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THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation from 07/14/26-07/17/26.	D 000		
D 254	10A NCAC 13F .0801 (c) Resident Assessment 10A NCAC 13F .0801 Resident Assessment (c) When a facility identifies a change in a resident's baseline condition based upon the factors listed in Parts (1)(A) through (M) of this Paragraph, the facility shall monitor the resident's condition for no more than 10 days to determine if a significant change in the resident's condition has occurred. The facility shall conduct an assessment of a resident within three days after the facility identifies that a significant change in the resident's baseline condition has occurred. The facility shall use the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows: (1) Significant change is one or more of the following: (A) deterioration in two or more activities of daily living including bathing, dressing, personal hygiene, toileting, or eating; (B) change in ability to walk or transfer, including falls if the resident experiences repeated falls, meaning more than one, on the same day, or multiple falls that occur over several days to weeks, new onset of falls not attributed to an identifiable cause, a fall with consequent change in neurological status, or physical injury; (C) pain worsening in severity, intensity, or duration, occurring in a new location, or new onset of pain associated with trauma; (D) change in the pattern of usual behavior, new	D 254		

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onset of resistance to care, abrupt onset or progression of agitation or combative behavior, deterioration in affect or mood, or violent or destructive behaviors directed at self or others;
(E) no response by the resident to the intervention for an identified problem;
(F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period;
(G) when a resident has been enrolled in hospice;
(H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crater, or any pressure ulcer determined to be greater than Stage II;
(I) a new diagnosis of a condition which affects the resident's physical, mental, or psychosocial well-being;
(J) improved behavior, mood or functional health status to the extent that the established plan of care no longer meets the resident's needs;
(K) new onset of impaired decision-making;
(L) continence to incontinence or indwelling catheter; or
(M) the resident's condition indicates there may be a need to use a restraint in accordance with Rule .1501 of this Subchapter and there is no current restraint order for the resident.
(2) Significant change does not include the following:
(A) changes that resolve with or without intervention;
(B) an acute illness or episodic event. For the purposes of this Rule "acute illness" means symptoms or a condition that develops quickly and is not a part of the resident's baseline physical health or mental health status;

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D 254	Continued From page 2 (C) an established, predictable cyclical pattern; or (D) steady improvement under the current course of care. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to complete a change in condition care plan within 3 days of identifying significant change in condition for 2 of 2 sampled residents (#1 and #8) including a resident who had 15 falls in 2 months (#8) and a resident who had 9 falls in 2 months (#1). The findings are: Review of the facility's undated Resident Assessment and care Planning policy revealed in the event of a significant change the Primary Care Provider (PCP) would be notified within 10 days of the significant change and a new care plan would be created. 1. Review of Resident #8's current FL2 dated 03/05/26 revealed: -Diagnoses included Parkinson's disease, osteoarthritis, and left 1-7 rib fractures. -He was ambulatory. -He needed assistance from staff with bathing.	D 254		

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D 254	Continued From page 3 Review of Resident #8's Resident Register revealed an admission date of 02/26/26. Review of Resident #8's admission care plan dated 03/02/26 revealed: -The care plan was signed by a physician on 04/14/26. -He ambulated with a walker. -He required limited assistance from staff with toileting, bathing, grooming and dressing/undressing. -He required supervision from staff with ambulation and transferring. -He was independent with eating. -His vision, hearing and speech were all adequate for daily activities. -He was sometimes disoriented and forgetful at times, needing reminders. Review of Resident #8's incident reports revealed: -On 05/06/26, Resident #8 had a witnessed fall in the common area at 2:45pm and was sent to the Emergency Department (ED) for evaluation due to hitting his head on the floor. -On 05/22/26, Resident #8 had an unwitnessed fall near the medication room at 7:45pm; he was not sent to the ED for evaluation. -On 05/25/26, Resident #8 had an unwitnessed fall in his room at 6:45am; he was not sent to the ED for evaluation. -On 05/28/26, Resident #8 had an unwitnessed fall in his room at 4:45am and was sent to the ED for evaluation due to complaint of back pain. -On 06/03/26, Resident #8 had a witnessed fall in the dining room at 7:45am and was sent to the ED for evaluation due to a cut on his left elbow. -On 06/06/26, Resident #8 had an unwitnessed fall in his room at 10:15am; he was not sent to the ED for evaluation.	D 254		

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D 254	Continued From page 4 -On 06/12/26 Resident #8 had a witnessed fall in the living room at 8:45am and was sent to the ED for evaluation for an undocumented reason. -On 06/12/26, Resident #8 had an unwitnessed fall in the dayroom at 9:45pm and was sent to the ED for evaluation because both of his legs and feet were swollen. -On 06/19/26, Resident #8 had an unwitnessed fall in the common area at 7:15am and was sent to the ED for evaluation due to complaint of shoulder pain. -On 07/08/26, Resident #8 had an unwitnessed fall in the living room at 4:00pm; he was not sent to the ED for evaluation. -On 07/09/26, Resident #8 had an unwitnessed fall in his room at 5:00am; he was not sent to the ED for evaluation. -On 07/09/16, Resident #8 had an unwitnessed fall in his room at 11:45pm; he was not sent to the ED for evaluation. -On 07/10/26, Resident #8 had an unwitnessed fall in the living room at 7:30am; he was not sent to the ED for evaluation. -On 07/13/26, Resident #8 had an unwitnessed fall in his room at 6:30am; he was not sent to the ED for evaluation. -On 07/13/26, Resident #8 had an unwitnessed fall in his room at 11:30am; he was not sent to the ED for evaluation. Review of Resident #8's care plan dated 06/30/26 revealed: -The significant change box was checked; no significant change date was indicated. -Resident #8 was independent with eating. -Resident #8 needed extensive assistance from staff for toileting. -Resident #8 needed limited assistance from staff for ambulation, bathing, dressing, grooming, and transferring.	D 254		

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-Resident #8 ambulated with a walker and wheelchair.
-Resident #8 would place self onto the floor.
-Resident #8 required frequent observation.
-The care plan was not signed by the Primary Care Provider (PCP).

Telephone interview with Resident #8's previous PCP on 07/17/26 at 10:47am revealed:
-She was no longer Resident #8's PCP per the family's request on 06/25/26.
-She received an email on 07/17/26 at 9:37am from the Special Care Unit Coordinator (SCC) with a significant change care plan attached requesting that she back date her signature.
-She did not sign the 06/30/26 significant change care plan.
-When she electronically signed a form, it automatically entered a date and timestamp on the form.

Interview with a personal care aide (PCA) on 07/17/26 at 10:09am revealed:
-The resident had a lot of falls during first shift trying to get out of his wheelchair.
-She tried to keep the resident out of his bedroom and in the dayroom so she could keep an eye on him.
-She provided Resident #8's care based on what was in the computer for her to document on.
-She did not remember seeing any change in Resident #8's care to be provided in the computer until the second week in July 2026.

Interview with a medication aide (MA) on 07/17/26 at 7:24am revealed:
-Resident #8 was at risk for falls.
-Most of the resident's falls occurred during third shift when he tried to get out of bed.
-She did not remember seeing any changes on

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D 254	Continued From page 6 Resident #8's care plan. Telephone interview with a third shift MA on 07/17/26 at 8:44am revealed: -Resident #8 had numerous falls. -Resident #8 was very busy at night if he could not sleep. -She would keep Resident #8 busy if he was awake on third shift by providing snacks, watching television and walking with him. -She did not remember seeing any changes on Resident #8's care plan. Interview with the Special Care Unit Coordinator (SCC) on 07/17/26 at 3:20pm revealed: -She knew a significant change care plan should have been completed in May 2026 due to Resident #8's increase in falls. -She did not complete a significant change care plan in May because the PCP made some medication changes; she wanted to see if the medication changes worked. -She thought Resident #8 had less falls after the medication changes. Refer to interview with the Administrator on 07/17/26 at 5:20pm. 2. Review of Resident #1's current FL2 dated 08/08/25 revealed: -Diagnoses included muscle weakness, unsteadiness on feet, disorder, and falls. -She was ambulatory. -She needed assistance from staff with bathing, feeding, and dressing. Review of Resident #1's Resident Register revealed an admission date of 01/14/25. Review of Resident #6's care plan dated 02/16/25	D 254		

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D 254	Continued From page 7	D 254		

revealed:
-She was oriented.
-She was ambulatory with the use of a walker.
-She had limited range of motion in her arms.
-She needed supervision from staff with toileting, bathing, grooming and personal hygiene.
-She needed limited assistance from staff with eating and dressing.
-She was independent with ambulation and transferring.
-It was signed by the Primary Care Provider (PCP) on 08/11/25.

Review of Resident #1's incident reports revealed:
-On 05/11/26, Resident #1 had a fall in her room at 12:45pm with no documented injury.
-On 05/15/26, Resident #1 had an unwitnessed fall in her room at 11:11am and was sent to the emergency room (ED) for evaluation of a head injury.
-On 05/18/26, Resident #1 had an unwitnessed fall in her room at 7:30am with no injury.
-On 05/20/26, Resident #1 had an unwitnessed fall in her room at 7:00am with a skin tear on her right cheek.
-On 05/21/26, Resident #1 had an unwitnessed fall in her room at 4:00pm with no injury.
-On 05/22/26, Resident #1 had an unwitnessed fall in her bathroom at 8:03am with a head injury; she was sent to the ED for evaluation.
-On 06/27/26, Resident #1 had an unwitnessed fall in her bathroom at 7:45am with a head injury; she was sent to the ED for evaluation.
-On 06/30/26, Resident #1 had an unwitnessed fall in her room at 1:04pm with a right arm skin tear.
-On 07/08/26, Resident #1 had an unwitnessed fall in her room at 6:45am with no injury.

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D 254	Continued From page 8 Review of Resident #1's care plan dated 05/21/26 revealed: -The significant change box was checked; no date of the significant change was indicated. -Due to change in condition was handwritten in the social/mental health history box. -Resident #1 needed limited staff assistance with eating and ambulation. -Resident #1 needed total staff assistance with toileting, bathing, dressing, grooming, and transferring. -Resident #1 needed increased supervision from staff. -It was not signed by the PCP. Interview with Resident #1 on 07/16/26 at 8:51am revealed: -She had fallen before but remembered falling more in May 2026 and thought it was because of her Parkinson's disease getting worse. -She had to get staples in 2 different locations on her head because of 2 different falls. Interview with Resident #1's PCP on 07/16/26 at 11:41am. -She was aware of Resident #1's falls. -She kept a copy of every document that she electronically signed. -She had no record that she signed a significant change care plan for Resident #1 on 05/21/26. -When she electronically signed a form, it automatically entered a date and timestamp on the form. Interview with a medication aide (MA) on 07/16/26 at 2:40pm revealed: -She noticed that Resident #1 needed more assistance and had increased falls in May 2026. -She was not sure why Resident #1 was falling more.	D 254		

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D 254	Continued From page 9 -There were no changes made to Resident #1's care plan that she could remember. Refer to the interview with the Special Care Coordinator (SCC) on 07/17/26 at 3:20pm revealed: Refer to the interview with the Administrator on 07/17/26 at 5:20pm. _____ Interview with the SCC on 07/17/26 at 3:20pm revealed: -Care plans were due annually and after a significant change. -The SCC and Administrator were responsible for completing the care plans. -She sent the care plan to the PCP through fax or email for signature. -She was not sure why the electronic signature on the care plans looked different from other electronic signatures the PCP signed. -She did not know why the PCP would say she did not sign the care plans. Interview with the Administrator on 07/17/26 at 5:20pm revealed. -Significant change care plans were due within 10 days of a resident's significant change. -The SCC was responsible for completing the care plans. -Any resident with an increase in falls was discussed during a monthly fall meeting; those documents were considered internal. -She was not sure why the electronic signature on the care plans looked different from other electronic signatures the PCP signed. -She did not know why the PCP would say she did not sign the care plans.	D 254		

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D 270	Continued From page 10	D 270		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: FOLLOW UP TO TYPE A1 VIOLATION Based on these findings, the previous Type A1 violation was not abated. Based on observations, interviews and record reviews, the facility failed to provide supervision for 2 of 3 sampled residents (#3 and #8) who had multiple falls including a resident who had multiple falls with the most recent fall resulting in a fractured hip (#3) and a resident who had 15 falls in two months (#8). The findings are: Review of the facility's undated falls management policy revealed: -It was the policy of the facility to ensure residents were monitored and identified for the risk of falls. -Recognizing the numerous factors that impact the propensity for falls, the team approach was to manage and reduce falls while allowing each	D 270		

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individual as much freedom and independence as possible.
-Residents were assessed on admission for fall risk using the Fall Risk Admission Evaluation as part of the fall management program.
-Ongoing assessment of the resident and any falls the resident sustained would be reviewed monthly during the Falls Management Team Meeting, appropriate interventions would be implemented as indicated, and the plan of care would be updated.
-Post-fall intervention care plans were completed as part of the fall management program after a fall for further care planning in fall prevention and management.
-Management would schedule care plan meetings with the resident and family or responsible party, as applicable, to determine next steps and additional interventions when evaluating resident falls, which included referral to the physician for further evaluation.

Review of the facility's undated supervision policy revealed staff should provide supervision of residents in accordance with each resident's assessed needs, care plan, and current symptoms.

1. Review of Resident #3's current FL2 dated 07/07/26 revealed:
-Diagnoses included dementia, glaucoma, hypertension, and kidney disease.
-She was semi-ambulatory.
-She was intermittently disoriented.
-She required assistance from staff with bathing, feeding, and dressing.
-She was incontinent of bowel and bladder.
-Her level of care was Special Care Unit (SCU).

Review of Resident #3's Resident Register

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D 270	Continued From page 12 revealed: -She was admitted to the facility on 10/07/24. -She required assistance with bathing, dressing, and feeding. -She was oriented to time and place. -She had significant memory loss and required direction. Review of Resident #3's care plan dated 08/11/25 revealed: -She wandered. -She was ambulatory with an assistive device and used a wheelchair. -She had limited strength and hand-eye coordination. -She had significant memory loss and required direction. -She required limited staff assistance with eating. -She required staff supervision with toileting. -She was independent with ambulation. -She required limited staff assistance with bathing. -She required extensive staff assistance with dressing. -She was independent with transferring. Review of Resident #3's Licensed Health Professional Support (LHPS) evaluation form dated 04/20/26 revealed: -She was ambulatory with assistive devices and was dependent on staff for wheelchair propulsion and one-person assistance with transfers and mobility. -Falls in the last 90 days totaled one. -LHPS tasks included ambulation using an assistive device with staff assistance and transfer assistance from staff. -Clinical findings included dependence on staff for transfers and mobility.	D 270		

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D 270	Continued From page 13 Review of Resident #3's Fall Risk Worksheet revealed: -The date of the initial assessment was 06/17/26. -Her final score was documented as 9. -Any score of 5 or more indicated a high risk for falls. -There was no documentation of a second, third, or fourth assessment. -The Resident Care Director (RCD) or the Administrator was to instruct staff in the utilization of interventions in the staff education binder. -The resident was to be monitored for 72 hours after a fall, including an immediate evaluation of the reason for the fall. Review of Resident #3's Service Plan dated 06/27/26 revealed: -Supervision was increased to every two hours. -Fall interventions included reminding the resident to use an assistive device three times per day. -Ensure adequate lighting three times per day. -Ensure bed and chair alarms were in place and functioning to alert staff of position changes three times per day. -Ensure items, including the call bell/pendant, phone, and remote, were within reach three times per day. -Clear pathways and minimize clutter three times per day. -Assist with toileting every two hours. Review of the facility's falls quality review record dated 07/07/26 revealed plans for Resident #3 included a care plan meeting, evaluation by the primary care provider (PCP), a possible medical appointment due to worsening of the disease process, review of interventions, and referral to physical therapy (PT) and occupational therapy (OT).	D 270		

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a. Review of Resident #3's progress note dated 05/19/26 at 7:01pm revealed:
-Resident #3 was found sitting upright on the floor in her room.
-Resident #3's family member reported she saw on the camera that Resident #3 was attempting to sit in her wheelchair.

