STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL087009	A. BUILDING: _____ B. WING _____	R 09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRYSON SENIOR LIVING	314 HUGHES BRANCH ROAD BRYSON CITY, NC 28713

(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 Swain County Department of Social Services conducted a follow-up survey on 09/16/25 through 09/17/25.	D 000		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to administer medications as ordered for 2 of 5 sampled residents (#3 & #4) related to a medication to control pain (Resident #3) and a medication used to treat gastroesophageal reflux disease (GERD) (Resident #4). The findings are: 1. Review of Resident #3's current FL2 dated 01/30/25 revealed diagnoses include hypertension, chronic pain, depression and diabetes. Review of Resident #3's physician orders dated 08/26/25 revealed an order for ibuprofen 200 mg, 2 tablets every 8 hours as needed (used to control pain). Observation of Resident #3's medications on	D 358		

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09/16/25 at 9:35am revealed:
-The medications were in a cup on a windowsill in Resident #3's bedroom.
-The cup contained 4 orange colored tablets with the marking "I-2".

Interview with Resident #3 on 09/16/25 at 9:35am revealed his morning medications were left in the cup on his windowsill because he was asleep when the medication aide (MA) came earlier.

Observation of Resident #3's medications on hand on 09/16/25 at 12:35pm revealed:
-There was a bubble pack containing ibuprofen, 200mg.
-Each bubble in the pack contained 2 tablets.
-When the bubble pack was looked at face on it appeared there was one tablet in each bubble, even though there were two tablets in each bubble.

Interview with the MA on 09/16/25 at 12:35pm revealed:
-The 4 tablets in Resident #3's cup that were marked "I-2" were the ibuprofen.
-When she popped Resident #3's medications into his cup earlier in the day she was in a hurry.
-Because she was in a hurry she did not look at the bubble pack closely and forgot that each bubble contained 2 tablets, so she popped 2 bubbles into his medication cup, for a total of 4 tablets.
-She did not look into the cup to see there were 4 tablets.

Attempted interview with Resident #3's primary care provider on 09/16/25 at 4:40pm was unsuccessful.

Interview with the Administrator on 09/16/25 at

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9:56am revealed:
-The MAs were trained to administer medications properly and he expected them to administer medications as they were trained.
-Being in a hurry was not an excuse for not paying attention.

2. Review of Resident #4's current FL2 dated 03/13/25 revealed:
-Diagnoses include chronic kidney disease and diabetes.
-An order for omeprazole 20mg twice daily (used to treat GERD).

Observation of Resident #4's medications on 09/16/25 at 9:41am revealed:
-The medications were in a cup on a nightstand in Resident #'4's bedroom.
-The cup contained a total of 9 tablets.

Interview with Resident #4 on 09/16/25 at 9:41am revealed:
-He was asleep when the medication aide (MA) brought his morning medications so she left them on his nightstand.
-He planned to take the medication in about 15 minutes.

Review of Resident #4's September 2025 electronic medication administration record (eMAR) revealed:
-There was documentation 9 medications were administered for a total of 10 tablets on 09/16/25.
-Omeprazole 20mg was documented as administered on 09/16/25.

Observation of Resident #4's medication on hand on 09/16/25 at 3:45pm revealed:
-Medications were packaged in a multi-dose pack.

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D 358	Continued From page 3 -Omeprazole 20mg was in a bubble pack and not included in the multi-dose package. -Omeprazole was stored in a different drawer on the medication cart. Interview with the MA on 09/16/25 at 3:45pm revealed: -Resident's multi-dose medications were kept in one drawer of the medication cart and medications that were delivered in a bubble pack were kept in a different drawer on the cart. -She was in a hurry when she was preparing Resident #4's morning medications and forgot to get the bubble pack containing the omeprazole from the other drawer. -Resident #4 should have a total of 10 tablets in his morning medication cup but since she forgot the omeprazole there were only 9 tablets. Attempted interview with Resident #4's primary care provider on 09/16/25 at 4:40pm was unsuccessful. Interview with the Administrator on 09/16/25 at 9:56am and 09/17/25 at 9:45am revealed: -The MAs were trained to administer medications properly and he expected them to administer medications as they were trained. -Being in a hurry was not an excuse for not paying attention and cutting corners. -If the MAs scanned the medications it would automatically document it as administered and they could see if they had left a medication in the cart.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 366		

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D 366	Continued From page 4 (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: TYPE B VIOLATION Based on observations, interviews and record reviews the facility failed to ensure 2 of 5 sampled residents (#3, #4) were observed taking medications and failed to ensure 1 of 5 sampled residents (#4) had the medications documented as administered by the person who administered the medications. The findings are: Observation on 09/16/25 at 2:00pm revealed: -A resident exited room #201. -The resident appeared confused, was partially clothed and held soiled underwear in her hands. -The bathroom inside room #201 had the confused residents' soiled pants, socks and shoes on the floor. -The Administrator redirected the resident and took her to her room on the other end of the building. Interview with the Administrator on 09/17/25 at 8:00am revealed the resident who needed to be redirected on 09/16/25 had a diagnosis of dementia and had a history of wandering around	D 366		

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the facility.

Review of the resident roster revealed the confused resident resided in room #107.

1. Review of Resident #4's current FL2 dated 03/13/25 revealed:
-Diagnoses include chronic kidney disease and diabetes.
-An order for dapagliflozin propanediol 10mg daily (used to treat chronic kidney disease).
-An order for Allopurinol 300mg, 1 1/2 tablets daily (used to treat kidney stones).
-An order for indapamide 1.25mg twice daily (used to control blood pressure).
-An order for Eliquis 5 mg twice daily (used as a blood thinner).
-An order for metoprolol 12.5mg twice daily (used to control blood pressure).
-An order for magnesium oxide 400mg daily (a supplement).
-An order for a multi-vitamin daily (a supplement).
-An order for calcium carbonate with Vitamin D3 1200mg-25mcg daily (a supplement).

