

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL036012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 08/19/2026
NAME OF PROVIDER OR SUPPLIER BROOKDALE UNION		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNION ROAD GASTONIA, NC 28054		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section and Gaston County Department of Social Services conducted a follow-up survey from August 17, 2026 to August 19, 2026.	{D 000}		
D 194	10A NCAC 13F .0608 (a)(b) Staffing for Facilities With A Census Of 21 10A NCAC 13F .0608 Staffing for Facilities With A Census Of 21 Or More Residents (a) Each facility with a census of 21 or more residents shall have staff on duty to meet the needs of the residents. (b) In addition to the requirement in Paragraph (a) of this Rule, each facility with a census of 21 or more residents shall comply with the following staffing requirements: (1) On first shift and second shift, the total aide duty hours shall be at least: (A) 16 hours of aide duty for facilities with a census of 21 to 40 residents. (B) 20 hours of aide duty for facilities with a census of 41 to 50 residents. (C) 24 hours of aide duty for facilities with a census of 51 to 60 residents. (D) 28 hours of aide duty for facilities with a census of 61 to 70 residents. (E) 32 hours of aide duty for facilities with a census of 71 to 80 residents. (F) 36 hours of aide duty for facilities with a census of 81 to 90 residents. (G) 40 hours of aide duty for facilities with a census of 91 to 100 residents. (H) 44 hours of aide duty for facilities with a census of 101 to 110 residents. (I) 48 hours of aide duty for facilities with a census of 111 to 120 residents. (J) 52 hours of aide duty for facilities with a	D 194		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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D 194	Continued From page 1 census of 121 to 130 residents. (K) 56 hours of aide duty for facilities with a census of 131 to 140 residents. (L) 60 hours of aide duty for facilities with a census of 141 to 150 residents. (M) 64 hours of aide duty for facilities with a census of 151 to 160 residents. (N) 68 hours of aide duty for facilities with a census of 161 to 170 residents. (O) 72 hours of aide duty for facilities with a census of 171 to 180 residents. (P) 76 hours of aide duty for facilities with a census of 181 to 190 residents. (Q) 80 hours of aide duty for facilities with a census of 191 to 200 residents. (R) 84 hours of aide duty for facilities with a census of 201 to 210 residents. (S) 88 hours of aide duty for facilities with a census of 211 to 220 residents. (T) 92 hours of aide duty for facilities with a census of 221 to 230 residents. (U) 96 hours of aide duty for facilities with a census of 231 to 240 residents. (2) On third shift, the total aide duty hours shall be at least: (A) 8 hours of aide duty for facilities with a census of 21 to 30 residents. (B) 16 hours of aide duty for facilities with a census of 31 to 60 residents. (C) 24 hours of aide duty for facilities with a census of 61 to 90 residents. (D) 32 hours of aide duty for facilities with a census of 91 to 120 residents. (E) 40 hours of aide duty for facilities with a census of 121 to 150 residents. (F) 48 hours of aide duty for facilities with a census of 151 to 180 residents. (G) 56 hours of aide duty for facilities with a census of 181 to 210 residents.	D 194		

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D 194	Continued From page 2 (H) 64 hours of aide duty for facilities with a census of 211 to 240 residents. (3) If the Department determines the needs of the residents at a facility are not being met by staffing requirements of Paragraph (b) of this Rule, the Department shall require the facility to employ staff to meet the needs of the residents. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure there was enough qualified staff working to meet the required staffing requirements in the Assisted Living (AL) for 26 of 45 sampled shifts from 07/19/26-08/02/26. The findings are: Review of the facility's 2026 license from the Division of Health Service Regulation revealed the facility was licensed for a capacity of 78 beds in the Assisted Living (AL). Review of the facility's census for 07/19/26-08/02/26 revealed there were 52 residents that required 32 aide hours on first and second shift and 16 aide hours on third shift. Review of the staff time punch detail report dated 07/19/26 revealed: -There were 22.50 aide hours provided on first	D 194		

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D 194	Continued From page 3 shift, with a shortage of 9.50 aide hours. -There were 26.75 aide hours provided on second shift, with a shortage of 5.25 aide hours. Review of the staff time punch detail report dated 07/20/26 revealed there were 30.25 aide hours provided on second shift, with a shortage of 1.50 aide hours. Review of the staff time punch detail report dated 07/21/26 revealed there were 26.75 aide hours provided on first shift, with a shortage of 5.25 aide hours. Review of the staff time punch detail report dated 07/22/26 revealed: -There were 26.50 aide hours provided on first shift, with a shortage of 5.5 aide hours. -There were 26.0 aide hours provided on second shift, with a shortage of 6.0 aide hours. Review of the staff time punch detail report dated 07/23/26 revealed: -There were 31.0 aide hours provided on first shift, with a shortage of 1.0 aide hours. - There were 27.75 aide hours provided on second shift, with a shortage of 4.25 aide hours. Review of the staff time punch detail report dated 07/24/26 revealed: -There were 26.25 aide hours provided on first shift, with a shortage of 5.75 aide hours. -There were 31.5 aide hours provided on second shift, with a shortage of 0.5 aide hours. Review of the staff time punch detail report dated 07/25/26 revealed: -There were 23.0 aide hours provided on first shift, with a shortage of 9.0 aide hours. -There were 26.50 aide hours provided on	D 194		

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D 194	Continued From page 4 second shift, with a shortage of 5.5 aide hours. Review of the staff time punch detail report dated 07/26/26 revealed there were 22.50 aide hours provided on first shift, with a shortage of 9.5 aide hours. Review of the staff time punch detail report dated 07/27/26 revealed: -There were 27.0 aide hours provided on first shift, with a shortage of 5.0 aide hours. -There were 27.25 aide hours provided on second shift, with a shortage of 4.75 aide hours. Review of the staff time punch detail report dated 07/28/26 revealed: -There were 27.0 aide hours provided on first shift, with a shortage of 5.0 aide hours. -There were 26.50 aide hours provided on second shift, with a shortage of 5.5 aide hours. Review of the staff time punch detail report dated 07/29/26 revealed: -There were 26.25 aide hours provided on first shift, with a shortage of 5.75 aide hours. -There were 25.50 aide hours provided on second shift, with a shortage of 6.5 aide hours. Review of the staff time punch detail report dated 07/30/26 revealed: -There were 30.25 aide hours provided on first shift, with a shortage of 1.75 aide hours. -There were 30.50 aide hours provided on second shift, with a shortage of 1.5 aide hours. Review of the staff time punch detail report dated 07/31/26 revealed there were 29.25 aide hours provided on second shift, with a shortage of 2.75 aide hours.	D 194			

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D 194	Continued From page 5 Review of the staff time punch detail report dated 08/01/26 revealed: -There were 30.0 aide hours provided on first shift, with a shortage of 2.0 aide hours. -There were 30.75 aide hours provided on second shift, with a shortage of 1.25 aide hours. Review of the staff time punch detail report dated 08/02/26 revealed: -There were 23.25 aide hours provided on first shift, with a shortage of 8.75 aide hours. -There were 26.75 aide hours provided on second shift, with a shortage of 5.25 aide hours. Interview with a resident on 08/18/26 at 3:20pm revealed: -Sometimes there were two staff on a shift instead of four staff. -When there were two staff it took longer for the staff to come check on us. -Sometimes there were less staff on the weekends. -When the facility was short staffed, it took longer to get help with bathroom assistance. Interview with a second resident on 08/17/26 at 9:50am revealed: -The facility did not have enough staff to help on the weekends. -When the facility was short of staff it took longer to get help with personal care needs. -During meal times, she and other residents had to wait for longer periods of time due to only two staff members being available to serve in the dining room. Interview with a second MA on 08/18/26 at 4:05pm revealed: -There were two MAs and two PCAs scheduled on each shift.	D 194		

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D 194	Continued From page 6 -On occasion, there were two MAs and one PCA on duty on a weekend. -When the shift was short staffed, it took longer to answer call bells especially if the MA was passing medications. -The MAs and PCAs were required to work together to assist the residents. Interview with the Resident Care Coordinator (RCC) on 8/17/26 at 3:50pm revealed: -She made a draft staff work schedule. -She put the staff hours in the computer system. -The staff had to download an app to see their schedules. -She did not know how or if the schedule could be printed for review. -She was only allowed 84.0 hours for staff to work per shift. -If a PCA called out, the facility attempted to get coverage with another PCA but there were times the facility could not find coverage and the shift was short staffed. -When an MA called out of work she filled in for the absent MA. Interview with the Business Office Manager (BOM) on 08/18/26 at 4:30pm revealed: -The facility was allowed 72.0 hours of work per shift after the RCC's time was removed from the 84.0 hours allowed. -They had four staff on duty to cover 32.0 hours of work for first and second shift and 16.0 hours on third shift. -She did not know the 32.0 hours, and 16.0 hours did not include the lunch break. Interview with the Area Nurse Manager on 08/18/26 at 4:25pm revealed: -She thought the facility had enough staff hours per shift since the staff were scheduled for 8.0	D 194		