Review of Resident #3's incident reports revealed there was no incident report dated 05/19/26 available for review.

Review of Resident #3's PCP after-visit summary dated 05/22/26 revealed the resident's fall history included a fall on 05/19/26.

Telephone interview with Resident #3's family member on 07/14/26 at 11:30am revealed:
-She saw Resident #3 on her electronic monitoring device (camera) lying on the floor and called the facility to ask staff to go to Resident #3's room.
-Based on her review of the camera footage, Resident #3 had been on the floor for approximately three hours on 05/19/26.
-Review of the camera footage showed staff brought Resident #3 into her room after lunch and left her in her wheelchair.
-When Resident #3 attempted to get out of the wheelchair, the wheels were not locked, and she fell.
-No staff were seen checking on her until the family member called the facility.
-She identified the three staff members who responded after she called the facility to report Resident #3 was on the floor.

Interview with the medication aide (MA) identified by Resident #3's family member on 07/16/26 at 10:53am revealed:

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D 270	Continued From page 15 -She had not seen Resident #3 on the floor while she was working. -She checked on Resident #3 every two hours. Interview with a personal care aide (PCA) on 07/17/26 at 5:18pm revealed: -She did not know why Resident #3 was not checked on for three hours the day she fell on 05/19/26. -Even at that time, Resident #3 was checked on every two hours. -She could not think of any reason why Resident #3 would not have been checked on every two hours. Interview with the Administrator on 07/17/26 at 6:47pm revealed: -She was not aware Resident #3 had been on the floor for three hours. -Resident #3's family member had not told her Resident #3 had been on the floor for three hours. -Resident #3 would not have been on frequent checks at that point if it had been her first fall. -Residents were checked according to their care plans. -If a resident was incontinent, the resident was checked every two hours. Interview with Resident #3's PCP on 07/16/26 at 11:45am revealed: -Not checking on a resident for three hours was not acceptable. -Resident #3 could have died. -Resident #3 could not have screamed for help. b. Review of Resident #3's incident report dated 06/06/26 at 2:30am revealed: -Resident #3 was seen on the floor by her family member.	D 270		

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D 270	Continued From page 16 -There were no injuries. Telephone interview with the MA on 07/17/26 at 8:30am revealed: -She completed the incident report dated 06/06/26 for Resident #3. -She could not recall any details related to the fall on 06/06/26. Review of Resident #3's progress notes revealed there was no progress note dated 06/06/26 available for review. Telephone interview with Resident #3's family member on 07/17/26 at 8:58am revealed: -She looked at the electronic monitoring device (camera) at 2:00am on 06/06/26 and saw Resident #3 lying on the floor. -She reviewed the camera footage and saw Resident #3 had been lying on the floor for one hour. -Resident #3 appeared to have become tangled in her blanket while attempting to get out of bed. -She could hear Resident #3 saying, "Help me," on the camera footage. c. Review of Resident #3's progress note dated 06/14/26 at 8:59am revealed: -The MA spoke to Resident #3's family member about a fall. -Resident #3's family member stated she had seen the fall on the electronic device (camera). Review of Resident #3's progress note dated 06/14/26 at 9:01am revealed: -The PCP was contacted regarding Resident #3's fall. -The PCP instructed staff to cover the skin tear with a dressing and apply antibiotic ointment.	D 270		

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D 270	Continued From page 17 Review of Resident #3's incident reports revealed there was no incident report dated 06/14/26 available for review. Telephone interview with Resident #3's family member on 07/17/26 at 8:58am revealed: -On 06/14/26, she received a telephone call that Resident #3 was found on the floor. -She reviewed the camera footage and saw that Resident #3 was getting out of her wheelchair, became tangled in her shawl, and fell. -Staff placed Resident #3 back in her wheelchair without her shawl and left the room. -She could then hear Resident #3 saying she was cold. -Resident #3 then attempted to get out of her wheelchair again and fell a second time. -The MA who entered the room saw that the heat had been turned off in Resident #3's room. -She had discussed with the Special Care Unit Coordinator (SCC) to ensure the heat was not turned off. d. Review of Resident #3's incident report dated 06/26/26 at 4:45pm revealed: -Resident #3 had a fall in her room while attempting to get out of bed. -There were no injuries. Review of Resident #3's progress note dated 06/26/26 revealed Resident #3 had a fall, there was no bruising or injury, and the family member did not want the resident sent to the emergency department (ED) for evaluation. Telephone interview with Resident #3's family member on 07/15/26 at 11:30am revealed she saw Resident #3 on the camera attempting to get up to go to the bathroom and fall.	D 270		

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e. Review of Resident #3's incident report dated 07/03/26 at 6:00am revealed:
-Resident #3 was seen on the floor by Resident #3's family member.
-Resident #3 had a facial contusion.
-Resident #3 was sent to the ED for evaluation.

Telephone interview with the MA on 07/17/26 at 8:30am revealed:
-Resident #3's family member called to inform her the resident had fallen, and she responded immediately.
-Resident #3's walker was in the bathroom, and her wheelchair was in the room.
-Resident #3 was sitting on the bathroom floor holding onto the shower curtain.
-Resident #3 had a bump on the side of her head.
-Resident #3's family member remained on the call throughout the assessment.
-Resident #3 was transported to the ED.

Review of Resident #3's progress note dated 07/03/26 revealed Resident #3 returned from the ED at 11:33am.

Review of Resident #3's progress note dated 07/04/26 at 2:01pm revealed Resident #3 was holding her head and complaining of pain due to the recent fall.

Review of Resident #3's progress note dated 07/05/26 revealed Resident #3 was monitored every two hours due to the fall.

Review of Resident #3's hospital after-care instructions dated 07/03/26 revealed:
-Resident #3 was diagnosed with a facial contusion.
-The skin, muscles, and other soft tissues of the face could become swollen and painful.

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D 270	Continued From page 19 -The bones beneath the face could also be bruised. -Staff were instructed to apply ice to the face to help reduce pain and swelling four times per day for at least 20 minutes. -Specific instructions were provided on how to apply the ice. -Staff were instructed to administer acetaminophen (a medication for pain) or ibuprofen (a medication for pain and inflammation) to decrease pain and inflammation; the PCP would determine if prescription medication was needed. -If symptoms of a head or neck injury developed, the resident was to return immediately to the nearest ED. -If any of the following symptoms occurred, the resident was to immediately return to the ED, including severe or worsening headaches, vomiting, lethargy, trouble with coordination, or dizziness. -Follow-up with the PCP was recommended within 2 to 3 days. Telephone interview with Resident #3's family member on 07/17/26 at 8:58am revealed: -She was checking on Resident #3 at 6:00am on 07/03/26 and could hear her calling out for help. -When she reviewed the camera footage, Resident #3 appeared to roll over in bed, fall out of bed, and hit her head on her wheelchair. -After Resident #3 fell, she was able to sit herself up on the floor and move around the room. -She could see the wheelchair and hear Resident #3 calling for help, so she knew she had fallen. -When Resident #3 hit her head, a loud sound could be heard. -Because she did not want Resident #3 to roll out of bed again, she purchased a small bed rail to help prevent her from rolling out of bed.	D 270		

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f. Review of Resident #3's incident report dated 07/09/26 at 8:45pm revealed:
-Resident #3 was observed on the floor.
-Resident #3's left knee was slightly swollen with light bruising.
-Resident #3 was not sent out to the ED for an evaluation.

Telephone interview with a MA on 07/17/26 at 10:14am revealed:
-She was working when Resident #3 fell on 07/09/26.
-She completed the incident report for the fall on 07/09/26.
-She was sitting in the medication room documenting.
-One of the PCAs had been in Resident #3's room within the previous 5-10 minutes when she was notified of the resident's fall.
-Staff checked on Resident #3 every two hours.
-Staff had checked on Resident #3 at 2:30pm, 4:30pm, and 6:30pm and were scheduled to return for the next round, but the family member called first.
-Resident #3 was sitting in her wheelchair when the MA last saw her.
-Resident #3's family member called and reported the resident was on the floor beside her bed.
-Resident #3 reported her left knee was hurting, and it appeared "a little" swollen and was larger than the other leg.
-The fall on 07/09/26 was the only fall Resident #3 had while she was working.
-Resident #3 was usually in bed after dinner and only got out of bed when the PCAs assisted her to the bathroom.

Review of Resident #3's progress notes revealed there was no progress note dated 07/09/26

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D 270	Continued From page 21 available for review. Review of Resident #3's progress note dated 07/10/26 revealed x-rays were taken, and a family member was present. Review of Resident #3's progress note dated 07/15/26 at 2:45pm revealed: -The PCP was notified that Resident #3's thigh was swollen and bruised from a possible previous fall. -The PCP stated she would see the resident on 07/16/26. Review of Resident #3's progress note dated 07/16/26 at 11:24am revealed that, upon the PCP seeing Resident #3, the resident was sent to the ED for a possible fracture. Telephone interview with Resident #3's family member on 07/15/26 at 11:30am revealed: -She was looking at the camera in Resident #3's room and saw the resident on the floor. -Resident #3's door was open, and she could see the MA sitting in the office across the hall from Resident #3's room. -When she reviewed the camera footage, she saw Resident #3 get out of bed and fall. Telephone interview with Resident #3's family member on 07/17/26 at 8:58am revealed: -She had left Resident #3's room on 07/09/26, and the resident was in bed. -When she reviewed the camera footage, she saw Resident #3 walk to the door, and a PCA saw her and assisted her into her wheelchair. -Resident #3 propelled herself around the room in the wheelchair. -Resident #3 got herself into bed. -Resident #3 then got back out of bed, pushed	D 270		

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her wheelchair, and fell against her closet.
-Resident #3 complained that her leg hurt.

Telephone interview with Resident #3's family member on 07/16/26 at 5:42pm revealed Resident #3 had a fracture in her hip area.

Interview with a PCA on 07/17/26 at 5:18pm revealed:
-She was working on 07/09/26 when Resident #3 fell.
-She had just been in Resident #3's room, and the MA was in the medication room.
-She had been in Resident #3's room five minutes before the MA checked on Resident #3 and found her on the floor.
-Resident #3 injured her knee.
-The day after Resident #3's fall, she was assisting the resident to the bathroom and observed that Resident #3 could not stand.
-She had to get another PCA to assist because Resident #3 could not stand.
-She thought Resident #3 was just being stubborn.
-She told a MA, but she did not recall which MA.

_____

Interview with a PCA on 07/16/26 at 9:24am revealed:
-Residents were checked on according to their care plan needs.
-She was able to review each resident's care plan.
-Resident #3 was a fall risk.
-She checked on Resident #3 every hour.
-No one told her how often to check on Resident #3; she just knew.

Interview with a second PCA on 07/16/26 at 2:37pm revealed:
-Resident #3's care plan directed staff to check

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on the resident every two hours, but she checked on her every thirty minutes.
-She had been attempting to keep Resident #3 out of her room and with staff for supervision.
-No one in management had instructed staff to do this; staff had decided this on their own.
-If Resident #3 was in her room, she was in bed.
-One staff member stayed in the day room with the residents, and another staff member was supposed to walk through the halls checking on residents.
-She had not been working on any days Resident #3 had any falls.
-Any resident who had a fall was listed on a board in the medication room and on a 24-hour report.

Interview with a third PCA on 07/17/26 at 8:03am revealed:
-Resident #3 was considered a fall risk.
-All residents were checked every two hours, and residents who were at risk for falls were checked more frequently.
-She had not been at the facility when Resident #3 had any falls.
-No staff had instructed her to do anything different for Resident #3 to prevent additional falls.
-Resident #3's falls occurred in her room.
-Resident #3 frequently attempted to get out of her wheelchair.
-Resident #3 did not have a chair alarm or a bed alarm.

Interview with a fourth PCA on 07/16/26 at 3:38pm revealed Resident #3 was checked on every two hours, but she usually checked on her every hour.

Interview with a fifth PCA on 07/16/26 at 3:44pm revealed:

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D 270	Continued From page 24 -No one told her to do anything different with Resident #3 after each fall. -She was told to check on Resident #3 every two hours. -She had not been working when Resident #3 had any falls. Interview with a MA on 07/16/26 at 10:53am revealed: -She had not seen Resident #3 on the floor. -Resident #3 was on checks every two hours for supervision. -She was not told to do anything different related to Resident #3 and her falls. -Supervision was based on what was documented in Resident #3's care plan; she could not recall anything specific staff were supposed to do. Interview with a second MA on 07/16/26 at 2:49pm revealed: -She was not aware of any interventions put in place after each fall other than checking on Resident #3 every two hours for 72 hours after each fall. -When Resident #3 was in her room, she was always in bed; she would not be left in her wheelchair in the room. Interview with a third MA on 07/16/26 at 4:05pm revealed the previous week was the first time she had seen an order to check on Resident #3 every two hours. Telephone interview with a fourth MA on 07/17/26 at 8:30am revealed: -Resident #3 had numerous falls according to the reports. -Resident #3 did not have a chair or bed alarm. -She started keeping Resident #3's door open,	D 270		

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but she did not recall when; she thought she documented it in Resident #3's progress note.
-Resident #3 tended to get up and walk.
-Resident #3 might get up and go anywhere during the night.
-Any changes to a resident's care plan were entered into the computer system by the Supervisor.
-She had no control over what management put into place as interventions.
-She thought a bed/chair alarm could help prevent falls.
-She was not aware of anything that was put in place to do differently after each fall other than two-hour checks for 72 hours.

Telephone interview with Resident #3's family member on 07/15/26 at 11:30am revealed:
-When she reviewed the camera footage, she routinely saw staff take Resident #3 to her room after a meal and did not see staff return to the room until the next mealtime.
-She was involved in a care plan meeting in March 2026, and she was told staff made rounds every two hours; the Administrator emphasized rounds would be made every two hours.
-She had a door alarm on Resident #3's door and received an alert every time the door was opened. Based on those alerts, she knew staff were not completing rounds every two hours.
-She had also left the call system on and could see that no one had entered the room every two hours.
-The first time the family was instructed to purchase a bed alarm for Resident #3 was on 07/07/26, when the SCC directed her to search online for a bed alarm.
-She did not know how bed alarms worked and asked the SCC how they worked. She was told the bed alarm was to teach a resident to stay in

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D 270	Continued From page 26 bed, and that was all that was discussed. Interview with a physical therapy assistant on 07/17/26 at 10:24am revealed: -Every time he saw an incident report related to a fall, he checked to see if the resident's insurance would pay for therapy and then requested an order for therapy. -He completed a screening on Resident #3 at the request of facility staff on 06/29/26 and noted Resident #3 could benefit from bed mobility and transfer training to prevent falls. -Resident #3 would have a twenty-dollar co-pay per visit. He reached out to the resident's family member multiple times, spoke with her on 07/07/26, and had not heard back from her after that conversation. -He could not make recommendations to staff regarding fall prevention without a physical therapy assessment because he was a PT assistant. Interview with the Special Care Unit Coordinator (SCC) on 07/17/26 at 4:43pm revealed: -She contacted Resident #3's family member on 07/08/26 to schedule a care plan meeting with the family to discuss the falls, but one family member wanted the other family member to also be present. -She attempted to schedule a care plan meeting after Resident #3 sustained an injury from falls. -Interventions put in place prior to Resident #3 having an injury from falls included staff redirecting Resident #3, scheduling an appointment with her eye doctor to determine if her glaucoma was progressing, and monitoring because she thought Resident #3's dementia was progressing. -Interventions were entered into the facility's computer system so care staff would know what	D 270		

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to do.
-Staff were expected to review the interventions and sign off after reviewing them.
-Staff also had a 24-hour shift report where they were supposed to communicate any changes with residents to each shift.
-The 24-hour shift report was supposed to include anything out of the ordinary with the residents.
-New interventions "popped up" in green so staff would know there was a new intervention.
-Each staff member would see the new intervention when they logged into the computer and reviewed the resident's service plan.
-She was concerned staff were not following the interventions that were put in place because a fall might have been prevented.
-She mentioned a bed/chair alarm to Resident #3's family member.
-She had planned to discuss additional fall prevention interventions with the family during the care plan meeting.
-She was concerned no one was monitoring/rounding on Resident #3 as they should and that the family was having to notify them of falls.

