

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032132	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 09/23/2026
NAME OF PROVIDER OR SUPPLIER CAROLINA RESERVE OF DURHAM		STREET ADDRESS, CITY, STATE, ZIP CODE 4523 HOPE VALLEY ROAD DURHAM, NC 27707		
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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on September 22, 2026-September 23, 2026.	{D 000}		
{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: Based on observations, record reviews, and interviews, the facility failed to ensure implementation of orders for 2 of 5 sampled residents (#1, #2) who had orders for blood pressure checks (#1) and application of compression stockings (#4). The findings are: 1. Review of Resident #1's current FL2 dated 05/12/26 revealed: -Diagnoses included moderate alzheimer's-dementia, diverticulitis of the colon, hypertension and chronic right knee pain. -He was ambulatory. -He was intermittently disoriented. Review of Resident #1's care plan dated 06/15/26 revealed: -Resident #1 needed supervision from the staff with bathing. -He was independent with eating, toileting,	{D 276}		

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

TITLE

(X6) DATE

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{D 276}	Continued From page 1 ambulating, dressing, grooming and transferring. Review of Resident #1's physician's order dated 08/17/26 revealed there was an order for blood pressure monitoring every day for 7 days due to changes to his blood pressure medications. Review of Resident #1's electronic medication administration record (eMAR) revealed: -There was no blood pressure monitoring documentation for 08/17/26-08/20/26. -Daily blood pressure monitoring started on 8/21/26. -On 8/21/26, Resident #1's blood pressure was documented as 106/54. -On 8/22/26, Resident #1's blood pressure was documented as 130/72. -On 8/23/26, Resident #1's blood pressure was documented as 127/65. Interview with the personal care aide (PCA) on 09/23/26 at 9:29am revealed: -Resident #1's blood pressure was checked every morning. -The blood pressures were documented on the eMAR. -New physician orders were processed by a PCA. -One copy was placed in the resident's chart, and one copy was faxed to the pharmacy then placed in a binder labeled order book that was kept at the staff's workstation. -He could not find documentation for blood pressure monitoring for 08/17/26, 08/18/26, 08/19/26 or 08/20/26. -There was a physician's order for blood pressure monitoring in Resident #1's chart. -There was no physician's order for blood pressure monitoring in the binder labeled "order book." -He did not know why the blood pressures were	{D 276}		

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{D 276}	Continued From page 2 not taken. -He could not identify who had faxed the physician order to the pharmacy. -He was concerned that the blood pressures were not taken because the PCP had ordered them. Interview with the Resident Care Coordinator (RCC) on 09/23/26 at 6:00pm revealed: -He was not aware that the blood pressure monitoring for Resident #1 not was not done from 08/17/26-08/20/26. -He did not know why the blood pressure monitoring was not done. -He was concerned that blood pressure monitoring was important information for the PCP due to the new blood pressure medication. Telephone interview with a representative from the facility's contracted pharmacy on 09/22/26 at 2:22pm revealed: -The facility was responsible for adding blood pressure monitoring to the eMAR. -A resident could have higher blood pressure after changing blood pressure medications. -It was important to check the blood pressure with new medication changes. -Changes in the blood pressure would be noticed within the first 7 days of starting the medication. Interview with Resident #1's PCP on 09/23/26 at 11:37am revealed: -The blood pressure monitoring was ordered to help manage the blood pressure medication. -The blood pressure monitoring was important because Resident's #1's blood pressures could have increased with the new medication. -Increased blood pressure could cause a stroke. -It was especially important to monitor blood pressures in the elderly when there was a blood pressure medication change.	{D 276}		