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D 194	Continued From page 7 hours per shift. -She did not know the 30-minute lunch was removed from the 8.0 hours making the hours per shift short by 30-minutes. Interview with the Administrator on 08/18/26 at 4:15pm revealed: -First and second shift had two MAs and two PCAs scheduled to work. -All staff took a 30-minute lunch break per shift. -She understood from the previous survey that third shift did not have enough work hours because staff took a 30-minute lunch break, so she fixed that. -A staff member was hired to work 5:00pm-1:00am to cover staff lunch times. -She thought they had enough work hours on each shift, since staff were scheduled for 8.0 hours per shift.	D 194		
D 256	10A NCAC 13F .0801 (e) Resident Assessment 10A NCAC 13F .0801 Resident Assessment (e) The assessments required in Paragraphs (a) and (c) of this Rule shall be completed and signed by the person designated by the administrator to perform resident assessments. This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to ensure 2 of 5 sampled residents (#1 & #4) had care plans that were signed by the person completing the resident assessment.	D 256		

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D 256	Continued From page 8 The findings are: 1. Review of Resident #4's current FL2 dated 06/10/26 revealed: -Diagnoses included complete AV (atrioventricular block (block of the heart's electrical signals) and muscle weakness. -Resident #4's level of care was Assisted Living Facility (ALF). -Resident #4 was semi-ambulatory. -Resident #4 was incontinent of bladder and bowel. Review of Resident #4's Resident Register revealed the admission date was blank. Review of Resident #4's record revealed an admission date of 06/19/26. Review of Resident #4's care plans dated 06/23/26 and 07/21/26 revealed: -Resident #4 required assistance with dressing, grooming, bathing and toileting. -Resident #4 was independent with mobility, using a manual wheelchair as a mobility aid. -Resident #4's care plans dated 06/23/26 and 07/21/26 were not signed by the assessor. Interview with the Administrator on 08/19/26 at 3:00pm revealed: -She knew Resident #4's care plan was completed because it was "locked" in the electronic system. -She did not know the date, but she had sent an email to the HWD instructing her to sign Resident #4's care plan. -She thought the HWD had signed Resident #4's care plan. -The facility had a temporary nurse auditing	D 256		

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D 256	Continued From page 9 residents' records for care plans but she did not know if she had reviewed Resident #4's record. Refer to the interview with the Resident Care Coordinator (RCC) on 08/19/26 at 2:40pm. Refer to the interview with the Administrator on 08/19/26 at 3:00pm. 2. Review of Resident #1's current FL2 dated 06/10/26 revealed: -Diagnoses included congestive heart failure, hyperlipidemia, anxiety and insomnia. -He was ambulatory. -He was oriented. -Resident #1's level of care was assisted living. Review of Resident #1's Resident Register dated 06/17/26 revealed an admission date of 06/19/26. Review of Resident #1's admission care plan dated 06/23/26 revealed: -He was ambulatory with a manual rollator or used a wheelchair. -He was oriented. -He was incontinent of bladder. -The care plan was not signed by the assessor. Refer to interview with the RCC on 08/19/26 at 2:40pm. Refer to interview with the Administrator on 08/19/26 at 3:00pm. Interview with the Resident Care Coordinator (RCC) on 08/19/26 at 2:40pm revealed the Health and Wellness Director (HWD) or Corporate Registered Nurse (RN) were responsible for completing and signing resident care plans.	D 256		

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D 256	Continued From page 10 Interview with the Administrator on 08/19/26 at 3:00pm revealed: -The HWD was responsible for completing resident care plans in the computer. -The HWD was responsible to notify her when a care plan was completed so she could "lock" it in the electronic system. -After the Administrator "locked" the care plan, the HWD was responsible to print the care plan and sign it.	D 256		
D 259	10A NCAC 13F .0802 (a) (c) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (a) The facility shall develop and implement a care plan for each resident based on the resident's assessment completed in accordance with Rule .0801 of this Section. The care plan shall be resident-centered and include the resident's preferences related to the provision of care and services. A copy of each resident's current care plan shall be maintained in a location in the facility where it can be accessed by facility staff who are responsible for the implementation of the care plan. (c) The care plan shall include the following: (1) a description of services, supervision, tasks, and level of assistance to be provided to address the resident's needs identified in the resident's assessment in Rule .0801 of this Section; (2) frequency of the services or tasks to be performed; (3) revisions of tasks and frequency based on reassessments in accordance with Rule .0801 of this Section; (4) licensed health professional tasks required according to Rule .0903 of this Subchapter; (5) a dated signature of the assessor upon	D 259		

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D 259	Continued From page 11 completion; and (6) a dated signature of the resident's physician or physician extender as defined in Rule .0102 of this Subchapter within 15 days of completion of the care plan certifying the resident is under this physician's care and has a medical diagnosis with associated physical or mental limitations warranting the provision of the personal care services in the above care plan in accordance with G.S. 131D-2.15. This shall not apply to residents assessed through the Medicaid State Plan Personal Care Services Assessment for the portion of the assessment covering tasks needed for each activity of daily living of this Rule for which care planning and signing are directed by Medicaid. This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to ensure 2 of 5 sampled residents (#1 & #4) had care plans that were signed by the resident's physician or physician extender within 15 days of completion. The findings are: 1. Review of Resident #4's current FL2 dated 06/10/26 revealed: -Diagnoses included complete AV (atrioventricular block (block of the heart's electrical signals) and muscle weakness. -Resident #4's level of care was Assisted Living Facility (ALF). -Resident #4 was semi-ambulatory. -Resident #4 was incontinent of bladder and bowel. Review of Resident #4's Resident Register revealed the admission date was blank.	D 259		

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D 259	Continued From page 12 Review of Resident #4's record revealed an admission date of 06/19/26. Review of Resident #4's care plans dated 06/23/26 and 07/21/26 revealed: -Resident #4 required assistance with dressing, grooming, bathing and toileting. -Resident #4 was independent with mobility, using a manual wheelchair as a mobility aid. -Resident #4's care plans dated 06/23/26 and 07/21/26 were not signed by Resident #4's Primary Care Provider (PCP). Telephone interview with Resident #4's PCP on 08/18/26 at 4:07pm revealed she did not know if she had been asked to sign Resident #4's care plans dated 06/2/26 and 07/21/26. Interview with the Administrator on 08/19/26 at 3:00pm revealed: -The HWD was responsible for completing resident care plans in the computer. -The HWD was responsible to notify her when a care plan was completed so she could "lock" it in the electronic system. -After the Administrator "locked" the care plan, the HWD was responsible to print the care plan, sign it and get it signed by the resident's PCP. Refer to the interview with the Resident Care Coordinator (RCC) on 08/19/26 at 2:40pm. Refer to the interview with the Administrator on 08/19/26 at 3:00pm. 2. Review of Resident #1's current FL2 dated 06/10/26 revealed: -Diagnoses included congestive heart failure, hyperlipidemia, anxiety and insomnia. -He was ambulatory.	D 259		

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D 259	Continued From page 13 -He was oriented. -Resident #1's level of care was assisted living. Review of Resident #1's Resident Register dated 06/17/26 revealed an admission date of 06/19/26. Review of Resident #1's admission care plan dated 06/23/26 revealed: -He was ambulatory with a manual rollator or used a wheelchair. -He was oriented. -He was incontinent of bladder. -The care plan was not signed by the PCP within 15 days following completion. Refer to interview with the RCC on 08/19/26 at 2:40pm. Refer to interview with the Administrator on 08/19/26 at 3:00pm. Interview with the Resident Care Coordinator (RCC) on 08/19/26 at 2:40pm revealed: -The Health and Wellness Director (HWD) or Corporate Registered Nurse (RN) were responsible for completing and signing resident care plans. -The HWD or the Corporate RN were responsible for printing the care plan and getting them signed by the residents' PCP. Interview with the Administrator on 08/19/26 at 3:00pm revealed: -The HWD was responsible for completing resident care plans in the computer. -The HWD was responsible to notify her when a care plan was completed so she could "lock" it in the electronic system. -After the Administrator "locked" the care plan, the HWD was responsible to print the care plan,	D 259			

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D 259	Continued From page 14 sign it and get it signed by the resident's PCP.	D 259		
{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: TYPE B VIOLATION The facility failed to administer medications as ordered for 2 of 5 sampled residents (#1 & #2) related to medications for anxiety, agitation and restlessness (#2) and constipation (#1). The findings are: Review of the facility's Medication Administration dated September 2025 revealed: -Trained and/or licensed staff may administer or assist the residents with medication management or medication administration and treatment per physician orders as per state regulation. -Trained or licensed staff administering or assisting with medications should follow the seven rights of medication administration: right medication, right dose, right time, right route, right resident, right documentation and right to refuse. -Follow the medication label, pharmacy and manufacture directions for each individual medication prescribed.	{D 358}		