Review of the resident roster revealed Resident #4 resided in room #203.

Observation of Resident #4's room on 09/16/25 at 9:41am revealed there was a small white medication cup beside the bed on the nightstand that contained 9 pills.

Interview with Resident #4 on 09/16/25 at 9:41am revealed:
-The pills in the cup were his morning medications the medication aide (MA) left for him earlier.
-Most mornings his medications were left at his bedside because he was asleep when the MA

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came to administer medications.
-The MAs leave his medications on his nightstand because they know he will take them properly.
-He would take the medications in about 15 minutes when he got out of bed.

Interview with a MA on 09/16/25 at 9:48am revealed:
-She was a MA and administered medications earlier today (09/16/25).
-She was late for her shift and was running behind schedule and knew medications were going to be late so she asked the PCA/MA (personal care aide/medication aide) who was working with her to administer the medications she prepared for Resident #4.
-She did not know the PCA/MA left Resident #4's medications on his nightstand.
-She documented the administration of Resident #4's medications even though the PCA/MA was the one who actually administered them.
-She knew she was not supposed to have the PCA/MA administer the medications unless the PCA/MA was going to document the administration of them in the electronic medication administration record (eMAR).
-She was trained in proper medication administration practices and she knew she did not follow proper procedure while administering medications earlier.

Interview with a PCA/MA on 09/16/25 at 9:50am revealed:
-She was working as a PCA today but also worked as a MA at the facility.
-She was helping the MA administer medications today because the MA was behind schedule.
-She left Resident #4's medications at his bedside earlier today because he was asleep when she attempted to administer them.

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-Resident #4 did not like to be awakened to take his medications so she left them there instead of awakening him.
-She had been a MA "long enough to know better than to do that."
-She was trained to properly administer medication.

Review of Resident #4's September 2025 eMAR revealed all 8:00am medications were documented as administered by the MA.

Review of Resident #4's 09/16/25 medication administration time report revealed all 8:00am medications were documented as administered at 8:38am.

Interview with the Administrator on 09/16/25 at 9:56am revealed:
-He was not aware the MAs were not observing residents take their medications.
-He was not aware a PCA/MA would administer medications and have the MA document the administration.
-Resident #4 did not like to be awakened in the morning and had a history of requesting the MAs leave the medications at his bedside so he could take them later but staff should not do that and they should still follow proper medication administration procedures.
-The MA and the PCA/MA were both trained to administer medications and document the administration properly and there was no excuse for them doing it wrong.

Attempted telephone interview with Resident #4's primary care provider on 09/16/25 at 4:40pm was unsuccessful.

2. Review of Resident #3's current FL2 dated

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D 366	Continued From page 8 01/30/25 revealed: -Diagnoses include hypertension, chronic pain, depression and diabetes. -An order for metformin 1000 mg twice daily (used to treat diabetes). -An order for lisinopril 20mg daily (used to treat hypertension). Review of Resident #3's physician orders revealed: -An order dated 04/29/25 for bupropion 150mg daily (used to treat depression) -An order dated 08/24/25 for tylenol 500mg, 2 tablets every 8 hours as needed (used to control pain). -An order dated 08/26/25 for ibuprofen 200 mg, 2 tablets every 8 hours as needed (used to control pain). Review of the resident roster revealed Resident #3 resided in room #204. Observation of Resident #3's room on 09/16/25 at 9:30am revealed there was a small white medication cup in the windowsill that contained 9 pills. Interview with Resident #3 on 09/16/25 at 9:34am revealed: -The pills in the cup were his morning medications the medication aide (MA) left for him earlier in the day. -Most mornings his medications were left at his bedside because he was asleep when the MA came. Observation of Resident #3 on 09/16/25 at 9:35am revealed he swallowed the 9 pills from the medication cup using water that was in a glass on the windowsill.	D 366		

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D 366	Continued From page 9 Interview with a MA on 09/16/25 at 9:48am revealed: -She was a MA and administered medications earlier today (09/16/25). -She was late for her shift and was running behind schedule and knew medications were going to be late so she left Resident #3's medications on his windowsill because he was asleep when she entered his room. -She was trained in proper medication administration practices and she knew she did not follow proper procedure while administering medications to Resident #3. Review of Resident #3's September 2025 eMAR revealed all 8:00am medications were documented as administered by the MA. Review of Resident #3's 09/16/25 medication administration time report revealed all 8:00am medications were documented as administered at 8:42am. Interview with the Administrator on 09/16/25 at 9:56am revealed: -He was not aware the MAs were not observing residents take their medications. -The MA was trained to administer medications properly. -Being in a hurry was not an excuse to cut corners and the MA made a judgement error when she chose to leave the medications at Resident #3's bedside. Attempted telephone interview with Resident #3's primary care provider on 09/16/25 at 4:40pm was unsuccessful. [Refer to tag 0358 10A NCAC 13F .1004a	D 366		

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D 366	Continued From page 10 Medication Administration]. _____ The facility failed to observe two residents take their morning medications, which included a medication to prevent blood clots, three medications used to treat high blood pressure, two medications used to lower blood sugar, a medication to treat diabetes and kidney disease, one medication to treat depression and two medications used to treat mild to moderate pain. The facility had a resident with dementia, who was known to have wandering behaviors and had to be redirected frequently. She was found exiting room 201 on 09/16/25 near the two rooms where twelve medications in two different rooms were left unattended for approximately 1 hour. This failure was detrimental to the health, safety and welfare of a resident and constitutes a Type B violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/17/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 01 2025.	D 366		