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{D 276}	Continued From page 3 -She was concerned that the blood pressures were not taken for 4 consecutive days. -She expected the blood pressure to be checked as ordered. -She had not been notified of abnormal blood pressure, headache or dizziness after starting the new medication for blood pressure. Interview with the Health and Wellness Director (HWD) on 09/23/26 at 3:00pm revealed: -She did not know the blood pressure monitoring was not done on Resident #1 on 8/17/26, 8/18/26, 8/19/26 and 8/20/26. -She was concerned that the blood pressure was not monitored as the PCP ordered. -She was concerned that Resident's #1's blood pressure values could have been abnormal after changing blood pressure medication. -She had no idea why the blood pressures were not monitored. Interview with the facility's Corporate Clinical Nurse Specialist on 09/23/26 at 7:03pm revealed: -She did not know about the order for monitoring blood pressures for Resident #1. -She was concerned that the blood pressures for Resident #1 were not monitored. -She was concerned that the PCP orders were not followed. -Resident #1 could have had abnormal blood pressure after starting new blood pressure medication. -She was concerned that the blood pressure values were not available for the PCP to change the medication if needed. Based on observations, record reviews, and interviews, it was determined Resident #1 was not interview able.	{D 276}		

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{D 276}	Continued From page 4 Based on observations and interviews, the Administrator was not available at the time of the survey. Attempted telephone interview with Resident #1's family member on 09/22/26 at 4:19pm was unsuccessful. 2. Review of Resident #4's current FL2 dated 04/28/26 revealed diagnoses included type 2 diabetes mellitus (DM), peripheral neuropathy, and hypertension. Review of Resident #4's care plan dated 06/23/26 revealed he required assistance from staff with bathing, dressing, grooming, and toileting. Review of Resident #4's physician's order dated 07/22/26 revealed: -Resident #4 had venous insufficiency. -The physician ordered compression stockings to be placed in the morning and removed in the evening. -The compression stockings were to allow his toes to remain exposed and not covered by the compression stockings. Review of Resident #4's August 2026 electronic medication administration record (eMAR) revealed: -There was an entry for compression stockings to be applied in the morning and removed in the evening, with a scheduled application time of 6:00am and removal time of 8:00pm. -There was documentation that compression stockings were applied and removed daily. -There was no documentation to ensure that open-toed compression stockings were applied. Review of Resident #4's September 2026 eMAR	{D 276}		

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{D 276}	Continued From page 5 from 09/01/26-09/22/26 revealed: -There was an entry for compression stockings to be applied in the morning and removed in the evening, with a scheduled application time of 6:00am and removal time of 8:00pm. -There was documentation that compression stockings were applied and removed daily from 09/01/26-09/22/26. -There was no documentation to ensure that open-toed compression stockings were applied. Observation of Resident #4 on 09/22/26 at 4:30pm revealed he was wearing black compression stockings with the toes covered. Observation of Resident #4 on 09/23/26 at 11:30am revealed he was wearing a pair of natural colored opened toed compression stockings. Observation of Resident #4's room on 09/23/26 at 11:30am revealed: -He had two pairs of compression stockings. -One black pair had closed toes, and one natural-colored pair had open toes. Interview with Resident #4 on 09/23/26 at 11:31am revealed: -He wore compression stockings daily. -He wore whatever compression stockings the staff put on. -He did not know if he was supposed to wear open-toed compression stockings or not. -He could not tell a difference in the way the compression stockings felt on his feet. Telephone interview with a representative from the facility's contracted pharmacy on 09/23/26 at 10:21am revealed: -The pharmacy received an order on 07/27/26 for	{D 276}		

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{D 276}	Continued From page 6 Resident #4's compression stockings. -The order included instructions to ensure the toes were not covered. -When a form to complete the sizes was sent to the facility, it was returned with documentation for profile only. -The compression stockings should have been open-toed. Interview with a medication aide (MA) on 09/23/26 at 12:02pm revealed: -Resident #4's compression stockings were usually applied by the third-shift MA. -She applied the compression stockings on 09/23/26. -Resident #4 was supposed to wear open-toed compression stockings. -Resident #4's private duty companion told her not to use closed-toe compression stockings. -She did not know if there was an order not to use closed-toe compression stockings. Interview with a second MA on 09/23/26 at 12:46pm revealed: -Resident #4 wore compression stockings. -She put on whatever color compression stocking was available. -The white compression stockings did not have enclosed toes. -The toes of the black compression stockings were covered. -She did not know that Resident #4's order specified that his toes were not to be covered. Interview with the Health and Wellness Director (HWD) on 09/23/26 at 2:41pm revealed: -She knew Resident #4 had an order for compression stockings but did not know the order specified that the stockings were to be open-toed. -There should not have been two different types	{D 276}		