Interview with the Administrator on 07/17/26 at 5:24pm revealed:
-Interventions were put in place for fall prevention after each incident.
-Interventions were entered into the computer system when an incident report was completed.
-The interventions then automatically populated into the residents' service plans.
-Interventions could be seen on the incident reports.
-Staff reviewed the service plans every shift.
-She expected staff to review each resident's service plan each shift and check off each task.
-She expected staff to review all newly

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implemented interventions.

Interview with Resident #3's PCP on 07/16/26 at 11:45am revealed:
-Resident #3 had several falls, which was concerning.
-She wanted to know how often staff were checking on the residents.
-Because Resident #3 had multiple falls, she would have expected staff to check on the resident every hour.
-Staff needed to determine why Resident #3 was falling in order to know what interventions to implement.

2. Review of Resident #8's current FL2 dated 03/05/26 revealed:
-Diagnoses included Parkinson's disease, osteoarthritis, and left 1-7 rib fractures.
-He was ambulatory.
-He needed assistance from staff with bathing.

Review of Resident #8's Resident Register revealed an admission date of 02/26/26.

Review of Resident #8's care plan dated 03/02/26 revealed:
-He ambulated with a walker.
-He required limited assistance from staff with toileting, bathing, grooming and dressing/undressing.
-He required supervision from staff with ambulation and transferring.
-He was independent with eating.
-His vision, hearing and speech were all adequate for daily activities.
-He was sometimes disoriented and forgetful at times, needing reminders.

a. Review of Resident #8's incident report dated

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05/06/26 revealed:
-Resident #8 had a fall in the common area at 2:45pm.
-The fall was witnessed by staff.
-He lost his balance and hit his head on the floor.
-The resident had no complaints.
-He was sent to the emergency department (ED) for an evaluation.

Review of Resident #8's Incident Tracking Log for the fall on 05/06/26 revealed:
-The assistive device functionality check was documented as completed by the Special Care Unit Coordinator (SCC).
-Resident #8's care plan was documented as updated by the SCC on 05/06/26.
-It was documented the service plan was reviewed and an intervention was added by the SCC on 05/06/26.
-The fall intervention was snacks.
-There were no further instructions related to snacks noted on the incident tracking log.
-The fall intervention was to monitor safety in the environment.
-There were no further instructions related to safety monitoring noted.

Review of Resident #8's care plans revealed there was no updated care plan related to the fall on 05/06/26 available for review.

Review of Resident #8's monthly task log for May 2026 revealed:
-The fall intervention for snacks was not entered onto the monthly task log .
-The fall intervention to monitor for safety was not entered onto the monthly task log .

Review of Resident #8's hospital after care instructions dated 05/06/26 revealed:

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D 270	Continued From page 30 -Resident #8 was seen for a head injury. -Resident #8 did not seem to have a serious brain injury. -He was discharged back to the facility with instructions to monitor for severe headache, fever, changes in ambulation and changes in behavior. b. Review of Resident #8's incident report dated 05/22/26 revealed: -Resident #8 had a fall near the medication room at 7:45pm. -The fall was not witnessed by staff. -The resident was sitting on the floor. -The resident had no complaints. -He was not sent to the ED for an evaluation. Review of Resident #8's incident tracking for the fall on 05/22/26 revealed: -The assistive device functionality check was documented as completed by the SCC on 05/26/26. -Resident #8's care plan was documented as updated by the SCC. -The service plan and intervention review was documented as not applicable by the SCC on 05/26/26. Review of Resident #8's care plans revealed there was no updated care plan related to the fall on 05/22/26 available for review. c. Review of Resident #8's incident report dated 05/25/26 revealed: -Resident #8 had a fall in his bedroom at 6:45am. -The fall was not witnessed by staff. -The resident was sitting on the floor with a hematoma on his right eyebrow. -The resident had no complaints. -He was not sent to the ED for an evaluation.	D 270		

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D 270	Continued From page 31 Review of Resident #8's Incident Tracking Log for the fall on 05/25/26 revealed: -The assistive device functionality check was documented as completed by the SCC on 05/29/26. -Resident #8's updated care plan was documented as not applicable by the SCC on 05/29/26. -It was documented the service plan was reviewed and an intervention was added by the SCC on 05/29/26. -The fall intervention was a night light. -There were no further instructions related to the night light noted on the incident tracking log. Review of Resident #8'smonthly task log for May 2026 revealed the fall intervention for night light was not entered onto the monthly task log for documentation by the personal care aides (PCA). d. Review of Resident #8's incident report dated 05/28/26 revealed: -Resident #8 had a fall in his room at 4:45am. -The fall was not witnessed by staff. -Staff heard the resident say "help". -The resident complained of back pain. -He was sent to the ED for an evaluation. Review of Resident #8's hospital after-care instructions dated 05/28/26 revealed: -He was seen in the ED after a fall. -He was diagnosed with a back strain. -He was diagnosed with an eye contusion. -He was diagnosed with a hematoma; the location was not documented. Review of Resident #8's Incident Tracking Log for the fall on 05/28/26 revealed: -The assistive device functionality check was	D 270		

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documented as completed by the SCC on 05/29/26.
-Resident #8's care plan update was documented as not applicable by the SCC on 05/29/26.
-The service plan was reviewed, and an intervention was added by the SCC on 05/29/26.
-The fall intervention was items within reach.
-There were no further instructions related to items within reach noted on the incident tracking log.

Review of Resident #8's monthly task log for May 2026 revealed the fall intervention for items within reach was not entered onto themonthly task log .

e. Review of Resident #8's incident report dated 06/03/26 revealed:
-Resident #8 stood up from the dining room chair, fell and hit his head at 7:45am.
-The fall was witnessed by staff.
-He complained his head was hurting.
-He had a laceration to his left elbow.
-He was sent to the ED for an evaluation.

Review of Resident #8's Incident Tracking Log for the fall on 06/03/26 revealed:
-The assistive device functionality check was documented as completed by the SCC on 06/06/26.
-Resident #8's care plan update was documented as not applicable by the SCC on 06/06/26.
-The service plan was reviewed and an intervention was added by the SCC on 06/06/26.
-The fall intervention was assistive device.
-There were no further instructions related to assistive device noted on the incident tracking log.

Review of Resident #8's monthly task log for June 2026 revealed the fall intervention for

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assistive device was not entered onto the monthly task log .

Review of Resident #8's record revealed there were no hospital after-care instructions available for review.

f. Review of Resident #8's incident report dated 06/06/26 revealed:
-Resident #8 had a fall in his room at 10:15am.
-The fall was not witnessed by staff.
-The resident was sitting upright on the floor.
-The resident had no complaints.
-He was not sent to the ED for an evaluation.

Review of Resident #8's record revealed there was no incident tracking log available for review.

g. Review of Resident #8's incident report dated 06/07/26 revealed:
-At 9:30am, Resident #8 was sitting in the day room with a blank stare on his face, eyes rolled in the back of his head, shaking, and unresponsive to staff.
-He was sent to the ED for an evaluation.

Review of Resident #8's record revealed there was no incident tracking log available for review.

h. Review of Resident #8's incident report dated 06/12/26 revealed:
-Resident #8 had a fall in the living room at 8:45am.
-The fall was witnessed by staff.
-The resident got up from the chair and tipped over because his shoes were coming off.
-The resident was sitting on the floor.
-The resident had no complaints.
-He was sent to the ED for an evaluation.

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Review of Resident #8's Incident Tracking Log for the fall on 06/12/26 revealed:
-The assistive device functionality check was documented as completed by the SCC on 06/13/26.
-Resident #8's care plan update was documented as not applicable by the SCC on 06/13/26.
-The service plan was reviewed, and an intervention was added by the SCC on 06/13/26.
-The fall intervention was to ensure adequate lighting.
-There were no further instructions related to ensuring adequate lighting noted on the incident tracking log.

Review of Resident #8's monthly task log for June 2026 revealed the fall intervention for ensuring adequate lighting was not entered onto monthly task log .

i. Review of Resident #8's incident report dated 06/12/26 revealed:
-Resident #8 had a fall in the dayroom at 9:45pm.
-The fall was not witnessed by staff.
-The resident was sitting on the floor.
-The resident had no complaints.
-Both legs and feet were swollen.
-He was sent to the ED for an evaluation.

Review of Resident #8's record revealed there was no hospital after care instructions available for review.

Review of Resident #8's Incident Tracking Log for a second fall on 06/12/26 revealed:
-The assistive device functionality check was documented as completed by the SCC on 06/15/26.
-Resident #8's care plan update was documented as not applicable by the SCC on 06/15/26.

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-The service plan was reviewed and an intervention was added by the SCC on 06/15/26.
-The fall intervention was call system.
-There were no further instructions related to the call system noted on the incident tracking log.

Review of Resident #8's monthly task log for June 2026 revealed the fall intervention for the call system was not entered onto the monthly task log .

Interview with a PCA on 07/17/26 at 7:42am revealed:
-A couple of months ago she witnessed Resident #8 slide out of his wheelchair and onto the floor in the dayroom.
-He was assessed and did not have an injury.
-Three months ago, the resident had a bed alarm placed on his bed.
-Staff were told to increase the residents' supervision to 2-hour rounds.
-Nothing else was put into place after the residents' multiple falls.
-The bed alarm was still being used.

j. Review of Resident #8's incident report dated 06/19/26 revealed:
-Resident #8 lost his balance and had a fall in the common area at 7:15am.
-He was sitting on the floor, screaming at the top of his lungs.
-The fall was not witnessed by staff.
-He complained of shoulder pain.
-He was sent to the ED for an evaluation.

Review of Resident #8's hospital after care instructions dated 06/19/26 revealed Resident #8 was seen after a fall and had no apparent injury.

Review of Resident #8's Incident Tracking Log for

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the fall on 06/19/26 revealed:
-The assistive device functionality check was documented as completed by the SCC on 06/23/26.
-Resident #8's care plan update was documented as not applicable by the SCC on 06/23/26.
-It was documented the service plan was reviewed and an intervention was added by the SCC on 06/23/26.
-The fall intervention was locking the wheelchair.
-There were no further instructions related to locking the wheelchair noted on the incident tracking log.

Review of Resident #8's monthly task log for June 2026 revealed the fall intervention for locking the wheelchair was not entered onto the monthly task log .

k. Review of Resident #8's incident report dated 06/21/26 revealed:
-At 3:30pm, Resident #8 had a red bruise on his arm, that was hot to the touch.
-Resident #8's family member requested the resident be sent out to the ED make sure his arm was not broken.
-The resident had no complaints.
-He was sent to the ED for an evaluation.

Review of Resident #8's record revealed there was no incident tracking log available for review.

l. Review of Resident #8's incident report dated 07/08/26 revealed:
-Resident #8 had a fall in the living room trying to sit in his wheelchair at 4:00pm.
-The fall was not witnessed by staff.
-The resident was sitting on the floor.
-The resident had no complaints.
-He was not sent to the ED for an evaluation.

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D 270	Continued From page 37 Review of Resident #8's record revealed there was no incident tracking log available for review. m. Review of Resident #8's incident report dated 07/09/26 revealed: -At 5:00am, Resident #8's family member observed him on camera lying on the floor in his room. -The fall was not witnessed by staff. -The resident had no complaints. Review of Resident #8's Incident Tracking Log for the fall on 07/09/26 revealed: -The assistive device functionality check was documented as completed by the SCC on 07/0926. -Resident #8's care plan update was documented as not applicable by the SCC on 07/09/26. -The service plan was reviewed and an intervention was added by the SCC on 07/09/26. -The fall intervention was an assistive device. -There were no further instructions related to an assistive device noted on the incident tracking log. -There was a fall intervention for increased supervision. -There was no further instructions related to increased supervision noted on the incident tracking log. Review of Resident #8's monthly task log for July 2026 revealed the fall interventions for an assistive device and increased supervision was not entered onto the service plan. Review of Resident #8's electronic medication administration record (eMAR) for July 2026 from 07/01/26-07/13/26 revealed: -There was an entry for increased supervision	D 270		

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with a start date of 07/02/26 at 12:30am.
-The increased supervision was scheduled every 2 hours.
-The end date of the increased supervision was 07/13/26 at 4:30pm.
-The increased supervision was documented as completed every 2 hours.

n. Review of Resident #8's incident report dated 07/09/26 revealed:
-Resident #8 had a fall in his room at 11:45pm.
-The fall was not witnessed by staff.
-The resident was sitting on the floor.
-The resident had no complaints.
-He was not sent to the ED for an evaluation.

Review of Resident #8's Incident Tracking Log for a second fall on 07/09/26 revealed:
-The assistive device functionality check was documented as completed by the SCC on 07/1026.
-Resident #8's care plan update was documented as not applicable by the SCC on 07/10/26.
-It was documented the service plan was reviewed and interventions were added by the SCC on 07/10/26.
-The interventions included an assistive device, a call system, a fall mat, handrails, a night light, and a seat alarm.
-There were no further instructions related to an assistive device, a call system, a fall mat, handrails, a night light, or a seat alarm noted on the incident tracking log.

Review of Resident #8's monthly task log for July 2026 from 07/01/26-07/17/26 revealed:
-There was an entry to educate Resident #8 on use of the call system and ensure it was within reach with a start date of 07/10/26 that was documented as completed 3 times daily.