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{D 358}	Continued From page 15 -Observe the resident taking the medication to verify administration or assist per state regulation. -Document medications administered or assisted with on the electronic medication administration record (eMAR). -Documentation of medications administered/assisted or treatments should occur promptly after the resident has taken the medication or the treatment performed. -Staff should knock on the resident's door before entering and positively identify the resident before giving the medication. -Medication or treatment directions on the physician order and pharmacy label should correlate with the medication or treatment directions on the eMAR. -Controlled medications are double locked. -A hard bound narcotic logbook will be used to verify accuracy and count of controlled substance/medications. -Retain the completed controlled substance count sheet (CSCS), eMAR change of shift audit forms and hardbound narcotic logbooks. -Staff should administer/assist medications and/or treatments to one resident at a time. -Residents should be observed taking the medication followed by the offering of water or fluids. -Medications should be administered within the parameters of physician orders. -Medications and/or treatment errors should be reported promptly and according to the facility reportable events policy and grid. 1. Review of Resident #2's current FL2 dated 01/06/26 revealed diagnoses included malignant neoplasm of rectum, restless leg disorder and major depressive disorder. Review of Resident #2's Resident Register	{D 358}			

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{D 358}	Continued From page 16 revealed an admission date of 02/17/25. Review of Resident #2's record revealed she was admitted under Hospice services on 04/13/25. a. Review of Resident #2's electronically signed Hospice Nurse Practitioner (NP) order dated 06/24/26 revealed an order for lorazepam (used to treat anxiety, agitation and restlessness) 1mg four times daily. Review of Resident #2's June, July and August 2026 electronic eMAR revealed there was not an entry for lorazepam 1mg four times daily. Review of Resident #2's June, July and August 2026 electronic eMAR revealed there was not an entry for lorazepam 1mg every four hours. Review of Resident #2's Control Substance Count Sheets (CSCS) on 08/17/26 revealed: -There was a handwritten label for lorazepam 1mg by four hours, quantity of 45 with a dispense date of 06/24/26. -There was no documentation of lorazepam 1mg being administered every four hours. -There was documentation of lorazepam 1mg was administered once daily on 07/25/26 through 08/16/26 between the hours of 7:00pm to 8:47pm -The last entry on the CSCS was 08/17/26 at 8:30pm with a balance of 24 remaining. Review of Telephone interview with a Pharmacist at the facility's contracted pharmacy on 08/18/26 at 9:04am and on 08/18/26 at 3:13pm revealed: -Resident #2 had an order for lorazepam 1mg every four hours with an order start date of	{D 358}		

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{D 358}	Continued From page 17 11/19/25. -Lorazepam 1mg every four hours with a total of 90 tablets was filled and dispensed by the pharmacy on 11/19/25, 12/10/25 and 06/24/26. -The facility entered all orders in the eMAR system. -Resident #2 could experience uncontrolled anxiety if she did not receive her medications as ordered. Review of Resident #2's record revealed there was no order for lorazepam 1mg every four hours dated 11/19/25. Observation of Resident #2's medications on hand on 08/17/26 at 2:48pm revealed there was a card of lorazepam 1mg tablets with instructions to administer every four hours with a dispense date of 06/24/25 for 45 tablets with 24 tablets remaining. Interview with a medication aide (MA) on 08/17/26 at 5:00pm revealed: -She did not know Resident #2 had an order for lorazepam 1mg every four hours. -Resident #2 had good days and bad days where she was more anxious. -The MAs were to verify the eMAR with the medication on the medication cart and the medication label on the CSCS. -The MAs completed controlled substance counts every shift where they compared the medications to the CSCS. -She did not pay attention to the label on the CSCS and just verified the number on the lorazepam card matched the number on the CSCS. -She had given Resident #2 lorazepam 1mg at bedtime. -She had not paid attention to the label on the	{D 358}		

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{D 358}	Continued From page 18 CSCS to see she had administered Resident #2's lorazepam 1mg every four hours. -The MAs, Resident Care Coordinator (RCC) and the Health and Wellness Director (HWD) entered orders in the eMAR system. -She did not know if there was a system in place to verify if orders were entered correctly. Interview with a second MA on 08/18/26 at 9:47am and on 08/19/26 at 12:37 revealed: -She did not know Resident #2 had an order for lorazepam 1mg every four hours. -The MAs were to verify the eMAR with the medication on the medication cart and the medication label on the CSCS. -The MAs completed controlled substance counts every shift where they compared the medications to the CSCS. -She did not realize the CSCS labels were for lorazepam 1mg every four hours. -She only made sure the CSCS counts were correct and only looked at the number of tablets left and not the medication labels. -The MAs, RCC and HWD entered orders in the eMAR system. -The RCC completed medication cart audits on the weekends. -MAs were to complete medication cart audits daily but she had not. -There was no documentation in place for medication cart audits. Interview with a third MA on 08/18/26 at 2:04pm revealed: -She did not know Resident #2 had an order for lorazepam 1mg every four hours. -She had administered Resident #2 lorazepam 1mg at bedtime. -She did not realize the label on the CSCS was for lorazepam 1mg, four times daily.	{D 358}		

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{D 358}	Continued From page 19 -She should have paid attention to the label on the CSCS. Refer to interview with Resident #2 on 08/18/26 at 9:56am. Refer to telephone interview with Resident #2's Hospice Registered Nurse (RN) on 08/18/26 at 9:47am. Refer to telephone interview with Resident #2's Hospice NP on 08/19/26 at 11:29am. Refer to the interview with the RCC on 08/18/26 at 4:02pm. Refer to the telephone interview with the HWD on 08/19/26 at 10:45am and at 1:23pm. Refer to the interview with the Administrator on 08/19/26 at 3:02pm. b. Review of Resident #2's electronically signed Physician orders dated 06/24/26 revealed an order for lorazepam 1mg by mouth at bedtime. Review of Resident #2's June 2026 eMAR revealed: -There was an entry for lorazepam 1mg at bedtime. -Lorazepam 1mg at bedtime was documented as administered from 06/01/26 through 06/30/26. Review of Resident #2's July 2026 eMAR revealed: -There was an entry for lorazepam 1mg at bedtime. -Lorazepam 1mg at bedtime was documented as administered from 07/01/26 through 07/31/26.	{D 358}		

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{D 358}	Continued From page 20 Review of Resident #2's August 2026 eMAR revealed: -There was an entry for lorazepam 1mg at bedtime. -Lorazepam 1mg at bedtime was documented administered on 08/01/26 to 08/04/26 and on 08/07/26 to 08/16/26. -On 08/05/26 and 08/06/26, lorazepam 1mg at bedtime was documented as not available/pharmacy action. Review of Resident #2's lorazepam 1mg at bedtime CSCS on 08/17/26 at 2:48pm revealed: -There was a handwritten label for lorazepam 1mg at bedtime, quantity of 30 with a dispense date of 06/24/26. -There was documentation lorazepam 1mg being administered once daily at bedtime on 06/25/26 through 07/24/26. -The last entry on the CSCS was 07/24/26 at 8:20pm with a zero-balance remaining and the word, "done" written on the CSCS. -There were no other CSCS for Resident #2's lorazepam 1mg at bedtime available for review. Observation of Resident #2's medications on hand on 08/17/26 at 2:48pm revealed there was no lorazepam 1mg at bedtime available to administer. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 08/18/26 at 9:04am and on 08/18/26 at 3:13pm revealed: -Resident #2 had an order for lorazepam 1mg at bedtime with an order start date of 06/13/25. -Lorazepam 1mg at bedtime with a total of 30 tablets was filled and dispensed by the pharmacy on 09/12/25, 11/10/25 and 06/24/26. -The facility entered all orders in the eMAR system.	{D 358}			

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{D 358}	Continued From page 21 -Resident #2 could experience uncontrolled anxiety if she did not receive her medications as ordered. Interview with a MA on 08/17/26 at 5:00pm revealed: -She did not know lorazepam 1mg at bedtime was not available to be administered. -Resident #2 had good days and bad days where she was more anxious. -The MAs were to verify the eMAR with the medication on the medication cart and the medication label on the CSCS. -The MAs completed controlled substance counts every shift where they compared the medications to the CSCS. -She did not pay attention to the label on the CSCS and just verified the number on the lorazepam card matched the number on the CSCS. -She had given Resident #2 lorazepam 1mg at bedtime but had not paid attention to the label on the CSCS to see she had administered Resident #2's lorazepam 1mg at bedtime. -The MAs, RCC and HWD entered orders in the eMAR system. -She did not know if there was a system in place to verify if orders were entered correctly. Interview with a second MA on 08/18/26 at 9:47am and on 08/19/26 at 12:37 revealed: -She did not know lorazepam 1mg at bedtime was not available to be administered. -The MAs were to verify the eMAR with the medication on the medication cart and the medication label on the CSCS. -The MAs completed controlled substance counts every shift where they compared the medications to the CSCS. -She did not realize the CSCS label was not for	{D 358}			