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{D 276}	Continued From page 7 of compression stockings in Resident #4's room. -Her concern was that the wrong type of compression stockings were being used. Interview with the facility's Corporate Clinical Nurse Specialist on 09/23/26 at 3:36pm revealed: -The pharmacy entered the order for compression stockings into the eMAR. -When the order was entered into the eMAR, it should have been entered completely to include the open-toe requirement. -The verbiage specifying open-toed compression stockings could have been added by the facility's staff to ensure the correct compression stockings were used. Based on observations and interviews, the Administrator was not available at the time of the survey. Attempted telephone interview with Resident #4's private duty companion on 09/23/26 at 12:59pm was unsuccessful. Attempted telephone interview with a third MA on 09/23/26 at 1:58pm was unsuccessful.	{D 276}		
{D 310}	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.	{D 310}		

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{D 310}	Continued From page 8 This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure that therapeutic diets were served as ordered for 3 of 3 sampled residents (#6, #7, #8), including two residents who had an order for a mechanical soft diet (#6, #8), and one resident who had an order for a finger food diet (#7). The findings were: Review of Resident #6's current FL2 dated 07/29/26 revealed diagnoses that included Parkinson's disease, obstructive sleep apnea, and atrial fibrillation. Review of Resident #6's diet order dated 07/27/26 revealed: -There was an order for a mechanical soft diet. -Mechanical soft included ground moist meats, canned fruits and vegetables, well-cooked soft vegetables, finely chopped fresh fruits and vegetables as tolerated, and soft breads and desserts. Review of the facility's diet list dated 09/22/26 revealed Resident #6's diet was documented as mechanical soft. Review of the facility's therapeutic diet list revealed meats were to be ground meat. Observation of the lunch meal on 09/22/26 from 12:12pm-12:49pm revealed: -Resident #6 was served sliced beef with gravy, rice, cooked vegetable blend, and a roll. -At 12:15pm, Resident #6 had a piece of beef partially inside his mouth that he appeared to be trying to chew. -At 12:17pm, Resident #6 asked a staff member	{D 310}		

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{D 310}	Continued From page 9 if she could cut his beef. -The staff member cut the beef into bite-size pieces. -He ate 100% of his beef and gravy and vegetable blend. -He ate 25% of his rice and did not eat his roll. Observation of the breakfast meal on 09/23/26 from 7:35am-7:58am revealed: -Resident #6 was served three slices of bacon, scrambled eggs, toast, and a muffin. -He ate 100% of his bacon, eggs, and muffin. -He ate one bite of his toast. Interview with Resident #6 on 09/23/26 at 8:05am revealed: -He had difficulty chewing because he did not have teeth on one side. -He also had Parkinson's disease. -He had to ask someone to cut up his meat on 09/22/26. -Sometimes when new staff helped serve meals, staff might forget to cut his food but would always cut it when he asked. -He did not need his bacon cut up on 09/23/26 because the bacon was cooked crispy. Telephone interview with Resident #6's family member on 09/22/26 at 8:06am revealed: -Staff were supposed to cut Resident #6's food into small bites. -Staff had been very good at cutting his food, as far as she knew. Interview with a dietary aide on 09/23/26 at 5:37pm revealed a mechanical soft diet was to include ground meats with gravy/sauce. Interview with the Dietary Manager on 09/23/26 at 5:47pm revealed:	{D 310}		