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D 270	Continued From page 39 -There was an entry to remind Resident #8 to use handrails with a start date of 07/10/26 that was documented as completed 3 times daily. -There was an entry to remind Resident #8 to lock his wheelchair as needed (PRN) with a start date of 07/17/26 with no documentation as completed. -There was an entry to remind Resident #8 to use a night light with a start date of 07/10/26 that was documented as completed 3 times daily. -There was an entry for a seat alarm with a start date of 07/10/26 that was documented as completed 3 times daily. -There was an entry to ensure Resident #8's items were within reach with a start date of 07/17/26 that was not documented as completed. -There was an entry to ensure Resident #8's fall mat was in place that was documented as completed 3 times daily. o. Review of Resident #8's incident report dated 07/10/26 revealed: -Resident #8 had a fall in the living room at 7:30am. -The fall was not witnessed by staff. -The resident had no complaints. -He was not sent to the ED for an evaluation. Review of Resident #8's Incident Tracking Log for a fall on 07/10/26 revealed: -The assistive device functionality check was documented as completed by the Administrator on 07/1026. -There was an intervention to ensure adequate lighting and an intervention to increase supervision. -There were no further instructions related to ensuring adequate lighting or increased supervision noted on the incident tracking log.	D 270		

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D 270	Continued From page 40 Review of Resident #8's monthly task log for July 2026 from 07/01/26-07/17/26 revealed the fall intervention to ensure adequate lighting and increased supervision was not entered onto the service plan. Review of Resident #8's eMAR for July 2026 from 07/10/26-07/17/26 revealed: -There was an entry for increased supervision every 2 hours until 07/13/26 at 4:30pm. -There was documentation increased supervision was completed every 2 hours. p. Review of Resident #8's incident report dated 07/13/26 revealed: -Resident #8 had a fall in the room at 6:30am. -The fall was not witnessed by staff. -The resident was sitting on the floor. -The resident had no complaints. -He was not sent to the ED for an evaluation. Review of Resident #8's Incident Tracking Log for a fall on 07/13/26 revealed: -The assistive device functionality check was documented as completed by the SCC on 07/14/26. -Resident #8's care plan update was documented as not applicable by the SCC on 07/14/26. -It was documented the service plan was reviewed and an intervention was added by the SCC on 07/14/26. -The fall intervention was assistive device. -There were no further instructions related to an assistive device noted on the incident tracking log. -There was an intervention for an exercise program, a fall mat, and to increase supervision. -There were no further instructions related to an exercise program, a fall mat, or increased supervision noted on the incident tracking log.	D 270		

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D 270	Continued From page 41 Review of Resident #8's monthly task log for July 2026 from 07/01/26-07/17/26 revealed: -The assistive device intervention and increased supervision intervention was not entered onto the service plan. -There was an entry for an exercise program that was documented as completed 3 times daily; there were no instructions for the exercise program documented. -There was an entry to ensure Resident #8's fall mat was in place while in bed that was documented as completed 3 times daily. Review of Resident #8's eMAR for July 2026 from 07/13/26-07/17/26 revealed there was no entry for increased supervision. q. Review of Resident #8's incident report dated 07/13/26 revealed: -Resident #8 had a fall in the room at 11:30am. -The fall was not witnessed by staff. -The resident was sitting on the floor. -The resident had no complaints. -He was not sent to the ED for an evaluation. Review of Resident #8's Incident Tracking Log for a second fall on 07/13/26 revealed: -The assistive device functionality check was documented as completed by the SCC on 07/14/26. -Resident #8's care plan update was documented as not applicable by the SCC on 07/14/26. -It was documented the service plan was reviewed and an intervention was added by the SCC on 07/14/26. -The fall intervention was alarms for the bed or chair to alert of position change. -There were no further instructions related to alarms noted on the incident tracking log.	D 270		

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D 270	Continued From page 42 -There was an intervention for a fall mat and for increased supervision. -There was no further instruction related to increased supervision or the fall mat noted on the incident tracking log. Review of Resident #8's monthly task log for July 2026 from 07/01/26-07/17/26 revealed: -There was an entry for a chair alarm with a start date of 07/10/26 that was documented as completed 3 times daily. -There was an entry to ensure Resident #8's fall mat was in place while in bed that was documented as completed 3 times daily. -The increased supervision intervention was not entered onto the service plan. Review of Resident #8's eMAR for July 2026 from 07/13/26-07/17/26 revealed there was no entry for increased supervision. _____ Telephone interview with Resident #8's family member on 07/17/26 at 12:39pm revealed: -She had purchased the bed alarm for Resident #8 in March or April 2026 and it had a remote that staff needed to carry with them to hear the alarm alert. -The bed alarm could also be used in a wheelchair, but she did not remember ever seeing it in his wheelchair. -There were many times she would come to visit Resident #8, and he would be in bed with the bed alarm turned off. -She made a sign to alert staff that Resident #8's bed alarm was not to be turned off. -There had been several times she had come to the facility, and staff did not have the bed alarm remote with them. -She would see the bed alarm remote sitting in the medication room and there were no staff	D 270		

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around.
-She had reported to the SCC and MAs that the bed alarm remote needed to be always carried with one of the staff.
-She had met with the SCC several times regarding Resident #8's falls but did not feel her concerns were being addressed.
-Resident #8 left the facility on 07/14/26 for a doctors appointment.
-Resident #8 was admitted into the hospital on 07/14/26.
-She thought he was admitted for dehydration due to loose stools but the hospital was still running tests.

Interview with a PCA on 07/17/26 at 10:09am revealed:
-The resident had a lot of falls during first shift trying to get out of his wheelchair.
-A bed alarm was placed on the resident's bed a few months ago and was still being used.
-She tried to keep the resident out of his bedroom and into the dayroom so she could keep an eye on him.
-Staff supervision was increased to 1-hour rounds two months ago.
-She had not been told to do anything after the increase in the resident #8's falls.

Telephone interview with a third shift MA on 07/17/26 at 8:44am revealed:
-Resident #8 had numerous falls.
-Resident #8 had an alarm in his room but she was not sure how it worked; she thought he had to step on the mat on the floor and the alarm would sound.
-She would keep Resident #8 busy if he was awake on third shift by providing snacks, watching television and walking with him.
-She had not been told by management any

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D 270	Continued From page 44 interventions in place for Resident #8. Interview with a MA on 07/17/26 at 7:24am revealed: -Resident #8 was at risk for falls. -Most of Resident #8's falls occurred during third shift when he tried to get out of bed. -He had a bed alarm and a fall mat. -Staff supervision was increased to 2-hour rounds two weeks ago and stopped after 2 weeks. -She was not told to do anything else besides the increased supervision. Telephone interview with a second shift MA on 07/17/26 at 10:19am revealed: -She thought Resident #8 had a bed alarm but was not sure how it worked; she had only heard it a couple times. -She was not aware of any fall interventions in place for Resident #8. Interview with the SCC on 07/17/26 at 3:20pm revealed: -Fall interventions were entered onto Resident #8's monthly task log to be documented as completed by the PCAs. -The MAs could not see the interventions on the monthly task log. -She would only enter the increased supervision intervention onto the eMAR for the MAs to document as completed. -She had verbally told the MAs about all of Resident #8's fall interventions. -Resident #8's bed alarm was purchased by his family member sometime before May 2026 and she was not sure how the bed alarm worked; she was not aware it had a remote that need to be carried with the staff. -She expected the MAs to train the PCAs on the use of Resident #8's bed alarm.	D 270		

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D 270	Continued From page 45 -She was aware that Resident #8's bed alarm was being turned off and suspected that Resident #8 was turning it off. -There were no interventions put in place to prevent Resident #8 from turning off the bed alarm. -She had told the staff about Resident #8's bed alarm being turned off at a staff meeting but could not remember when that was. -She met with Resident #8's family on 06/30/26 and a chair alarm was mentioned; the family member stated they could get an order for the chair alarm at his next doctor's appointment on 07/20/26. -She did not reach out to Resident #8's PCP to get an order for a chair alarm sooner than 07/20/26 because they did not have an on-call phone number. Interview with the Administrator on 07/17/26 at 5:20pm revealed: -Resident #8's fall interventions were entered onto his monthly task log for the PCAs to document as completed and onto his service plan. -When fall interventions were added to an incident report, the interventions automatically transferred onto the service plan. -The SCC was responsible for entering the fall interventions onto the monthly task log. -She expected the MAs to go into every resident's service plan each shift and look for new interventions. -The increased supervision check intervention was typically added to the resident's service plan for two weeks at a time depending on the needs of the resident. -She was not sure how Resident #8's bed alarm worked; she was not aware it had a remote that needed to always be with staff.	D 270		

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D 270	Continued From page 46 -She was not sure who taught the staff how Resident #8's bed alarm worked. -She expected the SCC to educate the staff on how Resident #8's bed alarm worked. -She was concerned that if the staff did not know how the bed alarm worked and did not carry the remote with them, then staff would not know when the bed alarm was going off. -She was aware the SCC met with the family regarding a chair alarm but was not aware they did not plan on getting the order until Resident #8's PCP appointment on 07/20/26. -She expected the SCC to get the chair alarm order from Resident #8's PCP sooner than at his next PCP appointment. _____ The facility failed to ensure supervision was provided according to the residents' assessed needs, for two residents (#3 and #8) including Resident #3 who experienced multiple unwitnessed falls, with the two most recent falls resulting in injuries. On 07/03/26, Resident #3 sustained a facial contusion and was sent to the emergency department (ED) for evaluation. Less than one week later, on 07/09/26, Resident #3 fell again, injured her leg, and was diagnosed with a fracture on 07/16/26. Resident #8 had repeated falls, which were not followed by consistent implementation and communication of increased supervision and other fall prevention interventions, resulting in continued falls, injuries, and multiple ED visits. The facility's failure to implement and follow appropriate fall prevention interventions resulted in physical harm and neglect, which constitutes an Unabated Type A1 Violation. _____ The facility provided an acceptable plan of protection in accordance with G.S. 131D-34 on 07/17/26.	D 270		

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D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow-up for 1 of 5 sampled residents (#3) by failing to recognize, assess, and follow up on the resident's ongoing pain after a fall. The findings are: Review of Resident #3's current FL2 dated 07/07/26 revealed: -Diagnoses included dementia, glaucoma, hypertension, and kidney disease. -She was semi-ambulatory. -She was intermittently disoriented. -She required assistance from staff with bathing, feeding, and dressing. -She was incontinent of bowel and bladder. -Her level of care was Special Care Unit (SCU). Review of Resident #3's care plan dated 08/11/25 revealed: -She wandered. -She was ambulatory with an assistive device; she used a wheelchair. -She had significant memory loss and required direction. -She required staff supervision with toileting. -She was independent with ambulation. -She required limited staff assistance with bathing.	D 273		

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D 273	Continued From page 48 -She required extensive staff assistance with dressing. -She was independent with transferring. Review of Resident #3's incident report dated 07/09/26 at 8:45pm revealed: -Resident #3 was observed on the floor. -Resident #3's left knee was a little swollen with light bruising. -Resident #3 was not sent out for an evaluation. Review of Resident #3's progress notes revealed there was no progress note for 07/09/26. Review of Resident #3's progress note dated 07/10/26 revealed X-rays were obtained, and a family member was present. Review of Resident #3's progress note dated 07/15/26 at 2:45pm revealed: -The primary care provider (PCP) was notified that Resident #3's thigh was swollen and bruised from a previous fall. -The PCP stated she would see the resident on 07/16/26. Review of Resident #3's progress note dated 07/16/26 at 11:24am revealed upon the PCP seeing Resident #3, the resident was sent to the emergency department (ED) for a possible fracture. Review of Resident #3's emergency medical services (EMS) report dated 07/16/26 revealed: -Facility staff reported Resident #3 fell on Thursday, 07/09/26, and injured her left hip and that a mobile X-ray company came out and performed an X-ray the previous week. -The PCP wanted her sent to the ED for an X-ray and evaluation.	D 273		

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-Resident #3 was moaning and combative.
-Facility staff stated this was not the resident's normal behavior and that she had been this way since the previous week after the fall.
-It was noted the resident also had a large bruise and hematoma to the left side of her face that was reported to be from a previous fall.
-The resident's hip was swollen.

Observation of Resident #3 on 07/14/26 at 12:09pm revealed:
-Resident #3 was sitting in the day room in her wheelchair with her feet on the floor.
-When the personal care aide (PCA) attempted to lift her leg to place it on the wheelchair leg rest, Resident #3 began to moan.

Interview with the PCA on 07/16/26 at 2:37pm revealed:
-Resident #3 was in a lot of pain on 07/16/26.
-Resident #3 was in pain on Wednesday, 07/15/26, but not to the extent she was on 07/16/26.
-On 07/16/26, Resident #3 did not want to be moved and was saying, "Don't move me."

Interview with another PCA on 07/16/26 at 3:44pm revealed:
-Resident #3 had not been able to stand on her own since she fell on 07/09/26, but prior to that fall, she could.
-She had seen bruising all the way up Resident #3's leg since the fall on 07/09/26.
-Resident #3 said her leg was hurting.
-Resident #3's leg pain had been "about the same" since the fall on 07/09/26.

Interview with a MA on 07/16/26 at 2:49pm revealed:
-Resident #3 had been in pain since her last fall

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on 07/09/26.
-Resident #3 "yelled" when she was moved, such as when staff got her up to be toileted, since the last fall.
-Resident #3's leg was "cocked out" at her knee.
-"Cocked out" meant the leg was bent outward from the knee down while the upper leg remained straight.
-She was told Resident #3's knee was injured.
-She did not recall seeing bruising on Resident #3's thigh originally.
-Resident #3 had bruising on her thigh and was yelling on 07/15/26, and she completed a triage note to the PCP.

Interview with another MA on 07/16/26 at 4:05pm revealed:
-Yesterday, 07/15/26, on second shift, Resident #3 did not want to be bothered and was combative.
-Resident #3 was saying, "Just let me pass."
-She had seen bruising on Resident #3's upper thigh one day the previous week.
-Resident #3 complained her knee was hurting, not her thigh.
-She had not told anyone Resident #3 had bruising on her thigh.
-Resident #3's family member knew Resident #3 had bruising on her thigh.
-She had never seen Resident #3 so agitated.
-Resident #3 did not have anything that could be given for pain.
-She saw Resident #3's family member apply Tylenol cream to Resident #3's leg.
-Resident #3's family member kept the Tylenol cream.
-She asked the SCC for an order for a PRN medication for pain for Resident #3; she did not recall when.
-If there had been an order to apply the cream,

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she would have applied it because Resident #3 was in so much pain.
-Resident #3's last fall on 07/09/26 "did something" to her leg.

Telephone interview with a third MA on 07/17/26 at 8:30am revealed:
-No one told her Resident #3 was experiencing pain after her fall.
-If she had known Resident #3 was experiencing pain, she would have notified the SCC and the PCP.
-She assisted Resident #3 to the bathroom on 07/13/26, and the resident did not complain of pain.
-Her experience was if a resident complained of pain, she would send the resident out to be evaluated because staff could not always tell the severity of what was going on.

Telephone interview with a fourth MA on 07/17/26 at 10:14am revealed:
-Resident #3's family member called on 07/09/26 and said the resident was on the floor beside her bed.
-Resident #3 reported her left knee was hurting, and it appeared "a little" swollen and larger than the other leg.
-She helped the PCA take Resident #3 to the bathroom on 07/13/26, and the resident did not complain of any pain.

Telephone interview with Resident #3's family member on 07/14/26 at 11:30am revealed:
-After Resident #3's fall on 07/09/26, if she was lying in a comfortable position she did not complain of pain, but when she was moved, she was in pain and would moan.
-The MA completed a telehealth triage note, and an X-ray was ordered.

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-She was at the facility when the mobile X-ray was done and noted only the knee was X-rayed.
-When she asked about it, staff reported they only had an order to X-ray the knee.
-She showed the SCC Resident #3's thigh area, and the SCC said the PCP had to read the X-ray.
-The X-ray results were received on Monday, 07/13/26, and showed no fracture but did note arthritis.
-It was clear that Resident #3's whole leg was hurting.
-Resident #3's knee was swollen and bruised, but her thigh was swollen and bruised too.
-She thought Resident #3's knee swelling had improved.
-Staff gave her a shower on Tuesday, 07/14/26, which she thought was unusual since the resident had the fall.
-She could only monitor Resident #3's room with the camera, so she did not know if the resident had another fall outside of the room.