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{D 358}	Continued From page 22 Resident #2's lorazepam 1mg at bedtime. -She only made sure the CSCS counts were correct and only looked at the number of tablets left and not the medication labels. -The MAs, RCC and HWD entered orders in the eMAR system. -The RCC completed medication cart audits on the weekends. -MAs were to complete medication cart audits daily but she had not. -There was no documentation in place for medication cart audits. Interview with a third MA on 08/18/26 at 2:04pm revealed: -She did not know lorazepam 1mg at bedtime was not available to be administered. -She had administered Resident #2 lorazepam 1mg at bedtime. -She did not realize the label on the CSCS was for lorazepam 1mg, four times daily and not at bedtime. -She should have paid attention to the label on the CSCS. Refer to interview with Resident #2 on 08/18/26 at 9:56am. Refer to telephone interview with Resident #2's Hospice RN on 08/18/26 at 9:47am. Refer to telephone interview with Resident #2's Hospice NP on 08/19/26 at 11:29am. Refer to the interview with the RCC on 08/18/26 at 4:02pm. Refer to the telephone interview with the HWD on 08/19/26 at 10:45am and at 1:23pm.	{D 358}		

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{D 358}	Continued From page 23 Refer to the interview with the Administrator on 08/19/26 at 3:02pm. c. Review of Resident #2's electronically signed Physician orders dated 06/24/26 revealed an order for lorazepam 1mg by mouth every six hours as needed. Review of Resident #2's June, July and August 2026 eMAR revealed there was not an entry for lorazepam 1mg every six hours as needed. Review of Resident #2's lorazepam 1mg every six hours as needed CSCS on 08/17/26 at 2:48pm revealed: -There was a handwritten label for lorazepam 1mg every six hours as needed, quantity of 30 with a dispense date of 06/24/26. -There was no documentation of lorazepam 1mg every six hours as needed being administered. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 08/18/26 at 9:04am and on 08/18/26 at 3:13pm revealed: -Lorazepam 1mg every six hours as needed with a total of 30 tablets was filled and dispensed by the pharmacy on 06/15/25, 11/10/25 and 06/24/26. -Resident #2 had an order for lorazepam 1mg every four hours with an order start date of 11/19/25. -Resident #2 could experience uncontrolled anxiety if she did not receive her medications as ordered. Observation of Resident #2's medications on hand on 08/17/26 at 2:48pm revealed there was a card with a quantity of 30 tablets with 30 tablets remaining of lorazepam 1mg every six hours as needed with a dispense date of 06/24/26.	{D 358}		

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{D 358}	Continued From page 24 Interview with a MA on 08/17/26 at 5:00pm revealed: -She did not know Resident #2 had an order for 1mg every six hours as needed. -She thought Resident #2 had an order for as needed lorazepam every four hours because that was on the eMAR. -Resident #2 had good days and bad days where she was more anxious. -The MAs were to verify the eMAR with the medication on the medication cart and the medication label on the CSCS. -The MAs completed controlled substance counts every shift where they compared the medications to the CSCS. -She did not pay attention to the label on the CSCS and just verified the number on the lorazepam card matched the number on the CSCS. -The MAs, RCC and the HWD entered orders in the eMAR system. -She did not know if there was a system in place to verify if orders were entered correctly. Interview with a second MA on 08/18/26 at 9:47am and on 08/19/26 at 12:37 revealed: -She did not know Resident #2 had an order for 1mg every six hours as needed. -She thought Resident #2 had an order for as needed lorazepam every four hours because that was on the eMAR. -Resident #2 had not asked her for any as needed medications. -The MAs were to verify the eMAR with the medication on the medication cart and the medication label on the CSCS. -The MAs completed controlled substance counts every shift where they compared the medications to the CSCS.	{D 358}		

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{D 358}	Continued From page 25 -She did not realize Resident #2's CSCS labels were for lorazepam 1mg every four hours, and every six hours as needed. -She only made sure the CSCS counts were correct and only looked at the number of tablets left and not the medication labels. -The MAs, RCC and HWD entered orders in the eMAR system. -The RCC completed medication cart audits on the weekends. -MAs were to complete medication cart audits daily but she had not. -There was no documentation in place for medication cart audits. Interview with a third MA on 08/18/26 at 2:04pm revealed: -She did not know Resident #2 had an order for lorazepam 1mg every six hours as needed. -She did not realize Resident #2's CSCS labels were for lorazepam 1mg every four hours, and every six hours as needed. -She should have paid attention to the label on the CSCS. Refer to interview with Resident #2 on 08/18/26 at 9:56am. Refer to telephone interview with Resident #2's Hospice RN on 08/18/26 at 9:47am. Refer to telephone interview with Resident #2's Hospice NP on 08/19/26 at 11:29am. Refer to the interview with the RCC on 08/18/26 at 4:02pm. Refer to the telephone interview with the HWD on 08/19/26 at 10:45am and at 1:23pm.	{D 358}		

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{D 358}	Continued From page 26 Refer to the interview with the Administrator on 08/19/26 at 3:02pm. Interview with Resident #2 on 08/18/26 at 9:56am revealed: -She did not know she had not received her lorazepam as ordered. -She had asked the MAs for anxiety medications and restless leg medications but was told she had already had what she could take. -She only received medication twice daily. -She had asked for more medication related to her anxiety because she felt anxious all the time and had issues with restless legs. Telephone interview with Resident #2's Hospice RN on 08/18/26 at 9:47am revealed: -She did not know Resident #2 was not receiving her lorazepam as ordered. -Resident #2 told her she had been really nervous and asked for an increase in her lorazepam. -She had encouraged Resident #2 to ask for her as needed lorazepam. -Resident #2 told her she had not been going to eat in the dining room or getting out of her room as much due to her being anxious. -Resident #2's Hospice NP did not feel comfortable increasing her lorazepam due to the resident already taking frequent doses of lorazepam. -She expected the facility to follow all medication orders to ensure the resident received all needed medications. Telephone interview with Resident #2's Hospice NP on 08/19/26 at 11:29am revealed: -She did not know Resident #2 was not receiving her lorazepam as ordered. -Resident #2 had been complaining of being anxious and had asked for an increase of her	{D 358}			

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{D 358}	Continued From page 27 medication. -She did not want to increase her medication due to her already prescribing frequent doses of lorazepam. -She and Resident #2's RN did ask staff on every visit if Resident #2 had been receiving her medications. -She expected the facility to follow all medication orders to ensure the resident received all needed medications. -Resident #2 could experience increased agitation, anxiety and restlessness if she did not receive lorazepam as ordered. Interview with the RCC on 08/18/26 at 4:02pm revealed: -She became the RCC in June of 2026. -She did not know Resident #2 had not received her lorazepam as ordered until the surveyor identified it. -She, the HWD and MAs entered orders on to the residents eMAR. -There was no system in place to ensure the correct orders were entered into the eMAR system. -The MAs were responsible for comparing medications on the medication cart to the eMAR and for verifying the medication label on the CSCS was correct. -If there was an issue with medications, the MA could call the pharmacy, the resident's provider or let the HWD know. -The MAs completed controlled medications counts every shift. -The Pharmacy and the MAs were to complete medication cart audits, but she did not know how often. -She did not complete any audits herself. Telephone interview with the HWD on 08/19/26 at	{D 358}			

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{D 358}	Continued From page 28 10:45am and at 1:23pm revealed: -She recently was hired as the HWD and was still in training. -She did not know Resident #2 had not received her lorazepam as ordered until the surveyor identified it. -The MAs were responsible for comparing medications on the medication cart to the eMAR and for verifying the medication label on the CSCS was correct. -She knew the facility had a policy on medication cart audits but due to her still being in training, she did not know what that policy was. -She thought the RCC completed medication cart audits but had not seen any documentation of medication cart audits. -She the RCC and MAs were responsible for entering orders on to the residents' eMARs. -There was no system in place to verify correct orders were entered into the eMAR system. -There was no system in place to verify medications were being administered correctly. -MAs were to complete controlled medications counts every shift. -No one completed an audit of the CSCS to verify the correct medication label, and medication had been administered correctly. Interview with the Administrator on 08/19/26 at 3:02pm revealed: -She did not know Resident #2 had not received her lorazepam as ordered until the surveyor identified it. -The MAs were responsible for comparing medications on the medication cart to the eMAR and for verifying the medication label on the CSCS was correct. -The HWD, RCC and MAs were responsible for entering orders on eMAR system. -All orders were to be placed in a box for the	{D 358}			

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{D 358}	Continued From page 29 HWD and RCC to review and verify the order was placed correctly into the eMAR system. -The HWD and RCC were then to place the order in the residents' charts. -The RCC implemented medication cart and eMAR audits in June this year. -Pharmacy completed medication cart audits every month. -She did not remember seeing any documentation of medication cart audits. Attempted telephone interview with a fourth MA on 08/19/26 at 11:23am was unsuccessful. 2. Review of Resident #1's current FL2 dated 06/10/26 revealed diagnoses included congestive heart failure, hyperlipidemia, anxiety and insomnia. Review of Resident #1's Resident Register dated 06/17/26 revealed an admission date of 06/19/26. Interview with Resident #1 on 08/17/26 at 9:40am revealed: -He went to the medication cart on his hallway, after breakfast today (08/17/26) and asked a MA for his morning medication. -He was administered eleven pills and a cup of water. -As he was taking the last four pills, he noticed white powder on the bottom of the cup of water that he drank from. -When he asked the MA what was on the bottom of his cup, she told him it was his medication for constipation (MiraLAX). -He informed the MA that he was not on MiraLAX and stopped drinking from the cup. Review of Resident #1's physician order summary dated 07/15/26 revealed no active order	{D 358}		

