP on

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D 366	Continued From page 22 06/02/26 at 5:04pm revealed: -He "used to think" Resident #5's memory was "pretty good," but recently she demonstrated having short-term memory loss. -He was not comfortable with Resident #5's medications being left in her room to take on her own. -Resident #5 was not "trustworthy" to take medications on her own because she might pick and choose what medications she wanted to take. Interview with the Resident Care Coordinator (RCC) on 06/02/26 at 4:16pm revealed: -The MA should watch the resident take their medications. -Medications should never be left in the resident's room. -She thought Resident #5 would take medications left in her room, without supervision, but Resident #5 did not have an order to self-administer her medications, and the medications should not have been left. Interview with the Administrator on 06/02/26 at 4:40pm revealed: -She expected the MAs to watch the resident take their medications and then document the administration on the MAR. -She knew Resident #5 did not like to get up early, but she would rather the resident's medications be administered late than leave the medications in the room.	D 366		