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{D 310}	Continued From page 10 -For a mechanical soft diet, the meat should be put into the blender to break it down. -The beef served to Resident #6 on 09/22/26 was cut up but may not have been cut up enough. -Resident #6's family member asked for gravy to be added to the resident's food so he could swallow it easier. -A cook told him she had served Resident #6 bacon by accident on 09/23/26. -As soon as it was brought to his attention, he told the Health and Wellness Director (HWD) the cook had accidentally served bacon to the resident. -He told the HWD there had been times Resident #6 had refused to have his sausage ground. Telephone interview with Resident #6's primary care provider (PCP) on 09/23/26 at 4:50pm revealed: -Resident #6 had Parkinson's disease. -When she became Resident #6's PCP, the mechanical soft diet order was already in place. -She expected the diet to be followed as ordered. Interview with the HWD on 09/23/26 at 7:08pm revealed a mechanical soft diet should include chopped meats for a resident to easily chew and swallow. Interview with the facility's Corporate Clinical Nurse Specialist on 09/23/26 at 6:59pm revealed if a resident was having difficulty chewing, the resident might not receive the full nutritional value of the meal served. Based on observations and interviews, the Administrator was not available at the time of the survey. Refer to the interview with a dietary aide on	{D 310}		

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{D 310}	Continued From page 11 09/23/26 at 5:37pm. Refer to the interview with the Dietary Manager on 09/23/26 at 5:47pm Refer to the interview with the Health and Wellness Director (HWD) on 09/23/26 at 7:08pm. Refer to the interview with the facility's Corporate Clinical Nurse Specialist on 09/23/26 at 6:59pm. 2. Review Of Resident #7's FL2 dated 03/02/26 revealed diagnoses included dementia. Review of Resident #7's diet order dated 02/27/26 revealed an order for regular diet with finger foods. Review of the facility's diet list dated 09/22/26 revealed Resident #7 was listed as having a regular diet with finger foods modification. Review of the lunch menu for a finger food diet for 09/22/26 revealed meat loaf, a rice roll, and mixed medley were to be served. Review of the facility's therapeutic diet menu revealed the rice should have the consistency of a rice ball. Review of the recipe for the rice ball revealed the rice should be cooked, mixed with starch, egg, and milk and shaped into a ball and then baked. Observation of lunch meal on 09/22/26 between 11:54am-12:30pm revealed: -At 11:57am, Resident #7 received her meal. -Resident #7 was served meat balls with sauce, mixed vegetables (broccoli, carrots with peppers),	{D 310}		

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{D 310}	Continued From page 12 and white rice. -The rice was not in the shape of a rice ball. -The rice was served steamed and loose with the grains separated. -At 12:09pm, Resident #7 was observed with white rice on the table, in the bowl with the mixed vegetables, in her lap and on the table. -She picked up the rice with her fingers and dropped most of the rice before reaching her mouth. -She ate 5% of the meat balls, 50% of the vegetables and 25% of the rice. Interview with Resident #7 on 09/22/26 at 12:20pm revealed she was finished and did not want to further complete her meal. Interview with a dietary aide on 09/23/26 at 5:37pm revealed a finger food diet did not include loose rice with separate grains. Interview with the Dietary Manager on 09/23/26 at 5:55 pm revealed: -Rice was on the therapeutic diet if it was served in a ball. -The cook baked the rice until it was dry, then scooped the rice for serving finger food diets. -He did not know the recipe to make the rice balls. -He did not know the rice was served loose to Resident #7. -He was concerned that Resident #7's rice was not served according to the therapeutic diet menu. Interview with Resident #7's primary care provider (PCP) on 09/23/26 at 4:30pm revealed: -Resident #7 was ordered finger foods to give her more independence. -It was important to allow Resident #7 to	{D 310}		

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{D 310}	Continued From page 13 participate with her meals and self-feeding. -She expected a finger food modification diet to be served to Resident #7. Interview with the Health and Wellness Director (HWD) on 09/23/26 at 7:15pm revealed a finger food diet was important to allow the resident to have some autonomy. Interview with the facility's Corporate Clinical Nurse specialist on 09/23/26 at 7:10pm revealed the therapeutic finger food diet was ordered by the PCP to give the resident independence. Based on observations and interviews the Administrator was not available at the time of the survey. Attempted telephone interview with Resident #7's family member on 09/23/26 at 1:00pm was unsuccessful. Refer to the interview with a dietary aide on 09/23/26 at 5:37pm. Refer to the interview with the Dietary Manager on 09/23/26 at 5:47pm Refer to the interview with the HWD on 09/23/26 at 7:08pm. Refer to the interview with the facility's Corporate Clinical Nurse Specialist on 09/23/26 at 6:59pm. 3. Review of Resident #8's current FL2 dated 03/23/26 revealed: -Diagnoses included Alzheimer's disease, dysphagia, hemiplegia, chronic pancreatitis, muscle wasting and atrophy, and cognitive communication deficit.	{D 310}		