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{D 358}	Continued From page 30 for MiraLAX. Review of Resident #1's July 2026 and August 2026 eMAR revealed no entries for MiraLAX. Observation of Resident #1's medications on hand revealed no MiraLAX. Interview with a MA on 08/17/26 at 2:25pm revealed: -She worked first shift from 6:00am to 2:00pm. -Resident #1 came to her medication cart to get his morning medications after breakfast. -She gave him his medication and mistakenly poured water in a pre-poured cup that contained MiraLAX for another resident. -Resident #1 retrieved the cup of MiraLAX water from the medication cart and drank it with his medications. -After Resident #1 drank most of the water with his medications, he asked what the substance was at the bottom of his cup. -She informed Resident #1 that the white substance was for constipation. -She prepared the MiraLAX with water for another resident and was about to go to that resident's room to administer it but was distracted when Resident #1 came to the medication cart for his medications. -She eventually administered MiraLAX to the intended "other" resident as prescribed. -She did not report the incident to her supervisor but planned to report the medication error before she left for the day and complete an incident report. Interview with a pharmacist from the facility's contracted pharmacy on 08/17/26 at 3:15pm revealed: -Resident #1 did not have an active order for	{D 358}			

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{D 358}	Continued From page 31 MiraLAX. -If Resident #1 received MiraLAX in error, the outcome could result in an increase in stool frequency. -There were no drug interactions or adverse outcomes with Resident #1's current prescribed medications. Interview with Resident #1 on 08/18/26 at 10:00am revealed: -He had three bouts of diarrhea yesterday (08/17/26) after breakfast and lunch but had no incidents today (08/18/26). -He did not report diarrhea to staff when they checked on him yesterday or today. Interview with Resident #1's Nurse Practitioner (NP) on 08/18/26 at 10:55am revealed: -She received communication about Resident #1's medication error and directed the facility to monitor for loose stools and any other side effects. -She planned to follow-up with a visit to further assess Resident #1 on 08/20/26. -She had not been notified Resident #1 had loose stools on 08/17/26. -If Resident #1 had no loose stools today (08/18/26), she did not have any concerns. Interview with the RCC on 08/18/26 at 4:30pm revealed: -The MA reported Resident #1's medication error related to being administered another resident's medication, after a surveyor interviewed the MA about the error on 08/17/26. -She reported the incident to the HWD who completed an incident report on 08/17/26. -She directed the MA to contact Resident #1 to contact the provider, Resident #1's POA, and obtain vitals.	{D 358}		

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{D 358}	Continued From page 32 -Resident #1 did not report loose stools since the medication error, although staff checked on him regularly since the medication error on 08/17/26. Interview with the HWD on 08/18/26 at 3:30pm revealed: -Resident #1's medication error was reported to her on 08/17/26, the provider was contacted and instructed the facility to monitor for loose stools and symptoms. -Resident #1's medications were reviewed and vital signs were obtained. -Resident #1's PCP and family were notified of the medication error. -She notified the Administrator and Corporate Director of Health and Wellness of Resident #1's medication error. -She did not know Resident #1 experienced loose stools after the medication error. -She expected the MA to prepare one resident's medication and administer the medication before preparing and moving on to administer another resident's medication. -She expected the MA to report the medication error immediately after it occurred. Interview with the Administrator on 08/19/26 at 3:00pm revealed: -She was informed of Resident #1's medication error on 08/18/26 by the HWD. -She expected MAs to check the eMAR against the medication cart before medications were administered to the right resident. -When a known medication error occurred, she expected the error to be reported immediately to the RCC, HWD or herself. _____ The facility failed to administer medications as ordered for Resident #2 who regularly experienced ongoing anxiety, anxiousness, and	{D 358}			

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{D 358}	Continued From page 33 complaints of restless legs who did not receive the prescribed anxiety medications as ordered (#2) and a resident who was given another resident's medication for constipation (#1). This failure was detrimental to the health, safety and welfare of the residents which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/18/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED 10/03/26.	{D 358}		
{D 366}	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, record review and interviews the facility failed to ensure the observation of 1 of 3 sampled residents taking their medication, related to a medication aide (MA) standing outside of the room (#5). The findings are:	{D 366}		

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{D 366}	Continued From page 34 Review of Resident #5's current FL2 dated 02/24/26 revealed diagnoses included acute osteomyelitis of left ankle and foot, anemia, and chronic pain. Review of Resident #5's physician order dated 08/06/26 revealed an order for ketoconazole 2% cream, apply to thighs, perineal area (groin), and scrotum three times each day for 30 days for a rash. Observation of the morning medication pass for Resident #5 on 08/17/26 at 8:55am revealed: -The Medication Aide (MA) prepared Resident #5's medications which included 12 oral medications and two topical medications, Ben-Gay and clotrimazole cream 1%. -The MA placed clotrimazole cream 1% in a medication cup. -The MA entered Resident #5's room and administered his 12 oral medications and topically administered the Ben-Gay to his lower back. -The MA asked Resident #5 if he wanted to put the clotrimazole cream 1% on himself. -The resident replied he did and walked to his bathroom with the clotrimazole cream 1% and shut the door. -After about one minute, the MA spoke through the door and asked Resident #5 if he was okay. -Resident #5 responded to the MA that he was fine and the MA left the resident's room. Review of Resident #5's record on 08/18/26 revealed there was no physician order for Resident #5 to self-administer medications. Interview with the MA on 08/17/26 at 9:00am revealed: -She did not administer Resident #5's	{D 366}		

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{D 366}	Continued From page 35 clotrimazole cream 1% to him. -She did not observe Resident #5 placing clotrimazole cream 1% to his legs when he was in his bathroom. -Resident #5 did not let the MAs administer clotrimazole cream 1% to his legs. -She did not know if Resident #5 had a self-administer order for clotrimazole cream 1%. Interview with Resident #5's Nurse Practitioner (NP) on 08/18/26 at 10:55am revealed: -Resident #5 did not have an order to self-administer any medications. -She expected Resident #5 to receive an assessment to determine his capacity to self-administer medications before a self-administer order could be written and added to his electronic medication record (e-MAR). Interview with the Resident Care Coordinator (RCC) on 08/18/26 at 4:30pm revealed: -Resident #5 did not have an order to self-administer medications. -She did not know Resident #5 self-administered clotrimazole. -She expected MAs to administer and/ or watch all residents administer their medications. -If a resident was able to self-administer medications, they would be assessed by the Health and Wellness Director (HWD) before receiving a physician's order to self-administer. Interview with the Health and Wellness Director (HWD) on 08/18/26 at 3:30pm revealed: -She was responsible for assessing residents for self-administering medications. -Resident #5 did not have an active order to self-administer any medication. -She was informed on 08/17/26 that a MA handed Resident #5 his clotrimazole, did not administer it	{D 366}			

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{D 366}	Continued From page 36 per the order and did not watch Resident #5 administer it. -She expected MAs to administer and or watch Resident #5 administer his clotrimazole and any other medications. Interview with the Administrator on 08/19/26 at 4:00pm revealed: -She did not know Resident #5 administered his clotrimazole without an MA observing the administration. -She expected MAs to observe residents take their medications or request a self-administration assessment for the physician to write a self-administer order.	{D 366}		
{D 367}	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be	{D 367}		

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{D 367}	Continued From page 37 documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure electronic medication administration records (eMARs) were accurate for 2 of 5 residents (#2, #4) related to documentation of a medication used to treat anxiety, agitation and restlessness (#2) and documentation of vital signs (#4). The findings are: 1. Review of Resident #2's current FL2 dated 01/06/26 revealed: -Diagnoses included malignant neoplasm of rectum, restless leg disorder and major depressive disorder. -There was an order for lorazepam (used to treat anxiety, agitation and restlessness) 1mg every four hours as needed. Review of Resident #2's Resident Register revealed an admission date of 02/17/25. Review of Resident #2's record revealed she was admitted under Hospice services on 04/13/25. a. Review of Resident #2's electronically signed Hospice Nurse Practitioner (NP) order dated 06/24/26 revealed an order for lorazepam 1mg every six hours as needed. Review of Resident #2's June, July and August 2026 electronic medication administration record (eMAR) revealed there was not an entry for lorazepam 1mg every six hours as needed. Review of Resident #2's lorazepam 1mg every six	{D 367}			

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{D 367}	Continued From page 38 hours as needed controlled substance count sheet (CSCS) on 08/17/26 at 2:48pm revealed: -There was a handwritten label for lorazepam 1mg every six hours as needed, quantity of 30 with a dispense date of 06/24/26. -There was no documentation of lorazepam 1mg every six hours as needed being administered. Observation of Resident #2's medications on hand on 08/17/26 at 2:48pm revealed there was a card with a quantity of 30 tablets with 30 tablets remaining of lorazepam 1mg every six hours as needed with a dispense date of 06/24/26. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 08/18/26 at 9:04am and on 08/18/26 at 3:13pm revealed: -Lorazepam 1mg every six hours as needed with a total of 30 tablets was filled and dispensed by the pharmacy on 06/15/25, 11/10/25 and 06/24/26. -The facility entered all orders in the eMAR system. -Resident #2 could experience uncontrolled anxiety if she did not receive her medications as ordered. Refer to interview with a medication aide (MA) on 08/17/26 at 5:00pm. Refer to interview with a second MA on 08/18/26 at 9:47am and on 08/19/26 at 12:37pm. Refer to interview with a third MA on 08/18/26 at 2:04pm. Refer to interview with the RCC on 08/18/26 at 4:02pm. Refer to the telephone interview with the HWD on	{D 367}			