Telephone interview with Resident #3's family member on 07/16/26 at 5:42pm revealed she was with Resident #3 at the hospital and was told the resident had a fracture in her hip area.

Interview with the SCC on 07/17/26 at 4:43pm revealed:
-She was informed of Resident #3's fall and swollen knee on 07/09/26 by a MA.
-She was present when the X-ray was done.
-The mobile X-ray technician only X-rayed Resident #3's knee because that was what the order said.
-No one told her Resident #3 had swelling or bruising on her thigh.
-She was not aware Resident #3 was having any pain or was unable to bear weight on her leg.
-If she had known, she would have sent the PCP

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a message and had Resident #3's hip checked.
-There was a lack of communication among the staff.
-She was concerned Resident #3 was in pain and was unable to communicate what was hurting.

Interview with Resident #3's PCP on 07/16/26 at 11:45am revealed:
-Resident #3's pain was not in her knee; it was in her hip and thigh.
-Resident #3 had swelling in her left thigh.
-She expected staff to have notified her that Resident #3 was having ongoing pain after the fall on 07/09/26.
-Resident #3 was in "so much pain" on 07/16/26.

Telephone interview with Resident #3's PCP on 07/17/26 at 12:30pm revealed:
-It was the facility's responsibility to follow up with her if the resident continued to have pain.
-Staff could not have a conversation with Resident #3, so they should have observed her body language and known what her baseline was.
-The facility staff should have known Resident #3's baseline, and if there were any changes in that baseline, she expected to be notified.
-A change in Resident #3's baseline would have meant she was not stable, and staff should have reached out to her.
-If Resident #3 was screaming and crying when her leg was moved, staff would have known something was broken.
-A delay in obtaining treatment for a broken bone delayed healing for the resident, placed the resident at risk for a blood clot, and caused the resident to remain in pain, which was all very concerning.

Interview with the Administrator on 07/17/26 at 6:47pm revealed:

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D 273	Continued From page 54 -She expected changes in Resident #3's condition to have been communicated to the SCC so the SCC could notify the PCP. -She was concerned Resident #3 was in pain longer than she needed to be. Attempted interview with Resident #3 on 07/16/26 at 3:00pm was unsuccessful due to the resident being in the hospital. _____ The facility failed to ensure health care referral and follow-up for 1 of 5 sampled residents (#3). Following a fall on 07/09/26, Resident #3 continued to exhibit signs and symptoms of pain, including moaning when she moved, inability to bear weight on her leg, swelling and bruising on her leg from the knee up to the thigh, and changes from her baseline functioning. Despite these ongoing changes in condition, the PCP was not notified until 07/15/26, six days after the fall. On 07/16/26, the PCP assessed Resident #3, noted swelling of the left thigh, significant pain, and suspected a fracture, resulting in the resident being sent to the ED for evaluation. The delay in obtaining medical evaluation delayed treatment of Resident #3's hip fracture, which further delayed healing and placed the resident at risk for complications, including blood clots, and caused the resident to remain in unnecessary pain. The facility's failure resulted in physical harm, pain, and neglect and constituted a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/17/26 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 16, 2026.	D 273		

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D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to ensure physicians' orders were implemented for 1 of 5 sampled residents (#3) related to an order for applying ice to a facial contusion after a fall. The findings are: Review of Resident #3's current FL2 dated 07/07/26 revealed: -Diagnoses included dementia, glaucoma, hypertension, and kidney disease. -She was intermittently disoriented. -She required assistance from staff with bathing, feeding, and dressing. -Her level of care was Special Care Unit (SCU). Review of Resident #3's incident report dated 07/03/26 at 6:00am revealed: -Resident #3 was seen on the floor by her family member. -Resident #3 had a facial contusion on the left side of her face. -Resident #3 was sent to the emergency	D 276		

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department (ED) to be evaluated.

Review of Resident #3's progress note dated 07/03/26 revealed Resident #3 returned from the ED at 11:33am.

Review of Resident #3's hospital after-care instructions dated 07/03/26 revealed:
-Resident #3 was diagnosed with a facial contusion.
-The skin, muscles, and other soft tissues of the face might become swollen and painful.
-The bones under the face might also be bruised.
-Apply ice to the face to help with pain and swelling four times per day for at least 20 minutes.
-Specific instructions were provided on how to apply the ice.

Review of Resident #3's July 2026 electronic medication administration records (eMAR) from 07/01/26 through 07/16/26 revealed:
-There was no entry for applying ice to the facial contusion.
-There was no documentation that ice had been applied.

Review of Resident #3's progress note dated 07/04/26 at 2:01pm revealed Resident #3 was holding her head and complaining of pain due to her recent fall.

Observation of Resident #3 on 07/16/26 at 11:30am revealed she had a large raised cone-shaped bump on her forehead, approximately 1 inch in height with dark red and purple bruising.

Interview with a personal care aide (PCA) on 07/16/26 at 2:37pm revealed no one told her to

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D 276	Continued From page 57 do anything with Resident #3's facial contusion. Interview with a medication aide (MA) on 07/16/26 at 2:49pm revealed no one told her to do anything with Resident #3's facial contusion. Interview with another MA on 07/16/26 at 4:05pm revealed: -Resident #3's family member told her to apply ice to Resident #3's facial contusion. -She did not see an order to apply ice to Resident #3's facial contusion, but she saw the family member apply ice. Telephone interview with a third MA on 07/17/26 at 8:30am revealed: -She was not told to do anything related to Resident #3's facial contusion when she returned to work. -The MA who was working when a resident returned from the hospital should have read the hospital discharge summary, entered the orders and recommendations into the system, and faxed a copy to the PCP. Telephone interview with Resident #3's family member on 07/17/26 at 8:58am revealed: -When Resident #3 returned from the hospital on 07/03/26, the Special Care Unit Coordinator (SCC) signed the hospital discharge papers. -The discharge summary instructed staff to apply ice to Resident #3's facial contusion. -No one applied ice to Resident #3's facial contusion, and once she saw no one was going to do it, she asked for ice so she could do it herself. -Resident #3 complained of a headache on 07/03/26 and 07/04/26 that she knew of. -She did not see any staff apply ice to Resident #3's facial contusion when she reviewed the	D 276		

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electronic monitoring footage (camera).
-She was concerned Resident #3 was in pain and no one saw the discharge papers to give her what she needed.

Interview with the SCC on 07/17/26 at 3:25pm revealed:
-The MA was responsible for reading the discharge summary, and faxing the discharge summary to the PCP and the pharmacy.
-She then reviewed the discharge summaries to make sure the orders were implemented.
-She recalled seeing an order for applying ice to Resident #3's facial contusion.
-She knew Resident #3's family member was applying the ice.
-The order for applying ice should have been entered into Resident #3's eMAR so staff would know what to do.
-Staff at the facility entered new treatment orders into the eMAR.

Interview with the Administrator on 07/17/26 at 5:24pm revealed:
-She and the SCC reviewed all new orders.
-The MAs were responsible for sending orders to the pharmacy.
-She was not aware Resident #3 had an order to apply ice to her facial contusion.
-She was concerned Resident #3's swelling would not have been reduced if the ice was not applied.
-She expected staff to follow the orders no matter how the order was received.

Telephone interview with Resident #3's PCP on 07/15/26 at 4:10pm revealed:
-She expected staff to follow the orders on the discharge summary.
-Ice was used to reduce swelling, and if ice was

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D 276	Continued From page 59 not applied, the swelling would have continued. -There would have been prolonged swelling and increased pain. -Pain could have caused more agitation, an increased risk of falls, and more confusion in residents with dementia. Attempted interview with Resident #3 on 07/16/26 at 3:00pm was unsuccessful due to the resident being in the hospital. _____ The facility failed to ensure a resident who fell and had a facial contusion was provided ice packs to her face four times a day to assist with pain management. This failure contributed to Resident #3's pain which was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of corrections in accordance with G.S. 131D-34 on 08/03/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHOULD NOT EXCEED AUGUST 31, 2026.	D 276		
D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect.	D 312		

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D 312	Continued From page 60 This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure feeding assistance was provided for 1 of 5 sampled residents (#3) and to ensure sugar and gravy were added to food items to encourage the resident's nutritional intake. The findings are: Review of Resident #3's current FL2 dated 07/07/26 revealed: -Diagnoses included dementia, glaucoma, hypertension, and kidney disease. -She was semi-ambulatory. -She was intermittently disoriented. -She required assistance from staff with bathing, feeding, and dressing. -Her level of care was Special Care Unit (SCU). Review of Resident #3's Resident Register revealed: -She was admitted to the facility on 10/07/24. -She required assistance from staff with bathing, dressing, and feeding. -She had significant memory loss and required direction. Review of Resident #3's care plan dated 08/11/25 revealed: -She was on a mechanical soft diet. -She had significant memory loss and required direction. -She required limited staff assistance with eating. Review of Resident #3's Licensed Health Profession Support (LHPS) evaluation form dated 04/20/26 revealed: -Resident #3 was on a mechanical soft diet with poor appetite and intake that primarily consisted	D 312		

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of nutritional supplements and occasional small bites of food.
-Recommendations were to continue monitoring intake and weight trends due to poor appetite despite nutritional shakes.

Observation of the lunch meal service on 07/14/26 at 12:11pm revealed:
-Resident #3 was served chopped meat with sauce, green beans, noodles, a roll, and dessert.
-A medication aide (MA) was sitting with Resident #3 and attempted to feed her a bite of chopped meat; the resident took a small bite, and when the MA attempted a second bite, the resident pushed the spoon back with her tongue.
-The MA was able, after multiple attempts, to get Resident #3 to eat some of her dessert.
-A personal care aide (PCA) told the MA staff they were supposed to add sugar to Resident #3's food.

Interview with the MA on 07/14/26 at 12:38pm revealed:
-She had only been working at the facility since June 2026.
-No one had told her to add sugar to Resident #3's food.

Observation of the lunch meal service on 07/15/26 from 12:10pm-12:44pm revealed:
-At 12:10pm, Resident #3's plate was placed in front of her.
-She was served chopped fried fish with tartar sauce in a cup, creamed potatoes, cooked zucchini, and a roll.
-There did not appear to be gravy or other sauce added to any of the food items.
-A PCA was sitting with Resident #3.
-Another staff member whispered into the PCA's ear, and the PCA took the sugar container from

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the wheelchair and put sugar on Resident #3's food.
-The PCA asked Resident #3 if she wanted something to eat, and the resident shook her head no.
-At 12:15pm, the PCA left the table and stated, "I tried."
-At 12:20pm, Resident #3 attempted to pick up a cup of milk but was unable to do so.
-Another resident's family member stated, "maybe someone will be back to help you out."
-The family member stated she had been told she could not assist other residents and that it broke her heart that no one fed Resident #3.
-At 12:23pm, dietary staff placed a dish containing cheesecake with fruit sauce on the table in front of Resident #3. No staff member offered or assisted Resident #3 with the dessert.
-From 12:30pm to 12:37pm, no staff member provided assistance to Resident #3.
-At 12:44pm, the PCA wheeled Resident #3 out of the dining room without making any additional attempts to offer or assist the resident with consuming the dessert.
-Resident #3 did not consume any food.

Observation of the breakfast meal service on 07/16/26 from 7:19am-7:42am revealed:
-At 7:25am, Resident #3 was served ground meat, eggs, pureed fruit, and a biscuit.
-There was no gravy on the food.
-There was syrup on the biscuit.
-A PCA was feeding Resident #3 by explaining what food was being offered, placing the spoon on her lips, and asking her to taste it; Resident #3 took small bites.
-At 7:35am, the PCA left the table to feed another resident; however, another PCA sat with that resident, and the PCA returned to sit with Resident #3.

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D 312	Continued From page 63 -At that time, the PCA did not attempt to feed Resident #3 any additional food. -The PCA asked Resident #3 if she wanted her nutritional supplement. -Staff left Resident #3 at the table with her nutritional supplement sitting on the table, and Resident #3 repeatedly stated, "help us." -At 7:42am, a PCA pushed Resident #3's wheelchair out of the dining room. Confidential interview with a resident's family member revealed: -She was at the facility during meals 4-5 times per week. -She observed residents who required feeding assistance but were not assisted by staff. -If Resident #3's family member was not present to feed the resident, Resident #3 would sit at the table without assistance. -She observed Resident #3 reaching for items but was unable to pick them up. -Staff did not take the time to feed Resident #3. -There was usually one staff member in the dining room, and that staff member was assisting another resident with feeding. -She had observed other staff walking through the dining room but not stopping to assist residents. -Resident #3 appeared to have lost weight and she was concerned it was because Resident #3 was not receiving assistance during meals. Interview with a PCA on 07/16/26 at 2:37pm revealed: -When she fed Resident #3, she attempted for approximately 10-20 minutes to get her to eat something. -Usually, staff provided Resident #3 with a nutritional supplement during meals. -Resident #3 had sugar available to sprinkle on	D 312		

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her food.
-She thought Resident #3 had run out of sugar because she did not see any on 07/16/26.
-Resident #3 always said no when she asked if she wanted something to eat.
-She would tell Resident #3 what food was being offered, and Resident #3 would say no.

Interview with a PCA on 07/17/26 at 8:03am revealed:
-There was only one resident who required feeding assistance; the resident was not Resident #3.
-Resident #3 did not really eat and might only place a taste of food on her tongue.
-Resident #3 was provided whatever food the dietary staff prepared.
-A MA told her to add sugar to Resident #3's food because she would be more likely to eat it.
-When she assisted Resident #3 with eating, she would tell her what food was being offered and ask if she wanted to taste it.
-Resident #3 was willing to taste the food but did not consume much.

Interview with a second MA on 07/16/26 at 2:49pm revealed she was not aware sugar should be added to Resident #3's food until 07/15/26.

Telephone interview with Resident #3's family member on 07/15/26 at 11:30am revealed:
-On 01/28/25, Resident #3 had a speech therapy consultation that recommended adding sugar to the resident's food to encourage consumption.
-The facility staff coordinated the speech therapy consultation, so she assumed the recommendation had been communicated to staff.
-She had not seen staff add sugar to Resident #3's food but always added it herself when she

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was present during meals.
-A sugar container was kept on the side of Resident #3's wheelchair.
-Other residents' family members told her staff were not assisting Resident #3 with meals.
-On 07/06/26, she observed that Resident #3's meal had not been eaten.
-When she asked the PCA about it, the PCA stated Resident #3 did not want anything to eat.
-She noticed Resident #3's silverware was still wrapped and had not been opened.
-After Resident #3's fall on 07/09/26, she was in significant pain and was not eating as well.

Request for Resident #3's speech therapy consultation notes from 2025 were requested on 07/15/26-07/17/26, but were not provided by survey exit.

Telephone interview with Resident #3's family member on 07/17/26 at 8:58am revealed:
-On 03/04/26, during Resident #3's care plan meeting, it was discussed that Resident #3's meals were too dry and gravy needed to be added to the meals.
-The order was given to the previous Special Care Unit Coordinator (SCC).

Request for Resident #3's care plan notes from the March 2026 care plan meeting were requested on 07/15/26-07/17/26, but were not provided by survey exit.

Interview with the Dietary Manager on 07/17/26 at 3:04pm revealed:
-The dietary staff prepared the meal trays, and care staff assisted residents who required assistance.
-She prepared Resident #3's meals with gravy added to the food.