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{D 310}	Continued From page 14 -There was an order for an advanced dysphagia diet. Review of Resident #8's diet order dated 06/01/26 revealed an order for a regular mechanical soft diet. Review of the facility's diet list dated 09/22/26 revealed Resident #8's diet was documented as mechanical soft. Review of the facility's therapeutic diet menu revealed meats and vegetables were to be ground, and breads were to be moist on a mechanical soft diet. Observation of the lunch meal on 09/22/26 from 11:54am-12:25pm revealed: -At 11:54am, Resident #8 received ground meatloaf, rice, ground vegetables and a roll that was not moistened. -At 12:01pm, Resident #8 attempted to bite the bread but laid it down. -At 12:12pm, Resident #8 completed 100% of his meal except the roll. Interview with a dietary aide on 09/23/26 at 5:45 pm revealed: -For a mechanical soft diet, bread should be moistened. -Meats and vegetables should be ground. Interview with the Dietary Manager on 09/23/26 at 5:55pm revealed: -For a mechanical soft diet, the bread should be moistened. -He was not aware the bread served to Resident #8 on 09/22/26 was not moistened. -He was concerned that Resident #8 could not eat the bread.	{D 310}			

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{D 310}	Continued From page 15 Telephone interview with Resident #8's primary care provider (PCP) on 09/23/26 at 4:30pm revealed: -Resident #8 was ordered a mechanical soft diet. -Resident #8 could only tolerate a mechanical soft diet. -Resident #8 needed all the calories from the therapeutic diet. -It was expected Resident #8 received a mechanical soft diet as ordered. Based on observations and record reviews, it was determined Resident #8 was not interviewable. Based on observations and interviews the Administrator was not available at the time of the survey. Attempted telephone interview a Resident #8's family member was unsuccessful on 09/23/26 at 4:30pm. Refer to the interview with a dietary aide on 09/23/26 at 5:37pm. Refer to the interview with the Dietary Manager on 09/23/26 at 5:47pm Refer to the interview with the HWD on 09/23/26 at 7:08pm. Refer to the interview with the facility's Corporate Clinical Nurse Specialist on 09/23/26 at 6:59pm. Interview with a dietary aide on 09/23/26 at 5:37pm revealed: -There was a diet order sheet in the kitchen for staff to know what diets were ordered for each resident.	{D 310}		

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{D 310}	Continued From page 16 -There was a diet book in the kitchen that showed what to serve for each diet. Interview with the Dietary Manager on 09/23/26 at 5:47pm revealed: -Staff used a book to see what each resident could be served who had a therapeutic diet. -The staff serving the residents' meals knew which residents had therapeutic diets, and which plates were to be served. Interview with the HWD on 09/23/26 at 7:08pm revealed: -She was responsible for making sure the dietary staff were given diet orders. -Mechanical soft should be chopped meats for the residents to easily chew and swallow. -She expected the dietary staff to prepare and serve the diets as ordered. Interview with the facility's Corporate Clinical Nurse Specialist on 09/23/26 at 6:59pm revealed: -The Dietary Manager and the dietary aides were responsible for making sure diets were served as ordered. -The diet orders were given to the dietary staff by the HWD and the Resident Care Coordinator (RCC). -She expected the dietary staff to serve the diets as ordered.	{D 310}		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the	D 344		