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{D 367}	Continued From page 39 08/19/26 at 10:45am and at 1:23pm. Refer to the interview with the Administrator on 08/19/26 at 3:02pm. b. Review of Resident #2's electronically signed Hospice NP order dated 06/24/26 revealed an order for lorazepam 1mg four times daily. Review of Resident #2's June, July and August 2026 eMAR revealed there was not an entry for lorazepam 1mg every four hours. Review of Resident #2's lorazepam 1mg my mouth every four hours CSCS on 08/17/26 at 2:48pm revealed: -There was a handwritten label for lorazepam 1mg by four hours, quantity of 45 with a dispense date of 06/24/26. -There was no documentation of lorazepam 1mg being administered every four hours. -There was documentation of lorazepam 1mg being administered once daily from 7:00pm to 8:47pm on 07/25/26 through 08/16/26. -The last entry on the CSCS was 08/17/26 at 8:30pm with a balance of 24 remaining. Observation of Resident #2's medications on hand on 08/17/26 at 2:48pm revealed there was a card with a quantity of 45 of 90 with 24 tablets remaining of lorazepam 1 mg every four hours with a dispense date of 06/24/26. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 08/18/26 at 9:04am and on 08/18/26 at 3:13pm revealed: -Resident #2 had an order for lorazepam 1mg every four hours with an order start date of 11/19/25. -Lorazepam 1mg every four hours with a total of	{D 367}		

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{D 367}	Continued From page 40 90 tablets was filled and dispensed by the pharmacy on 11/19/25, 12/10/25 and 06/24/26. -The facility entered all orders in the eMAR system. -Resident #2 could experience uncontrolled anxiety if she did not receive her medications as ordered. Refer to interview with a MA on 08/17/26 at 5:00pm. Refer to interview with a second MA on 08/18/26 at 9:47am and on 08/19/26 at 12:37pm. Refer to interview with a third MA on 08/18/26 at 2:04pm. Refer to interview with the RCC on 08/18/26 at 4:02pm. Refer to the telephone interview with the HWD on 08/19/26 at 10:45am and at 1:23pm. Refer to the interview with the Administrator on 08/19/26 at 3:02pm. _____ Interview with a MA on 08/17/26 at 5:00pm revealed: -She did not know Resident #2 had an order for lorazepam 1mg every four hours, or 1mg every six hours as needed. -The MAs were to verify the eMAR with the medication on the medication cart and the medication label on the CSCS. -The MAs completed controlled substance counts every shift where they compared the medications to the CSCS. -She did not pay attention to the label on the CSCS and just verified the number on the lorazepam card matched the number on the	{D 367}		

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{D 367}	Continued From page 41 CSCS. -The MAs, Resident Care Coordinator (RCC) and the Health and Wellness Director (HWD) entered orders in the eMAR system. -She did not know if there was a system in place to verify if orders were entered correctly. Interview with a second MA on 08/18/26 at 9:47am and on 08/19/26 at 12:37 revealed: -She did not know Resident #2 had an order for lorazepam 1mg every four hours, or 1mg every six hours as needed. -The MAs were to verify the eMAR with the medication on the medication cart and the medication label on the CSCS. -The MAs completed controlled substance counts every shift where they compared the medications to the CSCS. -She did not realize the CSCS labels were for lorazepam 1mg every four hours, and every six hours as needed. -She only made sure the CSCS counts were correct and only looked at the number of tablets left and not the medication labels. -The MAs, RCC and HWD entered orders in the eMAR system. -The RCC completed medication cart audits on the weekends. -MAs were to complete medication cart audits daily but she had not. -There was no documentation in place for medication cart audits. Interview with a third MA on 08/18/26 at 2:04pm revealed: -She did not know Resident #2 had an order for lorazepam 1mg every four hours, or 1mg every six hours as needed. -She did not realize the label on the CSCS was for lorazepam 1mg, four times daily.	{D 367}		

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{D 367}	Continued From page 42 -She had not realized Resident #2 did not have lorazepam 1mg at bedtime available for administration. -She should have paid attention to the label on the CSCS. Interview with the RCC on 08/18/26 at 4:02pm revealed: -She became the RCC in June of 2026. -She did not know Resident #2's lorazepam orders were not entered correctly into the eMAR system. -She, the HWD and MAs entered orders on to the residents eMAR. -There was no system in place to ensure the correct orders were entered into the eMAR system. -The MAs were responsible for comparing medications on the medication cart to the eMAR and for verifying the medication label on the CSCS was correct. -If there was an issue with medications, the MA could call the pharmacy, the resident's provider or let the HWD know. -The MAs completed controlled medications counts every shift. -The Pharmacy and the MAs were to complete medication cart audits, but she did not know how often. -She did not complete any audits herself. Telephone interview with the HWD on 08/19/26 at 10:45am and at 1:23pm revealed: -She recently was hired as the HWD and was still in training. -She did not know Resident #2's lorazepam orders were not entered correctly into the eMAR system until the surveyor brought it to her attention. -The MAs were responsible for comparing medications on the medication cart to the eMAR	{D 367}		

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{D 367}	Continued From page 43 and for verifying the medication label on the CSCS was correct. -She knew the facility had a policy on medication cart audits but due to her still being in training, she did not know what that policy was. -The thought the RCC completed medication cart audits but had not seen any documentation of medication cart audits. -She the RCC and MAs were responsible for entering orders on to the residents' eMARs. -There was no system in place to verify correct orders were entered into the eMAR system. -There was no system in place to verify medications were being administered correctly. -MAs were to complete controlled medications counts every shift. -No one completed an audit of the CSCS to verify the correct medication label, and medication had been administered correctly. Interview with the Administrator on 08/19/26 at 3:02pm revealed: -She did not know Resident #2's lorazepam orders were not entered correctly into the eMAR system until the surveyor brought it to her attention. -The MAs were responsible for comparing medications on the medication cart to the eMAR and for verifying the medication label on the CSCS was correct. -The HWD, RCC and MAs were responsible for entering orders on eMAR system. -All orders were to be placed in a box for the HWD and RCC to review and verify the order was placed correctly into the eMAR system. 2. Review of Resident #4's current FL2 dated 06/10/26 revealed diagnoses included complete AV (atrioventricular block)(block of the heart's electrical signals).	{D 367}		

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{D 367}	Continued From page 44 Review of Resident #4's Nurse Practitioner's order dated 07/16/26 revealed an order to check the resident's blood pressure, pulse and oxygen saturation daily for seven days and weekly thereafter. Review of Resident #4's July 2026 electronic medication administration record (eMAR) revealed: -There was an entry with a start date of 07/17/26 for daily blood pressure, pulse and oxygen saturation every day-shift for seven days. -The entry was documented completed daily during day-shift from 07/17/26 through 07/23/26. -There was no documentation of Resident #4's blood pressure, pulse and oxygen saturation daily from 07/17/26 through 07/23/26 on the July 2026 eMAR, just a check mark indicating it was completed. -There was a second entry with a start date of 07/24/26 for blood pressure, pulse and oxygen saturation every day-shift on Thursdays. -The second entry was documented completed during the day-shift on 07/30/26. -There was no documentation of Resident #4's blood pressure, pulse and oxygen saturation on 07/30/26, just a check mark indicating it was completed. Review of Resident #4's July 2026 staff progress notes revealed there was no documentation of Resident #4's blood pressure, pulse and oxygen saturation from 07/17/26 through 07/23/26 and weekly beginning 07/30/26. Review of Resident #4's weights and vital signs summary report revealed there were no documented blood pressure, pulse and oxygen saturation recorded from 07/17/26 through	{D 367}		

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{D 367}	Continued From page 45 07/23/26 and weekly beginning 07/30/26. Review of Resident #4's August 2026 eMAR revealed: -There was an entry with a start date of 07/24/26 for blood pressure, pulse and oxygen saturation on day-shift on Thursdays. -The entry was documented completed during the day-shift on 08/06/26 and 08/13/26. -There was no documentation of Resident #4's blood pressure, pulse and oxygen saturation on 08/06/26 and 08/13/26, just a check mark indicating it was completed. Review of Resident #4's August 2026 staff progress notes revealed there was no documentation of Resident #4's blood pressure, pulse and oxygen saturation on day shift on 08/06/26 and 08/13/26. Review of Resident #4's weights and vital signs summary report revealed: -There were no documented blood pressure, pulse and oxygen saturation recorded on 08/06/26. -Resident #4's blood pressure and pulse were documented on 08/13/26 at 6:39am but there was no documentation of Resident #4's oxygen saturation on 08/13/26. Telephone interview with Resident #4's NP on 08/18/26 at 4:07pm revealed: -Resident #4 was a new resident to her and her initial visit was on 07/16/26. -She ordered Resident #4's blood pressure, pulse and oxygen saturation daily for seven days to get baseline readings. -She did not know if she asked to review Resident #4's blood pressure, pulse and oxygen saturation readings when she next saw Resident	{D 367}			