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D 312	Continued From page 66 -A picture was shown to her of Resident #3's breakfast on 07/15/26; she stated she used syrup for breakfast meat, not gravy, and used gravy for lunch and dinner meats only. -A picture was shown to her of Resident #3's fish on 07/15/26; she stated she did not add gravy to the fish and expected staff to dip the fish in the tartar sauce. -She added gravy or sauce to Resident #3's meats because the recipe book instructed staff to moisten meats; no one had instructed her to add gravy specifically to Resident #3's meals. Interview with the SCC on 07/17/26 at 3:25pm revealed: -Resident #3's family was usually present during her meals. -If Resident #3's family was not present, staff were expected to attempt to feed her. -She expected staff to be patient when assisting Resident #3 with meals. -Resident #3 usually did not have her eyes open, and staff should tell her what food was being offered, encourage her to take a bite, and try a different approach if she refused. -Staff should continue working with her until she consumed some of her meal. -If staff left Resident #3 to assist other residents, she expected staff to return and try again with encouragement. -She was concerned that not enough effort was made to encourage Resident #3 to eat. -She knew Resident #3's family member added sugar to her meals, but staff had not been instructed to do so. -She had seen meats that dietary staff had added gravy to. Interview with the Administrator on 07/17/26 at 6:47pm revealed:	D 312		

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D 312	Continued From page 67 -Resident #3 fed herself at times and required staff assistance at other times. -Staff encouraged Resident #3 to feed herself. -Staff were instructed that if Resident #3 refused food, they should attempt multiple times and, if unsuccessful, step away and allow another staff member to try. -She knew staff added sugar to Resident #3's food; however, even with sugar added, Resident #3 did not eat. Attempted telephone interview with the previous SCC on 07/15/26 at 7:59am was unsuccessful. Attempted interview with Resident #3 on 07/16/26 at 3:00pm was unsuccessful due to the resident being in the hospital.	D 312		
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 Based on these findings, the previous Type A1 violation was not abated. Based on observations, interviews, and record reviews, the facility failed to ensure medications	D 358		

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were administered as ordered for 2 of 7 residents (#6 and #7) observed during the medication pass including errors with a medication to treat anxiety and an antibiotic (#7), and a supplement and a medication used to remove excess fluid (#6); and for 3 of 5 residents (#1, #3, and #4) sampled for record review including a medication used to treat symptoms of Parkinson's disease (#1), a pain medication (#3), and a topical pain reliever (#4).

The findings are:

1. The medication error rate was 8% as evidenced by the observation of 3 errors out of 34 opportunities during the morning medication pass on 07/15/26.

a. Review of Resident #6's current FL2 dated 01/09/26 revealed diagnoses included Alzheimer's disease, hypertension, osteoporosis, and atrial fibrillation.

1. Review of Resident #6's signed physician's order dated 06/03/26 revealed there was an order for furosemide (used to remove excess fluid) 20mg, take 1 tablet daily as needed (PRN) for increased edema or weight gain of 3 pounds in 1 day or 5 pounds in 1 week.

Observation of the morning medication pass on 07/15/26 at 8:15am revealed:
-The medication aide (MA) removed Resident #6's schedule medications from the medication cart and compared them to the electronic medication administration record (eMAR).
-The MA placed Resident #6's scheduled medications into a medication cup and administered the medications to Resident #6.
-The MA returned to the medication cart, documented on the eMAR and began preparing

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another resident's medications.
-The MA did not weigh Resident #6 to see if furosemide should be administered for weight gain.

Observation of Resident #6's medications on hand on 07/15/26 at 8:27am revealed:
-There was a blister pack labeled furosemide 20mg, take 1 tablet daily PRN for increased edema or weight gain of 3 pounds in 1 day or 5 pounds in 1 week with a dispense date of 04/07/26.
-There were 30 of 30 tablets remaining in the blister pack.

Review of Resident #6's July 2026 eMAR from 07/01/26 to 07/15/26 revealed:
-There was an entry for furosemide 20mg, take 1 tablet daily PRN for increased edema (excess fluid in the body) or weight gain of 3 pounds in 1 day or 5 pounds in 1 week.
-There were no documented weights for Resident #6.
-There was no documentation furosemide was administered from 07/01/26-07/15/26.

Observation of Resident #6 on 07/15/26 at 9:10am revealed that her legs were slightly swollen.

Interview with the MA on 07/16/26 at 10:57am revealed:
-She did not weigh Resident #6 daily.
-Resident #6 was only weighed monthly.
-She did not know that Resident #6 had a PRN furosemide order.
-She had not noticed if Resident #6 had edema or gained weight.

Interview with Resident #6's Primary Care

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D 358	Continued From page 70 Provider (PCP) on 07/16/26 at 11:41am revealed: -Furosemide was used to remove excess fluid from the body. -If Resident #6's furosemide was not administered as ordered, she would not know if the treatment was effective, the resident could have shortness of breath, or fluid overload. -She expected the MAs to follow the order as written and check Resident #6's weights daily. Interview with the Special Care Unit Coordinator (SCC) on 07/17/26 at 3:20pm revealed: -When the MAs signed onto the eMAR system, the PRN medications populated at the top for the MAs to see. -She remembered seeing Resident #6's PRN furosemide order but did not realize it had a weight parameter. -She expected the PCP to let her know how often to check Resident #6's weights. Interview with the Administrator on 07/17/26 at 5:20pm revealed she expected furosemide to be administered as ordered. 2. Review of Resident #6's signed physician's order dated 06/03/26 revealed there was an order for vitamin D3 (a supplement) 50mcg, take 1 tablet once daily. Observation of the morning medication pass on 07/15/26 at 8:15am revealed: -The MA removed a bottle of vitamin D3 from the medication cart and compared it to the eMAR. -The MA removed 1 tablet from the bottle and placed it in a medicine cup. -The MA administered vitamin D3 to Resident #6. -The MA returned to the medication cart and documented the administration of vitamin D3.	D 358		

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Review of Resident #6's electronic medication administration record (eMAR) for 07/15/26 revealed vitamin D3 was documented as administered on 07/15/26.

Observation of Resident #6's medications on hand on 07/15/26 at 8:16am revealed the bottle of vitamin D3 expired in October 2025.

Interview with the MA on 07/16/26 at 10:57am revealed:
-She did medication cart audits but did not have a schedule of when to do the cart audits.
-One of the things she would look for was expired medications.
-She did a medication cart audit within the last two weeks but could not remember when.
-She did not notice Resident #6's vitamin D3 was expired.

Interview with the Lead MA on 07/15/26 at 5:30pm revealed:
-She did a medication cart audit on 07/10/26 and included all medication carts.
-There was no set schedule to complete medication cart audits.
-There was no form to fill out when a medication cart audit was completed.
-One of the things she looked for during a medication cart audit was expired medications.
-She was not sure how she missed the expired vitamin D3.

Interview with Resident #6's PCP on 07/16/26 at 11:41am revealed:
-Resident #6 had a diagnosis of osteoporosis which caused weak and brittle bones.
-Vitamin D3 was ordered to help the bones absorb calcium, which was good for bone health.
-She was concerned Resident #6 would not get

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the full benefits of vitamin D3 if it was expired.
-She was concerned Resident #6 could experienced bone pain.
-She expected the MAs to check for expired medications before administration.

Interview with the SCC on 07/17/26 at 3:20pm revealed:
-The SCC and Lead MA did cart audits at least weekly.
-One of the things they looked for was expired medication.
-She had not completed a cart audit since taking the SCC position in May 2026.
-The last cart audit was completed by the Lead MA on 07/10/26.
-She expected the Lead MA to find the expired vitamin D3.

Interview with the Administrator on 07/17/26 at 5:20pm revealed:
-The SCC and Lead MA were responsible for completing medication cart audits weekly.
-One of the tasks completed during a cart audit was to check for expired medications.
-The Lead MA and a Corporate Operation Specialist did a cart audit on 07/10/26.
-She was not sure why the expired vitamin D3 was missed during the cart audit.
-She expected the cart audits to be completed weekly and checked for expired medications.

Based on observation, interviews and record reviews it was determined Resident #6 was not interviewable.

b. Review of Resident #7's current FL2 dated 02/02/26 revealed diagnoses included hypertension, atrial fibrillation, and generalized weakness.

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D 358	Continued From page 73 Review of Resident #7's signed physician order dated 07/13/26 revealed an order for nitrofurantoin microcrystals (an antibiotic used to prevent urinary tract infections) 100mg, take 1 capsule daily. Observation of the morning medication pass on 07/15/26 at 8:39am revealed nitrofurantoin microcrystals was not administered. Review of Resident #7's July 2026 electronic medication administration record (eMAR) for 07/15/26 revealed: -There was an entry for nitrofurantoin microcrystals 100mg, take 1 capsule daily scheduled at 8:00am. -There was no documentation nitrofurantoin microcrystals was administered. Interview with the medication aide (MA) on 07/15/26 at 5:30pm revealed: -She knew Resident #7's nitrofurantoin microcrystals was scheduled to be administered at 8:00am. -She did not administer nitrofurantoin microcrystals because she knew Resident #7 would not take it in the morning. -She had been holding Resident #7's nitrofurantoin microcrystals until dinner and then administered it to her. -She had tried to change the administration time for nitrofurantoin microcrystals in the facility's eMAR system, but she could not change it. -She did not call the pharmacy to have the nitrofurantoin microcrystals administration time changed. -She emailed the eMAR company on 07/15/26 at 4:25pm to see why she could not change the time after the Secure Care Unit Coordinator (SCC)	D 358		

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had asked her to.
-She was not sure why she did not email the eMAR company before 07/15/26 to see why she could not change the administration time.

Interview with Resident #7 on 07/16/26 at 8:40am revealed:
-She took nitrofurantoin microcrystals to prevent urinary tract infections.
-She kept nitrofurantoin microcrystals in her room, but the facility removed them last week.
-When the MA tried to administer nitrofurantoin microcrystals last week, she let them know she only took it once daily after dinner.
-The MAs would give her the nitrofurantoin microcrystals on her way to dinner to administer after she ate.

Interview with the SCC on 07/17/26 at 3:20pm revealed:
-Resident #7 had a bottle of nitrofurantoin microcrystals in her room and did not have an order.
-She called Resident #7's Primary Care Provider (PCP) and received an order on 07/08/26 for nitrofurantoin microcrystals 100mg twice daily.
-Resident #7 told her last week that she only took nitrofurantoin microcrystals once daily after dinner.
-She called the PCP and received an order on 07/13/26 for nitrofurantoin microcrystals once daily.
-The pharmacy entered nitrofurantoin microcrystals onto the eMAR to be administered at 8:00am.
-She did not contact the pharmacy to have the administration time changed.
-She asked the MA on 07/15/26 to email the eMAR company to see why she could not change the nitrofurantoin microcrystals administration

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D 358	Continued From page 75 time. Interview with the Administrator on 07/17/26 at 5:20pm revealed she expected nitrofurantoin microcrystals to be administered as ordered. Attempted telephone interview with Resident #7's PCP on 07/15/26 at 3:33pm was unsuccessful. 2. Review of Resident #1's current FL2 dated 08/08/25 revealed diagnoses included major depressive disorder, and catatonic disorder. Review of Resident #1's neurologist's after visit summary dated 05/13/26 revealed: -There was an order for to increase Resident #1's carbidopa/levodopa 25/100mg (used to treat symptoms of Parkinson's disease) immediate-release tablets with meals as follows: week one take 1.5 tablets 3 times daily; week two take 2 tablets 3 times daily; week three take 2.5 tablets 3 times daily; week four and afterward take 3 tablets 3 times daily. -The possible side effects of carbidopa/levodopa were listed and included lightheadedness, low blood pressure, and wiggling movements. -A diagnosis of Parkinson's disease (affects the body's ability to control movement) was listed. Review of Resident #1's electronic medication administration record (eMAR) for May 2026 from 05/14/26-05/31/26 revealed: -There was an entry for carbidopa/levodopa 25/100mg take 3 tablets 3 times daily scheduled at 8:00am, 2:00pm, and 8:00pm. -There was no titration schedule entered onto the eMAR. -There was documentation Resident #1's carbidopa/levodopa was administered as 3 tablets 3 times daily 19 of 19 opportunities.	D 358		

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D 358	Continued From page 76 Review of Resident #1's eMAR for June 2026 revealed: -There was an entry for carbidopa/levodopa 25/100mg take 3 tablets 3 times daily scheduled at 8:00am, 2:00pm, and 8:00pm. -There was no titration schedule entered onto the eMAR. -There was documentation Resident #1's carbidopa/levodopa was administered as 3 tablets 3 times daily 90 of 90 opportunities. Review of Resident #1's July 2026 eMAR from 07/01/26-07/14/26 revealed: -There was an entry for carbidopa/levodopa 25/100mg take 3 tablets 3 times daily scheduled at 8:00am, 2:00pm, and 8:00pm. -There was documentation Resident #1's carbidopa/levodopa was administered as 3 tablets 3 times daily 43 of 43 opportunities. Review of Resident #1's incident reports for May 2026 revealed: -She had a fall on 05/15/26 that resulted in a head injury; she was transported to the emergency department (ED). -She had a fall on 05/18/26 that resulted in no injury. -She had a fall on 05/20/26 that resulted in a skin tear to her right cheek; she was not transported to the ED. -She had a fall on 05/21/26 that resulted in no injuries. -She had a fall on 05/22/26 that resulted in a head injury; she was transported to the ED. Review of Resident #1's triage note from the local ED dated 05/22/26 revealed: -Resident #1 returned earlier today 05/22/26. -Resident #1's head wound was bleeding and had	D 358		

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D 358	Continued From page 77 a gash. -There was an order to send Resident #1 to the ED for sutures to be placed in her head. Review of Resident #1's incident reports for June 2026 revealed: -She had a fall on 06/27/26 that resulted in a head injury; she was transported to the ED. -She had a fall on 06/30/26 that resulted in a skin tear to her right arm; she was not transported to the ED. Review of Resident #1's incident reports for July 2026 revealed she had a fall on 07/08/26 that resulted in no injures.: Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/15/26 at 11:28am revealed: -The pharmacy received an electronic prescription on 05/13/26 for Resident #1's carbidopa/levodopa to increase to 3 tablets 3 times daily. -The pharmacy did not receive titration instructions. -If the pharmacy had received the carbidopa/levodopa titration instructions, they would have entered them as ordered onto the eMAR. Telephone interview with Resident #1's neurologist's nurse on 07/15/26 at 1:23pm revealed: -Resident #1 was prescribed carbidopa/levodopa to treat Parkinsonism. -Resident #1's carbidopa/levodopa dose was increased but the neurologist wanted it to be titrated up to the ordered dose of 3 tablets 3 times daily to monitor how she was tolerating the increased dosages.	D 358		

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-The after-visit summary with clear titration instructions was sent to the facility on 05/13/26.
-An electronic prescription for carbidopa/levodopa was sent to Resident #1's pharmacy.
-The electronic prescription did not have the titration instructions attached.
-Some side effects of carbidopa/levodopa included dizziness and low blood pressure.
-The increase in Residents #1's carbidopa/levodopa to the final dose of 3 tablets 3 times daily instead of titrating it up could have contributed to an increase in falls.
-She was not surprised that Resident #1 experienced an increase in falls after the carbidopa/levodopa dosage was increased from a low dose to a higher dose in such a short period of time.
-She expected the facility to administer carbidopa/levodopa as instructed in the after visit summary.

Interview with the Lead Medication Aide (MA) on 07/15/26 at 5:30pm revealed:
-When she received an after visit summary for a resident, she would give it to the Secure Care Unit Coordinator (SCC) to review.
-She then would fax the after visit summary to the pharmacy if the SCC instructed her to.
-She did not see the order change for Resident #1's carbidopa/levodopa.
-She administered the carbidopa/levodopa as it was entered onto the eMAR.