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D 344	Continued From page 17 resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 1 of 5 sampled residents (#2), including an order for blood pressure (BP) checks with parameters. The findings are: Review of Resident #2's current FL2 dated 03/23/26 revealed: -Diagnoses included hypertension. -There were orders for four medications with the purpose documented as treatment for high blood pressure: dextroamphetamine, amlodipine, losartan, and metoprolol succinate. -There was an order for BP checks weekly. Review of Resident #2's physician's order dated 08/05/26 revealed: -There was an order to check BP daily before medication. -If the systolic BP was lower than 100, the BP medication was to be held, and BP rechecked in one hour. -If the BP remained low, the medication was to be held for 24 hours, and BP rechecked the following day.	D 344		

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D 344	Continued From page 18 -If the pulse was consistently less than 60 beats per minute, the Primary Care Provider (PCP) was to be contacted. -There was a handwritten note that read, "order can only say check BP daily, notify PCP when parameters," with a line drawn through the order. -There was documentation typed in and electronically signed on 08/05/26 at 1:48pm that read, "check manual BP once daily. Notify PCP if BP was greater than 170/100 or less than 90/50." Review of Resident #2's August 2026 electronic medication administration record (eMAR) from 08/05/26-08/31/26 revealed: -There were entries for each of the four blood pressure medications; there were no parameters documented with the medications. -There was no entry for daily BP checks. -There were BP readings documented in the medication notation section of the eMAR every day during the 5:00pm medication pass. -There were no systolic BPs documented as less than 100, or BP readings less than 90/50. -On 08/08/26, the BP reading was documented as 174/86; there was no documentation the PCP was notified. -On 08/24/26, the BP reading was documented as 177/88; there was no documentation the PCP was notified. Review of Resident #2's September 2026 eMAR from 09/01/26-09/22/26 revealed: -There were entries for each of the four blood pressure medications; there were no parameters documented with the medications. -There was no entry for daily BP checks. -There were BP readings documented in the medication notation section of the eMAR every day during the 5:00pm medication pass. -There were no systolic BPs documented as less	D 344		

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D 344	Continued From page 19 than 100. -On 09/04/26, the BP reading was documented as 180/91; there was no documentation the PCP was notified. -On 09/03/26, the BP reading was documented as 135/49; there was no documentation the PCP was notified. Review of Resident #2's care history from 08/02/26-09/23/26 revealed: -There was documentation that Resident #2's BP was checked daily between 8:51am-11:24am. -There were no systolic BPs documented as less than 100. -There was documentation that Resident #2's BP reading on 09/03/26 at 11:24am was 139/46. Telephone interview with a representative from the facility's contracted pharmacy on 09/22/26 at 2:15pm revealed: -The pharmacy only entered BP parameters in the eMAR if the order was attached to a specific medication. -The facility entered BP orders that were not attached to a medication. Interview with a medication aide (MA) on 09/22/26 at 2:55pm revealed: -Resident #2 did have an order for BP checks with his BP medication and to hold the medication if the BP was outside the parameter, but the order had been discontinued "a while" ago. -Resident #2's BP was "bad" and had to be checked with a manual BP cuff. -Resident #2's BP order was not on the eMAR but was a scheduled treatment. -There was an order to notify the PCP if Resident #2's BP was greater than 170/100 or less than 90/50.	D 344		

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D 344	Continued From page 20 Interview with a second MA on 09/23/26 at 12:46pm revealed: -Resident #2's BP was checked three times a day. -She thought the BP was supposed to be checked before his medication was administered. -The BP reading would determine whether the medication was administered. -The BP parameters were to call the PCP if the BP readings were too high or low; she could not recall the parameters. -When she was shown a BP reading of 120/45, she stated she would not have called the PCP because the systolic BP was greater than 90. -She thought the BP parameters meant both the systolic and diastolic readings had to be outside the parameters. Telephone interview with Resident #2's PCP nurse on 09/22/26 at 5:35pm revealed: -Resident #2 had an order to check BP daily before medication. -If the systolic BP was lower than 100, the BP medication was to be held, and BP rechecked in one hour. -If the BP remained low, the medication was to be held for 24 hours, and BP rechecked the following day. -If the pulse was consistently less than 60 beats per minute, the PCP was to be contacted. -She did not see an order in Resident #2's record related to calling the PCP when the systolic and/or diastolic readings were outside any parameters. -Any orders signed by the PCP should be followed as ordered. -There had been no calls when Resident #2's BP had been above 170 systolic or less than 50 diastolic.	D 344		