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{D 367}	Continued From page 46 #4 on 07/23/26. -She expected staff to obtain and document resident vital signs on the eMAR when they were ordered. Interview with a medication aide (MA) on 08/19/26 at 10:00am and 12:42pm revealed: -She worked day shift on Resident #4's hall on 07/17/26, 07/21/26 and 07/22/26 and documented she checked the resident's blood pressure, pulse and oxygen saturation. -She could not find documentation of Resident #4's blood pressure, pulse and oxygen saturation on the resident's eMAR or in the staff progress notes for 07/17/26, 07/21/26 and 07/22/26. -She thought the staff member that entered the order into Resident #4's eMAR probably forgot to add the drop-down boxes to enter the readings. -She should have documented the readings in Resident #4's progress notes if there was no place to enter them on the eMAR. Interview with the Resident Care Coordinator (RCC) on 08/19/26 at 2:40pm revealed: -The MAs, RCC and the Health and Wellness Director (HWD) could all enter orders into the resident's eMAR. -The staff member that entered the order should have entered drop-down boxes to enter the vital signs into. -The MAs should have documented Resident #4's blood pressure, pulse and oxygen saturation readings into a progress note if there were no drop-down boxes. Interview with the Administrator on 08/19/26 at 3:00pm revealed: -The RCC or HWD were responsible to enter vital sign orders on the resident's eMAR. -If the order was not entered with drop-down	{D 367}			

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{D 367}	Continued From page 47 boxes to enter the vital signs, the MA should have documented the readings in Resident #4's progress notes. -The MAs could have made the RCC, HWD or herself aware there were no drop-down boxes for the vital signs, and they would have added them. -The Corporate Registered Nurse (RN) reviewed some charts to ensure orders were completed but not all the resident charts. -She was not aware Resident #4's vital signs were not documented on the resident's eMAR or in the progress notes.	{D 367}		
D 375	10A NCAC 13F .1005 (a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 1 of 2 sample residents (#3) had physician's orders and assessment completed to self-administer	D 375		

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D 375	Continued From page 48 medications related to a nasal medication to treat allergy symptoms, a moisturizing nasal spray and three eye drops. The findings are: Review of the facility's Self-Administration of Medication policy dated 03/2006 and last revised 03/26 revealed: -If a resident desired to self-administer medications, and the resident Primary Care Provider (PCP) agreed, the nurse should conduct a self-administration assess of the resident's cognitive, physical and visual abilities. -If the resident successfully passed the self-administration evaluation, orders would be obtained from the resident's PCP for self-administration. Review of Resident #3's current FL2 dated 06/11/26 revealed: -Diagnoses included major depressive disorder, anxiety disorder and hypertension. -There was an order for fluticasone (a nasal medication to treat allergy symptoms)50mcg/actuation, two sprays in each nostril daily. -There were no orders for eye drop medications or sodium chloride 0.65% moisturizing nasal spray. Observation of Resident #3's room on 08/17/26 at 10:44am revealed: -There was a bottle of fluticasone 50mcg/actuation, approximately half full on the bedside table. -There was a bottle of Visine Red Eye comfort eye drops, three-quarters full, on the bedside table -There was an opened bottle of ketotifen	D 375			

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D 375	Continued From page 49 fumarate ophthalmic solution 0.035% on the bedside table. -There was an opened bottle of thera tears lubricant eye drops on the bedside table. -There was a bottle of sodium chloride 0.65% moisturizing nasal spray on a second bedside table. Interview with Resident #3 on 08/17/26 at 10:44am revealed: -His right eye had been red and bothering him for about two weeks. -He had an eye doctor appointment that day (08/17/26). -He had his family member bring in the eye medications with hopes they would help his eye irritation. -He was not sure when the fluticasone and the moisturizing nasal sprays began being at his bedside. -He thought maybe a medication aide (MA) had left the fluticasone nasal spray in his room. -Facility staff knew the over-the-counter eye drops were on his bedside stand. -No staff member had said he could not have eye drops and nasal sprays at his bedside. Telephone interview with a representative with the facility's contracted pharmacy on 08/18/26 at 3:07pm revealed Resident #3 did not have orders for Visine Red Eye comfort eye drops, ketotifen fumarate ophthalmic solution 0.035%, thera tears lubricant eye drops or sodium chloride 0.65% moisturizing nasal spray. Telephone interview with a representative with Resident #3's Primary Care Provider (PCP) on 08/19/26 at 11:08am revealed: -Resident #3 did not have orders to self-administer any of his medications.	D 375			

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D 375	Continued From page 50 -His medication list included fluticasone 50mcg/act, two sprays twice daily. -Resident #3 did not have orders for Visine Red Eye comfort eye drops, ketotifen fumarate ophthalmic solution 0.035% and sodium chloride 0.65% moisturizing nasal spray. Interview with a MA on 08/19/26 at 12:42pm revealed: -Residents were not to have medications in their rooms unless they had an order for self-administration. -If she saw medications in a resident's room who did not have a self-administration order, she removed them and gave them to the Resident Care Coordinator (RCC). -Facility staff did not perform routine room checks for medications, but all MAs should be aware to remove medications from residents who did not have self-administration orders. -She could not remember when, but she removed fluticasone nasal spray from Resident #3's room. -She thought an MA left it in his room accidentally after administering the medication. Interview with the RCC on 08/17/26 at 3:13pm revealed: -Residents were not to have medications in their room unless they had a self-administration assessment and self-administration order. -The MAs were responsible to look for medications in resident rooms and remove them if the resident did not have a self-administration order. Interview with the Administrator on 08/19/26 at 3:00pm revealed: -Residents were not to have medications in their rooms unless they had a medication self-administration assessment and a physician's	D 375		

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D 375	Continued From page 51 order. -The HWD was responsible for completing the self-administration assessments. -The MAs were responsible for removing medications from resident rooms if the resident did not have a self-administration order. -All staff were required to report medications in resident rooms to the RCC, HWD or the Administrator.	D 375		
D 392	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure readily retrievable records that accurately reconciled the receipt and administration, and disposition of controlled medications for 1 of 2 sampled residents (#2) related to a Schedule IV controlled anti-anxiety medication. The findings are: Review of the facility's Medication Administration policy last revised date of September 2025' revealed: -Trained and/or licensed associates may administer or assist the resident with medication management or medication administration and treatment per physician orders as per state	D 392		

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D 392	Continued From page 52 regulation. -Trained or licensed associates administering or assisting with medications should follow the seven rights of medication administration: right medication, right dose, right time, right route, right resident, right documentation and right to refuse. -Follow the medication label, pharmacy and manufacture directions for each individual medication prescribed. -Controlled medications are double locked. -A hard bound narcotic logbook will be used to verify accuracy and count of controlled substance/medications. -Retain the completed controlled substance count sheet (CSCS), electronic medication administration record (eMAR) change of shift audit forms and hardbound narcotic logbooks. Review of Resident #2's current FL2 dated 01/06/25 revealed: -Diagnoses included malignant neoplasm of rectum, restless leg disorder and major depressive disorder. -There was an order for lorazepam (used to treat anxiety, agitation and restlessness) 1mg at bedtime. Review of Resident #2's Resident Register revealed an admission date of 02/17/25. Review of Resident #2's record revealed she was admitted under Hospice services on 04/13/25. a. Review of Resident #2's electronically signed Hospice Nurse Practitioner (NP) order dated 06/24/26 revealed an order for lorazepam 1mg four times daily. Review of Resident #2's June, July and August 2026 eMAR revealed there was not an entry for	D 392		

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NAME OF PROVIDER OR SUPPLIER BROOKDALE UNION		STREET ADDRESS, CITY, STATE, ZIP CODE 1717 UNION ROAD GASTONIA, NC 28054		
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D 392	Continued From page 53 lorazepam 1mg every four hours. Review of Resident #2's lorazepam 1mg my mouth every four hours CSCS on 08/17/26 at 2:48pm revealed: -There was a handwritten label for lorazepam 1mg by four hours, quantity of 45 with a dispense date of 06/24/26. -There was no documentation of lorazepam 1mg being administered every four hours. -There was documentation of lorazepam 1mg being administered once daily from 7:00pm to 8:47pm on 07/25/26 through 08/16/26. -The last entry on the CSCS was 08/17/26 at 8:30pm with a balance of 24 remaining. Observation of Resident #2's medications on hand on 08/17/26 at 2:48pm revealed there was a card with a quantity of 45 of 90 with 24 tablets remaining of lorazepam 1 mg every four hours with a dispense date of 06/24/26. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 08/18/26 at 9:04am and on 08/18/26 at 3:13pm revealed: -Resident #2 had an order for lorazepam 1mg every four hours with an order start date of 11/19/25. -Lorazepam 1mg every four hours with a total of 90 tablets was filled and dispensed by the pharmacy on 11/19/25, 12/10/25 and 06/24/26. -The facility entered all orders in the eMAR system. -Resident #2 could experience uncontrolled anxiety if she did not receive her medications as ordered. Refer to interview with a medication aide (MA) on 08/17/26 at 5:00pm.	D 392		