Interview with Resident #1 on 07/16/26 at 8:51am revealed:
-She knew her neurologist increased the carbidopa/levodopa but was not sure about the titration schedule.
-She had fallen before but remembered falling more in May 2026 but thought it was because of

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her Parkinson's disease getting worse.
-She had to get staples in 2 different locations on her head because of 2 different falls.
-She could not remember if she had any dizziness in May 2026.

Interview with a MA on 07/16/26 at 2:40pm revealed:
-It was the responsibility of the SCC to review the after visit summary and fax it to the pharmacy if there were any new orders.
-She noticed that Resident #1 needed more assistance and had increased falls in May 2026.
-She remembered seeing Resident #1's new carbidopa/levodopa order with the titration scheduled laying on a table in the medication room.
-She did not send it to the pharmacy because she thought it had already been sent.

Interview with the SCC on 07/17/26 at 3:20pm revealed:
-The MAs were responsible for reviewing the after visit summary and faxing to the pharmacy to be entered onto the eMAR.
-The MAs would then put the after visit summary in her box so she could make sure the orders were accurately entered onto the eMAR.
-She faxed Resident #1's after visit summary to the pharmacy but could not remember when.
-She was not sure why Resident #1's carbidopa/levodopa titration order was not entered onto the eMAR.

Interview with the Administrator on 07/17/26 at 5:20pm revealed:
-The SCC and MAs were responsible for all new orders.
-The MAs had been instructed to fax new orders to the pharmacy to be entered onto the eMAR.

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D 358	Continued From page 80 -The MAs would then give the new orders to the SCC to ensure the orders were entered onto the eMAR. -She expected the after visit summary to be sent to the pharmacy and ensure it was entered onto the eMAR as ordered. 3. Review of Resident #3's current FL2 dated 07/07/26 revealed diagnoses included dementia, glaucoma, hypertension, and kidney disease. Review of Resident #3's primary care provider's (PCP) after visit summary dated 05/28/26 revealed an order for Tylenol (used to treat mild to moderate pain) 500mg, take one tablet twice daily as needed (PRN) for pain. Review of Resident #3's hospital after-care instructions dated 07/03/26 revealed: -Resident #3 was diagnosed with facial contusion secondary to a fall. -The skin, muscles and other soft tissues of the face may become swollen and painful. -The bones under the face may also be bruised. -Apply ice to the face to help with pain and swelling four times per day for at least 20 minutes. -Specific instructions were provided on how to apply the ice. -Use Tylenol or ibuprofen (used to reduce pain and inflammation) to decrease pain and inflammation; the PCP would decide if a prescription medication was needed. -If symptoms of a head or neck injury developed, return immediately to the nearest emergency department (ED). -If any of the following symptoms occurred, the resident should immediately go to the ED, including headaches were severe or became worse, vomiting, lethargic, trouble with	D 358		

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coordination, or feeling dizzy.
-Follow-up with the PCP in 2-3 days.

Review of Resident #3's PCP's triage note dated 07/04/26 revealed :
-Resident #3 was complaining of a headache after a fall on 07/03/26 per the medication aide (MA).
-Resident #3 had not said how bad her head was hurting but had been holding her head and saying it hurt.
-Resident #3's family had provided Tylenol 500mg but an order was needed.
-Send the order to the facility's contracted pharmacy to be profiled for her to take the Tylenol.
-There were directions to give the resident one Tylenol now and then one tablet every six hours PRN.
-There was an order for Tylenol Extra Strength 500mg, give one tablet every six hours PRN for pain and monitor for worsening headaches or altered mental status.

Review of Resident #3's PCP's triage note dated 07/09/26 revealed an order to continue Tylenol as needed.

Review of Resident #3's May 2026, June 2026, and July 2026 from 07/01/26 through 07/16/26 electronic medication administration records (eMARs) revealed:
-There was no entry for Tylenol 500mg PRN for pain.
-There was no documentation that Tylenol had been administered.

Observation of Resident #3's medications on hand on 07/14/26 at 3:28pm revealed there was no Tylenol available to be administered.

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D 358	Continued From page 82 Interview with the MA on 07/14/26 at 3:32pm revealed Resident #3 did not have any other medications available to be administered. Telephone interview with the Interim Director of the facility's contracted pharmacy on 07/15/26 at 9:52am revealed: -He did not see an order for Tylenol for Resident #3. -There were no documents attached to Resident #3's profile for 05/28/26. -Tylenol was used for pain. -If the resident was in pain and Tylenol was not administered, the resident would have continued to be in pain. -Medication orders were entered by the pharmacy but would not "pop" onto the eMAR until approved by the facility staff. Telephone interview with Resident #3's family member on 07/14/26 at 11:30am revealed an MA gave Resident #3 one Tylenol on 07/03/26, but she never saw staff administer another Tylenol or ask Resident #3 if she was hurting. Telephone interview with Resident #3's family member on 07/17/26 at 11:30am revealed: -She was with Resident #3 when she complained of a headache on 07/03/26, and she asked the MA for Tylenol. -The MA reported there was no order for Tylenol for Resident #3. -She told the MA there was an order for PRN Tylenol for Resident #3 that was from "months ago." -The MA gave Resident #3 a Tylenol. -Resident #3 complained of a headache again on 07/04/26, and a different MA called her about Resident #3's complaint and asked what she	D 358		

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wanted her to do.
-She told the MA to give Resident #3 Tylenol, and the MA said there was no order.
-She was concerned Resident #3 was in pain and no one reviewed the discharge papers to provide her with what she needed.

Interview with another MA on 07/16/26 at 10:53am revealed:
-She saw Resident #3 with her head in her hands.
-A personal care aide (PCA) told her Resident #3 complained of a headache.
-When she looked in the eMAR, she did not see an order for Tylenol.
-She contacted the triage team with the PCP's office on 07/04/26 and was told she could give Resident #3 Tylenol immediately and as needed.
-She attempted to give Resident #3 Tylenol, but the resident kept spitting it out.

Interview with a third MA on 07/16/26 at 4:05pm revealed:
-She did not administer Tylenol to Resident #3 because there was no order available.
-She saw Resident #3's family member apply a Tylenol cream to Resident #3's leg, but she did not have an order to apply the cream, so she did not.

Telephone interview with a fourth MA on 07/17/26 at 10:14am revealed:
-She was working when Resident #3 had a fall on 07/09/26.
-When she notified the PCP's office, they ordered an X-ray and were going to enter an order for Tylenol.
-She did not administer any Tylenol because she did not have an order.
-Resident #3 had not complained of any pain since 07/09/26.

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D 358	Continued From page 84 Telephone interview with Resident #3's PCP on 07/15/26 at 4:10pm revealed: -She expected staff to follow the orders on the discharge summary. -If Resident #3 expressed pain and Tylenol was not given, the resident would have continued to be in pain. -Pain could have caused more agitation, an increased risk of falls, and more confusion in residents with dementia. Interview with the Special Care Unit Coordinator (SCC) on 07/17/26 at 3:25pm revealed: -Resident #3's order for Tylenol was sent to the pharmacy. -Resident #3's family member provided a bottle of Tylenol. -She was not aware of Resident #3 being in any pain or requesting Tylenol. -Resident #3's Tylenol was on the medication cart, but the resident did not need any. -She emailed the facility's pharmacy and told them to profile the order for Tylenol. Interview with the Administrator on 07/17/26 at 5:24pm revealed: -The MAs knew if they had an order, they could write the order on a paper MAR so the medication could be administered until the pharmacy entered the order in the eMAR. -She expected the SCC to have written the order on a paper MAR if she was the one who saw the order so staff could administer and document the medication. -She was concerned Resident #3 was in pain and the medication was not administered. Attempted interview with Resident #3 on 07/16/26 at 3:00pm was unsuccessful due to the resident	D 358		

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D 358	Continued From page 85 being in the hospital. 4. Review of Resident #4's current FL2 dated 08/06/25 revealed diagnoses included dementia, macular degeneration, and hypothyroidism. Review of Resident #4's after visit summary dated 04/26/26 revealed there was an order for lidocaine topical patch (used to treat pain) 5%, apply 1 patch to skin, leave on for up to 12 hours, then remove for 12 hours daily. Review of Resident #4's signed physician order dated 05/01/26 revealed there was an order for lidocaine topical patch (used to treat pain) 5%, apply 1 patch to skin, leave on for up to 12 hours, then remove for 12 hours daily. Review of Resident #4's April 2026 electronic medication administration record (eMAR) from 04/29/26 to 04/30/26 revealed: -There was an entry for lidocaine topical patch 5%, apply 1 patch to skin, leave on for up to 12 hours, then remove for 12 hours daily scheduled at 8:00am. -Lidocaine topical patch 5% was documented as administered on 04/29/26 and on 04/30/26. Review of Resident #4's May 2026 eMAR revealed: -There was an entry for lidocaine topical patch 5%, apply 1 patch to skin, leave on for up to 12 hours, then remove for 12 hours daily scheduled at 8:00am. -Lidocaine topical patch 5% was documented as administered daily from 05/01/26 to 05/31/26. Review of Resident #4's June 2026 eMAR revealed: -There was an entry for lidocaine topical patch	D 358		

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5%, apply 1 patch to skin, leave on for up to 12 hours, then remove for 12 hours daily scheduled at 8:00am.
-Lidocaine topical patch 5% was documented as administered daily from 06/01/26 to 06/30/26.

Review of Resident #4's July 2026 eMAR from 07/01/26 to 07/14/26 revealed:
-There was an entry for lidocaine topical patch 5%, apply 1 patch to skin, leave on for up to 12 hours, then remove for 12 hours daily scheduled at 8:00am.
-Lidocaine topical patch 5% was documented as administered from 07/01/26 to 07/14/26.

Observation of Resident #4's medication on hand on 07/15/16 at 10:48am revealed there were 6 lidocaine topical patches 5% available for administration.

Telephone interview with a representative from the facility's contracted pharmacy on 07/15/26 at 5:22pm revealed:
-Resident #4 had a current order for lidocaine topical patch 5%, apply 1 patch to skin, leave on for up to 12 hours, then remove for 12 hours.
-Lidocaine topical patch was used to treat pain.
-A quantity of 30 lidocaine topical patches 5% was dispensed on 04/26/26 and would have lasted for 30 days.
-Staff were supposed to request a refill but had not.
-If Resident #4 did not receive lidocaine topical patches 5%, he could have increased pain.

Interview with Resident #4 on 07/15/26 at 11:42am revealed:
-He used the lidocaine patches for pain in his leg.
-Staff did not place the patches on his leg daily.
-He never refused to receive the patches

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D 358	Continued From page 87 because his leg hurt. Interview with Resident #4's Primary Care Provider (PCP) on 07/15/16 at 10:40am revealed: -Resident #4 complained to her that he was experiencing pain in his left leg. -She was concerned that the resident's pain was not controlled because he was not receiving the lidocaine patch as ordered. Interview with a personal care aide (PCA) on 07/16/26 at 4:26pm revealed she showered Resident #4 within the last month and only saw him wearing his patch once. Interview with another PCA on 07/16/26 at 4:39pm revealed: -She showered Resident #4 on 07/13/26 and he did not have on a patch. -She could not recall the last time she saw the resident with his patch. Interview with a medication aide (MA) on 07/15/26 at 2:36pm revealed she had not applied the lidocaine patch to Resident #4's leg because it was not shown on the eMAR, because it was discontinued months ago. Interview with another MA on 07/16/26 at 2:20pm revealed: -First shift MAs applied Resident #4's patch and the second shift MAs were to remove the patch. -The lidocaine patches were always available to administer to Resident #4. -She was not sure how the resident still had 6 patches remaining, if they had not been ordered since 04/26/26. -She was concerned the resident was in pain if staff were not applying his patch.	D 358		

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D 358	Continued From page 88 Interview with a third MA on 07/16/16 at 2:36pm revealed: -She applied Resident #4's lidocaine patch when she worked first shift and removed the patch when she worked second shift. -He did not refuse his lidocaine patch. -He always had lidocaine patches available on the cart for administration. -She would have called the pharmacy if there were no lidocaine patches available for administration. Interview with the Special Care Unit Coordinator (SCC) on 07/17/26 at -The MAs were responsible for ordering Resident #4's lidocaine patch when the patches were getting low. -She was not sure how there were 6 patches on the medication cart if thirty patches were ordered on 04/26/26; all of those patches should have been used. -She was concerned the resident was in pain because his patches were not being applied as ordered. Interview with the Administrator on 07/17/26 at 5:24pm revealed: -She expected the MAs to order Resident #4's patches prior to them running out. -She was concerned Resident #4 experienced pain because he did not receive his lidocaine patch as ordered. _____ The facility failed to administer medications as ordered to a resident (#1) whose neurologist ordered a gradual titration of carbidopa/levodopa (a medication to treat symptoms of Parkinson's disease); however, the titration schedule was not implemented and the resident, instead, received the full prescribed dose immediately, placing the	D 358		

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D 358	Continued From page 89 resident at risk for dizziness and low blood pressure, and contributed to an increase in falls resulting in multiple emergency department visits and a head injury that required sutures. Another resident (#3) who had an order for Tylenol as needed following a fall and complaints of headache did not have the medication entered onto the medication administration record or administered as ordered, causing the resident to have unmanaged pain. A third resident was ordered daily lidocaine pain patches but the pathces were not consistently applied, causing the resident to have unmanaged pain (#4). The failure of the facility resulted in physical harm and neglect to the residents, which constitutes an Unabated Type A1 Violation. _____ The facility provided an acceptable plan of protection in accordance with G.S. 131D-34 on 07/15/26.	D 358		
D 390	10A NCAC 13F .1007 (e) Medication Disposition 10A NCAC 13F .1007 Medication Disposition e) Records of medications destroyed or returned to the pharmacy shall include the resident's name, the name and strength of the medication, the amount destroyed or returned, the method of destruction if destroyed in the facility and the signature of the administrator or the administrator's designee and the signature of the licensed pharmacist, dispensing practitioner or designee of the licensed pharmacist or dispensing practitioner. These records shall be maintained by the facility for a minimum of one year.	D 390		

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D 390	Continued From page 90 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure medications were returned to the pharmacy when a resident had duplicate medications, resulting in the resident being charged for the medications. The findings are: Review of the Disposal of Medication Policy and Procedure dated November 2018 revealed: -With the exception of controlled substances or where prohibited by state law, discontinued or unused medications were returned to the provider pharmacy for credit whenever possible. -Medications may be returned to the provider pharmacy if the medication was in a sealed package or container such as a unit-dose package or sealed bottle. -Medications returned to the pharmacy should be secured until the time of pick up. Review of Resident #3's current FL2 dated 07/07/26 revealed: -Diagnoses included dementia, glaucoma, hypertension, and kidney disease. -There was an order for donepezil (used to treat dementia) 5mg once daily. -There was an order for mirtazapine (used to treat depression) 30mg once daily. Review of Resident #3's progress note dated 05/21/26 revealed: -The Special Care Unit Coordinator (SCC) spoke to Resident #3's family member, who wanted an update regarding medication she was being billed for through the facility's contracted pharmacy. -The SCC informed the family member that the medication had been sent back and the	D 390		

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pharmacy still billed her due to their policy.
-The SCC spoke to a representative at the facility's contracted pharmacy regarding the medication and was informed that even if the medication was untouched, the resident would still be billed for the medication.
-The representative stated she would have to speak to a manager to have the charge removed.