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D 344	Continued From page 21 Interview with the Health and Wellness Director (HWD) on 09/23/26 at 2:41pm revealed: -The BP order was not attached to a specific BP medication, and the MAs would not know which BP medication to apply the order to. -She thought the order to hold the BP medication was being discontinued and that only the order with parameters to call the PCP was the new order. Interview with the facility's Corporate Clinical Nurse Specialist on 09/23/26 at 3:36pm revealed: -She was the staff member who had written the note on the PCP's BP order because she thought it needed to be clarified. -She saw the order for daily BP checks but did not see any parameters and requested them. -The order did not identify which BP medication; therefore, it needed to be clarified. -The order had been faxed to the PCP, but she did not see that the parameters had been returned to the facility. -She thought the order still needed to be clarified. Based on observations and interviews, the Administrator was not available at the time of the survey.	D 344		
{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	{D 358}		

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{D 358}	Continued From page 22 and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 5 sampled residents (#2, #4) for a topical pain reliever (#2) and insulin used to treat diabetes (#4). The findings were: 1. Review of Resident #4's current FL2 dated 04/28/26 revealed: -Diagnoses included type 2 diabetes mellitus (DM), peripheral neuropathy, and hypertension. -There was an order for Humulin (an intermediate-acting insulin used to treat diabetes) to be injected subcutaneously (SQ), 10 units in the morning and 6 units at night. Review of Resident #4's physician's order dated 07/31/26 revealed there was an order for Humulin 10 units in the morning and 6 units at night; insulin was to be held if his finger stick blood sugar (FSBS) was less than 120. Review of Resident #4's August 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Humulin N U-100, inject 10 units SQ every morning scheduled at 7:00am; hold insulin if FSBS was less than 120. -There were 5 opportunities when Humulin should have been held for FSBS values less than 120 but was documented as administered. Examples included: -On 08/06/26 at 7:29am, the FSBS was documented as 116, and the location of injection	{D 358}		

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{D 358}	Continued From page 23 was the left abdomen; Humulin was documented as administered. -On 08/23/26 at 8:57am, the FSBS was documented as 111, and the location of injection was the left abdomen; Humulin was documented as administered. -On 08/27/26 at 8:35am, the FSBS was documented as 95, and the location of injection was the left abdomen; Humulin was documented as administered. -There was an entry for Humulin N U-100, inject 6 units SQ every evening scheduled at 5:00pm; hold insulin if FSBS was less than 120. -There were 5 opportunities when Humulin should have been held for FSBS values less than 120 but was documented as administered. Examples included: -On 08/03/26 at 5:05pm, the FSBS was documented as 109, and the location of injection was the right abdomen; Humulin was documented as administered. -On 08/21/26 at 4:51pm, the FSBS was documented as 108, and the location of injection was the right abdomen; Humulin was documented as administered. -On 08/27/26 at 4:59pm, the FSBS was documented as 109, and the location of injection was the left abdomen; Humulin was documented as administered. Review of Resident #4's September 2026 eMAR from 09/01/26-09/22/26 revealed: -There was an entry for Humulin N U-100, inject 10 units SQ every morning scheduled at 7:00am; hold insulin if FSBS was less than 120. -There were 4 opportunities when Humulin should have been held for FSBS values less than 120 but was documented as administered. Examples included: -On 09/03/26 at 7:36am, the FSBS was	{D 358}		