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D 392	Continued From page 54 Refer to interview with a second MA on 08/18/26 at 9:47am and on 08/19/26 at 12:37. Refer to interview with a third MA on 08/18/26 at 2:04pm. Refer to interview with the Resident Care Coordinator (RCC) on 08/18/26 at 4:02pm. Refer to the telephone interview with the Health and Wellness Director (HWD) on 08/19/26 at 10:45am and at 1:23pm. Refer to the interview with the Administrator on 08/19/26 at 3:02pm. b. Review of Resident #2's electronically signed Hospice NP order dated 06/24/26 revealed an order for lorazepam 1mg at bedtime. Review of Resident #2's June 2026 eMAR revealed: -There was an entry for lorazepam 1mg at bedtime. -Lorazepam 1mg at bedtime was administered from 06/01/26 through 06/30/26. Review of Resident #2's July 2026 eMAR revealed: -There was an entry for lorazepam 1mg at bedtime. -Lorazepam 1mg at bedtime was administered from 07/01/26 through 07/31/26. Review of Resident #2's August 2026 eMAR revealed: -There was an entry for lorazepam 1mg at bedtime. -Lorazepam 1mg at bedtime was administered on 08/01/26 to 08/04/26 and on 08/07/26 to	D 392			

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D 392	Continued From page 55 08/16/26. -On 08/05/26 and 08/06/26, lorazepam 1mg at bedtime was documented as not available/pharmacy action. Review of Resident #2's lorazepam 1mg at bedtime CSCS on 08/17/26 at 2:48pm revealed: -There was a handwritten label for lorazepam 1mg at bedtime, quantity of 30 with a dispense date of 06/24/26. -There was documentation of lorazepam 1mg being administered once daily at bedtime on 06/25/26 through 07/24/26. -The last entry on the CSCS was 07/24/26 at 8:20pm with a zero-balance remaining and the word, "done" written on the CSCS. -There were no other CSCSs for Resident #2's lorazepam 1mg at bedtime available for review. Observation of Resident #2's medications on hand on 08/17/26 at 2:48pm revealed there was no lorazepam 1mg at bedtime available for administration. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 08/18/26 at 9:04am and on 08/18/26 at 3:13pm revealed: -Resident #2 had an order for lorazepam 1mg at bedtime with an order start date of 06/13/25. -Lorazepam 1mg at bedtime with a total of 30 tablets was filled and dispensed by the pharmacy on 09/12/25, 11/10/25 and 06/24/26. -The facility entered all orders in the eMAR system. -Resident #2 could experience uncontrolled anxiety if she did not receive her lorazepam as ordered. Refer to interview with a MA on 08/17/26 at 5:00pm.	D 392			

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D 392	Continued From page 56 Refer to interview with a second MA on 08/18/26 at 9:47am and on 08/19/26 at 12:37. Refer to interview with a third MA on 08/18/26 at 2:04pm. Refer to interview with the RCC on 08/18/26 at 4:02pm. Refer to the telephone interview with the HWD on 08/19/26 at 10:45am and at 1:23pm. Refer to the interview with the Administrator on 08/19/26 at 3:02pm. Interview with a MA on 08/17/26 at 5:00pm revealed: -She did not know Resident #2 had an order for lorazepam 1mg every four hours. -The MAs were to verify the eMAR with the medication on the medication cart and the medication label on the CSCS. -The MAs completed controlled substance counts every shift where they compared the medications to the CSCS. -She did not pay attention to the label on the CSCS and just verified the number on the lorazepam pills in the card matched the number on the CSCS. -She had given Resident #2 lorazepam 1mg at bedtime. -She had not paid attention to the label on the CSCS to see she had administered Resident #2's lorazepam 1mg every four hours. -She did not know Resident #2's lorazepam 1mg at bedtime was not available for administration. -The MAs, RCC and the HWD entered orders in the eMAR system.	D 392			

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D 392	Continued From page 57 Interview with a second MA on 08/18/26 at 9:47am and on 08/19/26 at 12:37 revealed: -She did not know Resident #2 had an order for lorazepam 1mg every four hours. -The MAs were to verify the eMAR with the medication on the medication cart and the medication label on the CSCS. -The MAs completed controlled substance counts every shift where they compared the medications to the CSCS. -She did not know the CSCS labels were for lorazepam 1mg every four hours and not at bedtime. -She only verified the CSCS number count matched the number of tablets left and did not verify the medication labels. -The MAs, RCC and HWD entered orders in the eMAR system. -The RCC completed medication cart audits on the weekends. -The MAs were to complete medication cart audits daily but she had not. -There was no documentation in place for medication cart audits. Interview with a third MA on 08/18/26 at 2:04pm revealed: -She did not know Resident #2 had an order for lorazepam 1mg every four hours. -She had administered Resident #2 lorazepam 1mg at bedtime. -She did not know the label on the CSCS was for lorazepam 1mg, four times daily. -She did not know Resident #2 did not have lorazepam 1mg at bedtime available for administration. -She should have paid attention to the label on the CSCS. Interview with the RCC on 08/18/26 at 4:02pm	D 392		

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D 392	Continued From page 58 revealed: -She became the RCC in June of 2026. -She did not know Resident #2 had an order for lorazepam 1mg every four hours. -The MAs were responsible for comparing medications on the medication cart to the eMAR and for verifying the medication label on the CSCS was correct. -The MAs completed controlled medications counts every shift. -The Pharmacy and the MAs were to complete medication cart audits, but she did not know how often. -She did not complete any audits herself. Interview with the HWD on 08/19/26 at 10:45am and at 1:23pm revealed: -She recently was hired as the HWD and was still in training. -She did not know Resident #2's CSCS was not accurate. -The MAs were responsible for comparing medications on the medication cart to the eMAR and for verifying the medication label on the CSCS was correct. -The MAs were responsible for completing controlled medications counts every shift. Interview with the Administrator on 08/19/26 at 3:02pm revealed: -She did not know Resident #2's CSCS was not accurate. -The MAs were responsible for comparing medications on the medication cart to the eMAR and for verifying the medication label on the CSCS was correct.	D 392		
D 433	10A NCAC 13F .1201(a) Resident Records	D 433		

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D 433	Continued From page 59 10A NCAC 13F .1201Resident Records (a) The following shall be maintained on each resident in an orderly manner in the resident's record in the adult care home and made available for review by representatives of the Division of Health Service Regulation and county departments of social services: (1) FL-2 or MR-2 forms and the patient transfer form or hospital discharge summary, when applicable; (2) Resident Register; (3) receipt for the following as required in Rule .0704 of this Subchapter: (A) contract for services, accommodations and rates; (B) house rules as specified in Rule .0704(a)(2) of this Subchapter; (C) Declaration of Residents' Rights (G.S. 131D-21); (D) the home's grievance procedures; and (E) civil rights statement; (4) resident assessment and care plan; (5) contacts with the resident's physician, physician service or other licensed health professional as required in Rule .0902 of this Subchapter; (6) orders or written treatments or procedures from a physician or other licensed health professional and their implementation; (7) documentation of immunizations against influenza virus and pneumococcal disease according to G.S. 131D-9 or the reason the resident did not receive the immunizations based on this law; and (8) the Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form if the resident is being or has been discharged. When a resident leaves the facility for a medical evaluation, records necessary for that medical	D 433		

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D 433	Continued From page 60 evaluation such as Subparagraphs (1), (4), (5), (6) and (7) above may be sent with the resident. This Rule is not met as evidenced by: Based on resident records and interviews, the facility failed to maintain resident records that were readily available for review for 1 of 5 sampled residents (#2) related to the resident's visits with a Hospice provider. The findings are: 1. Review of Resident #2's current FL2 dated 01/06/25 revealed diagnoses included malignant neoplasm of rectum, restless leg disorder and major depressive disorder. Review of Resident #2's Resident Register revealed an admission date of 02/17/25. Review of Resident #2's record revealed she was admitted under Hospice services on 04/13/25. Review of Resident #3's record on 08/17/26 revealed there were no Hospice Provider visit notes located in the record. Telephone interview with the with the Health and Wellness Director (HWD) on 08/19/26 at 1:23pm revealed: -She did not know Resident #2 did not have any Hospice progress notes available for the facility to review in the resident's record. -Resident #2's Hospice provider had not provided visit notes. -She did not know if anyone from the facility had	D 433		

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D 433	Continued From page 61 requested any progress notes. -Having the resident's progress notes on her record would have been very helpful due to recent issues with the resident's medications. -She had not requested Hospice progress notes from Resident #2's provider until the surveyor made her aware there was no documentation in the resident's record. Interview with the Administrator on 08/19/26 at 3:02pm revealed: -She did not know Resident #2 did not have any Hospice progress notes available for the facility to review in the resident's record. -Resident #2's Hospice provider had not provided visit notes. -She did not know if anyone from the facility had requested any progress notes.	D 433			