Review of Resident #3's progress note dated 06/25/26 revealed:
-The SCC spoke to a supervisor at the facility's contracted pharmacy.
-The supervisor stated the pharmacy did not receive any documentation when medication was returned to the pharmacy and that the medication was destroyed as soon as it was received.
-The supervisor also confirmed the resident would still be billed even if the medication was returned to the pharmacy.
-The medication would have had to be returned to the pharmacy at the time it was delivered in order for the medication to be credited.

Review of Resident #3's pharmacy billing statement dated 04/30/26 revealed:
-Resident #3's mirtazapine 30mg was refilled on 03/05/26.
-Resident #3's donepezil 5mg was refilled on 03/05/26.
-There was a message associated with each medication stating that, per the insurance company, the refill was too soon due to a previous fill on 03/03/26 at another pharmacy.
-The insurance company would not permit an override per the pharmacy request.
-Resident #3 had the right to appeal directly with the insurance plan.

Telephone interview with the Interim Director of

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the facility's contracted pharmacy on 07/15/26 at 9:52am revealed:
-The process for returning medications was for the facility to call the pharmacy to discuss the medication being returned to determine if the medication was eligible for credit and to receive instructions for returning the medication.
-Medications should not be handed directly to a delivery driver.
-If medication was unused and returned, the billing department would credit the resident for the returned medication.
-When medication was returned to the pharmacy, the information was documented.
-He would investigate Resident #3's mirtazapine and donepezil further.

Telephone interview with the Interim Director of the facility's contracted pharmacy on 07/16/26 at 8:41am revealed:
-He did not see any requests for credit regarding Resident #3's medications.
-Usually, all calls were documented.
-He did not have proof that staff did or did not call regarding Resident #3's medications being returned.
-He would process the return of Resident #3's medications and a corrected invoice would be sent to the resident.

Telephone interview with Resident #3's family member on 07/16/26 at 11:03am revealed:
-She called the SCC on 05/19/26 to discuss the pharmacy billing statement and was told extra medication was not stored at the facility and that the medication had been sent back to the facility's contracted pharmacy.
-She requested the date and documentation of the return shipment, and the SCC stated the facility did not have records showing the

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medication was returned.
-The SCC also stated the facility's contracted pharmacy did not have documentation that the medication was received.
-The SCC stated returned medication would be destroyed by the pharmacy and that she was responsible for payment of the duplicate medication that was ordered.
-The only reason she started using a local pharmacy was because she received notification from the facility's contracted pharmacy in November 2025 that the pharmacy would no longer accept Resident #3's supplemental insurance.
-She located a local pharmacy that packaged Resident #3's medications and began using the local pharmacy.
-She received a bill from the facility's contracted pharmacy in January 2026 and spoke to the previous SCC about it.
-She was told staff were selecting the facility's contracted pharmacy refill option and that a note needed to be entered indicating Resident #3 used a different pharmacy.

Telephone interview with a representative from Resident #3's current pharmacy on 07/16/26 at 10:51am revealed:
-Resident #3 was enrolled in their medication multidose packaging system.
-Resident #3 was placed in their multidose packaging system in March 2026.
-Resident #3's medications were filled on 03/03/26 and delivered on 03/05/26.

Telephone interview with the medication aide (MA) on 07/17/26 at 8:30am revealed:
-She had never returned medications to the pharmacy.
-She was told by the Supervisor on 06/06/26 what

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form should be used if medication was returned to the pharmacy.
-She was not aware of anything related to Resident #3's medications being returned to the pharmacy.

Interview with the SCC on 07/17/26 at 3:25pm revealed:
-Medications returned to the pharmacy were returned during third shift.
-A medication return form was required to be completed.
-The medications were placed in a tote with the completed return form and returned to the pharmacy.
-The care coordinators were responsible for maintaining a copy of the medication return form.
-She was not the SCC at the time and was unable to locate a copy of the return form.
-She had discussed the medication issue with Resident #3's family member.
-The MAs ordered medications through the facility's contracted pharmacy by selecting the reorder button in the eMAR.
-The MA had profiled all of Resident #3's medications, which meant the pharmacy should not have dispensed the medications.
-The pharmacy informed her that it did not maintain documentation of medications that had been returned.

Interview with the Administrator on 07/17/26 at 5:24pm revealed:
-There was no form required for staff to complete when returning medications to the pharmacy.
-The MA should place the medication in a crate and return it to the pharmacy.
-There was no tracking system in place to ensure medications were returned to the pharmacy.

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D 390	Continued From page 95 Attempted telephone interview with the previous SCC on 07/15/26 at 7:59am was unsuccessful.	D 390		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to notify the local county Department of Social Services (DSS) of an incident that required emergency medical evaluation for 1 of 1 sampled residents (#8) who had multiple falls. The findings are: Review of Resident #8's current FL2 dated 03/05/26 revealed: -Diagnoses included Parkinson's disease, chronic obstructive pulmonary disease (COPD), and osteoarthritis. -Resident #8 was intermittently disoriented. -Resident #8 was semi-ambulatory. Review of Resident #8's incident reports from 05/08/26 to 07/13/26 revealed Resident #8 had 9 falls that required the resident to be seen in the	D 451		

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D 451	Continued From page 96 Emergency Department (ED). Interview with the Adult Home Specialist (AHS) on 07/17/26 at 2:19pm revealed: -She received two incident reports for Resident #8 for falls and emergency care was needed. -The incident report for 05/28/26 was received on 06/01/26 and the incident report for 06/12/26 was received on 06/15/26. -The facility should send all incident reports that required emergency care by email or fax within 48 hours. Interview with the Special Care Unit Coordinator (SCC) on 07/17/26 at 3:26pm revealed: -She and the medication aides (MA) were responsible for completing incident reports and emailing them to DSS. -Incident reports were supposed to be sent to DSS within 3 days of an incident. -She was not aware incident reports were to be sent to DSS within 48 hours. Interview with the Administrator on 07/17/26 at 5:24pm revealed the SCC was responsible for completing incident reports and sending them to DSS within 48 hours.	D 451		
D 610	10A NCAC 13F .1801(a) Infection Prevention & Control Policies & Pro 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL POLICIES AND PROCEDURES (a) In accordance with Rule .1211(a)(4) of this Subchapter and G.S. 131D-4.4A(b)(1), the facility shall establish and implement infection prevention and control policies and procedures consistent with the federal Centers for Disease	D 610		

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D 610	Continued From page 97 Control and Prevention (CDC) published guidelines on infection prevention and control. The Department shall approve a set of policies and procedures for infection prevention and control consistent with the federal CDC published guidelines on infection prevention and control that shall be made available on the Division of Health Service Regulation, Adult Care Licensure Section website at https://info.ncdhhs.gov/dhsr/acls/acforms.html at no cost. The facility shall either: (1) utilize the set of policies and procedures for infection prevention and control approved by the Department; (2) develop policies and procedures for infection prevention and control that are consistent with the set of Department approved policies and procedures; or (3) develop policies and procedures for infection prevention and control that are based on nationally recognized standards in infection prevention and control that are consistent with the federal CDC published guidelines on infection prevention and control. This Rule is not met as evidenced by: FOLLOW UP TO TYPE A2 VIOLATION. Based on these findings, the previous Type A2 Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to implement ensure proper infection control procedures for the use of glucometers for 2 of 2 sampled residents (#9 and #10) with orders for blood sugar monitoring. The findings are: Review of the Centers for Disease Control and	D 610		

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Prevention (CDC) guidelines for infection control dated 08/07/24 revealed:
-The CDC recommended that blood glucose monitoring devices (glucometers) should not be shared between residents.
-If a glucometer was to be used for more than one resident, it should be cleaned and disinfected according to the manufacturer's instructions.
-If the manufacturer did not provide disinfection instructions, the glucometer should not be shared between residents.

Review of the manufacturer's manual for Brand A glucometers revealed:
-All parts of the system were considered biohazardous and could potentially transmit infectious diseases even after cleaning and disinfection.
-The Brand A glucometer was for single-patient use only and was not for use on multiple patients.

Review of the facility's undated policy for residents receiving diabetic medications and treatments revealed it was the policy of the facility to adhere to CDC infection prevention guidelines.

Observation of the medication cart on 07/14/26 at 12:54pm revealed:
-There were 2 plastic containers, and each container was labeled with a resident's name.
-Each glucometer in the container was also labeled with the same resident's name as the container.

1. Review of Resident #10's current FL2 dated 06/10/26 revealed:
-Diagnoses included type 2 diabetes.
-There was an order for finger stick blood sugar (FSBS) checks twice daily.

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Review of Resident #10's physician's order dated 06/17/26 revealed there was an order for FSBS checks three times daily before meals.

Observation of Resident #10's glucometer on 07/14/26 at 4:17pm revealed:
-The glucometer, a Brand A glucometer, was labeled with Resident #10's name.
-The current date programmed in the glucometer was 10/03 (no year was shown), and the time was 4:31am.
There were only three days of FSBS readings stored in the glucometer, representing the period from 07/12/26 through 07/14/26.

Review of Resident #10's July 2026 eMAR from 07/12/26-07/14/26 and glucometer history revealed:
-There was an entry on the eMAR for FSBS checks three times daily before meals scheduled at 7:00am, 12:00pm, and 5:00pm.
-There was documentation that Resident #10's FSBS was checked at 7:00am, 12:00pm, and 5:00pm.
-There were 9 FSBS readings in Resident #10's glucometer history, and 6 of the 9 FSBS readings were documented on Resident #10's eMAR.
-On 07/13/26, there was a glucometer reading of 123 at 7:40pm that was not documented on Resident #10's eMAR.

Observation of Resident #10's glucometer history on 07/15/26 at 3:22pm revealed there were no FSBS readings in the glucometer.

Interview with Resident #10 on 07/15/26 at 4:02pm revealed:
-The MAs checked his FSBS before every meal.
-His glucometer had his name on it.
-He had not seen another glucometer used but he

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D 610	Continued From page 100 did not look at it every time. Refer to the telephone interview with the Interim Director of the facility's contracted pharmacy on 07/15/26 at 9:52am. Refer to the interview with a Supervisor on 07/15/26 at 3:25pm. Refer to the interview with the facility's contracted primary care provider (PCP) on 07/15/26 at 4:10pm. Refer to the telephone interview with the facility's Licensed Health Professional Support (LHPS) nurse on 07/16/26 at 3:24pm. Refer to the interview with the with a medication aide (MA) on 07/16/27 at 7:22am. Refer to the interview with the Special Care Unit Coordinator (SCC) on 07/17/26 at 3:25pm. Refer to the telephone interview with the Administrator on 07/17/26 at 5:24pm. 2. Review of Resident #9's current FL2 dated 08/06/25 revealed diagnoses included hypertensive heart disease and chronic kidney disease with heart failure. Review of Resident #9's physician's order dated 02/02/26 revealed an order to check Resident #9's finger stick blood slugger (FSBS) once daily at bedtime. Observation of Resident #9's glucometer on 07/14/26 at 4:17pm revealed: -The glucometer, a Brand A glucometer, was labeled with Resident #9's name.	D 610		

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D 610	Continued From page 101 -The current date programmed in the glucometer was 05/06 (no year was shown), and the time was 5:25pm. There were only three days of FSBS readings stored in the glucometer, representing the period from 07/12/26 through 07/14/26. Review of Resident #9's July 2026 electronic medication administration records (eMAR) from 07/12/26-07/13/26 and glucometer history revealed: -There was an entry on the eMAR for FSBS checks once daily at bedtime scheduled at 8:00pm. -There was documentation that Resident #9's FSBS was checked at 8:00pm on 07/12/26 and 07/13/26. -There were 13 FSBS readings in Resident #9's glucometer history, and 10 of the 13 FSBS readings were documented on Resident #9's eMAR. -On 07/13/26, there was an FSBS reading of 123 documented on Resident #9's eMAR; however, that reading was not in Resident #9's glucometer history. Observation of Resident #9's glucometer history on 07/15/26 at 3:22pm revealed there were no FSBS readings in the glucometer. Interview with Resident #9 on 07/15/26 at 3:27pm revealed: -The MA checked her FSBS every night around 8:30pm. -She had her own glucometer with her name on it. -When she noticed the glucometer, it had her name on it. -She had not missed any FSBS checks.	D 610		

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D 610	Continued From page 102 Refer to the telephone interview with the Interim Director of the facility's contracted pharmacy on 07/15/26 at 9:52am. Refer to the interview with a Supervisor on 07/15/26 at 3:25pm. Refer to the interview with the facility's contracted primary care provider (PCP) on 07/15/26 at 4:10pm. Refer to the telephone interview with the facility's Licensed Health Professional Support (LHPS) nurse on 07/16/26 at 3:24pm. Refer to the interview with the with a medication aide (MA) on 07/16/27 at 7:22am. Refer to the interview with the Special Care Unit Coordinator (SCC) on 07/17/26 at 3:25pm. Refer to the telephone interview with the Administrator on 07/17/26 at 5:24pm. _____ Telephone interview with the Interim Director of the facility's contracted pharmacy on 07/15/26 at 9:52am revealed glucometers should not be shared. Interview with a Supervisor on 07/15/26 at 3:25pm revealed: -A resident's FSBS was checked according to the order, documented on the eMAR, and the glucometers were then cleared. -She did not know when this process started. Interview with the facility's contracted PCP on 07/15/26 at 4:10pm revealed: -Each resident should have their own glucometer. -If a glucometer was shared, there could be	D 610		

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D 610	Continued From page 103 cross-contamination between the residents. Telephone interview with the facility's LHPS nurse on 07/16/26 at 3:24pm revealed: -Each resident should have his or her own glucometer for infection control purposes. -Shared glucometers would put residents at risk for the transmission of infections. Interview with a MA on 07/16/26 at 7:22am revealed: -She confirmed that her initials were the MA who checked the FSBS for the residents on 07/13/26. -She checked Resident #9 and Resident #10's FSBS at bedtime. -She pulled up the resident's name on the eMAR, read the order, made sure she had the correct glucometer, and checked the resident's FSBS. -The FSBS readings were then documented on the eMAR, and the glucometer was cleared. -The SCC and the previous nurse were the individuals she thought told her to clear the glucometer. -She was not told why she was supposed to clear the glucometer. -If Resident #9's glucometer did not have a reading of 123, but 123 was documented in her eMAR, and if Resident #10's glucometer had a reading of 123, but 123 was not documented in his eMAR, it was because she documented the reading in the wrong resident's vitals. -There was no way she used the wrong glucometer. Interview with the SCC on 07/17/26 at 3:25pm revealed: -Every resident had his or her own glucometer. -Each resident's glucometer was labeled with his or her name and was in a container labeled with the resident's name.	D 610		

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THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 610	Continued From page 104 -Staff were supposed to check a resident's FSBS, document the FSBS reading in the eMAR, and then clear the glucometer. -She could not say what anyone else did, but that was how she did it. -She thought someone in management may have told them to clear the glucometer after the FSBS was documented. Interview with the Administrator on 07/17/26 at 5:24pm revealed: -Staff were expected to check one resident's FSBS at a time, document the FSBS reading, and then do the next resident. -The glucometers were labeled to prevent them from being mixed up and used for the wrong residents. -The SCC, Resident Care Coordinator (RCC) and the Supervisor should be doing audits to make sure the glucometer readings matched the resident's eMAR. -She was not aware the glucometers were being cleared after each FSBS. -She did not tell the MAs to clear the glucometers and did not know who told the staff to do this. -She had no concerns that the glucometers were being cleared after each finger stick because she knew the staff were using the glucometers correctly; she had monitored the process.	D 610		