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{D 358}	Continued From page 24 documented as 115, and the location of injection was the right abdomen; Humulin was documented as administered. -On 09/07/26 at 7:47am, the FSBS was documented as 117, and the location of injection was the right abdomen; Humulin was documented as administered. -On 09/07/26 at 12:05pm, the FSBS was documented as 83. -On 09/09/26 at 7:14am, the FSBS was documented as 110, and the location of injection was the right abdomen; Humulin was documented as administered. -There was an entry for Humulin N U-100, inject 6 units SQ every evening scheduled at 5:00pm; hold insulin if FSBS was less than 120. -There were 5 opportunities when Humulin should have been held for FSBS values less than 120 but was documented as administered. Examples included: -On 09/02/26 at 5:16pm, the FSBS was documented as 114, and the location of injection was the right abdomen; Humulin was documented as administered. -On 09/11/26 at 4:54pm, the FSBS was documented as 106, and the location of injection was the right abdomen; Humulin was documented as administered. -On 09/12/26 at 4:51pm, the FSBS was documented as 106, and the location of injection was the left abdomen; Humulin was documented as administered. -On 09/20/26 at 5:48pm, the FSBS was documented as 80, and the location of injection was the left abdomen; Humulin was documented as administered. Observation of Resident #4's medication on hand on 09/22/26 at 4:25pm revealed: -There was a Humulin insulin Kwik Pen with	{D 358}		

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{D 358}	Continued From page 25 instructions to inject 10 units every morning and 6 units every evening; prime pen with 2 units. -The pen was labeled as opened on 09/14/26. -There were less than 180 units remaining in the pen. Telephone interview with a representative from the facility's contracted pharmacy on 09/23/26 at 10:21am revealed: -The pharmacy received an order on 04/28/26 for Resident #4's Humulin insulin with instructions to inject 10 units at breakfast and 6 units in the evening; there were no parameters. -The pharmacy had not received the order dated 07/31/26 that included the parameters. -She could see where someone at the facility had added a note with the parameters to the medication pass. Review of the dispensing records from the facility's contracted pharmacy for Resident #4's Humulin revealed two Kwik Pens of Humulin N U-100 were dispensed on 07/27/26 and 08/27/26; each pen contained 300 units. Telephone interview with Resident #4's primary care provider (PCP) on 09/23/26 at 11:42am revealed: -On 09/18/26, Resident #4's hemoglobin A1C (HbA1c) was 6.0 (The HbA1c determines the average level of blood sugar over the past 2 to 3 months. According to the American Diabetes Association, an HbA1c value less than 7.0 is a goal for diabetic residents, with the normal range for HbA1c being 4 to 5.9 for someone who is not diabetic.). -It was dangerous for an 86-year-old to have low FSBS. -If Resident #4's FSBS dropped low, he could become unconscious based on his age.	{D 358}		

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{D 358}	Continued From page 26 -He would experience hypoglycemia, which could include sweating, dizziness, and increased heart rate. -A low FSBS also increased Resident #4's risk of falls. -She expected Resident #4's Humulin to be administered as ordered. Interview with a medication aide (MA) on 09/23/26 at 12:02pm revealed: -Resident #4 did not receive Humulin insulin if his FSBS was less than 120. -If she documented that she administered Resident #4's Humulin for an FSBS reading of 118, she might have clicked it off by accident. -She hoped she did not administer Resident #4's Humulin, "I am usually pretty good with that." -If she did not administer Resident #4's Humulin because his FSBS reading was less than 120, she usually documented it as held. -She recalled there were a few times Resident #4's FSBS reading was low, but most of the time Resident #4 received his insulin. Interview with a second MA on 09/23/26 at 12:46pm revealed: -Resident #4 had parameters if his FSBS was less than 100, but his FSBS was never less than 100. -She never had to hold Resident #4's Humulin. -She had documented Resident #4's FSBS as less than 120 three times in August/September but thought she had documented the Humulin as administered in error. Telephone interview with a third MA on 09/23/26 at 1:48pm revealed: -Resident #4's FSBS parameters with his Humulin insulin were put in place within the last one to two months.	{D 358}		

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{D 358}	Continued From page 27 -If she documented that she administered insulin, then she administered the insulin. -She did not know why she documented administering Resident #4's Humulin when his FSBS reading was less than 120. Interview with Resident #4 on 09/23/26 at 11:31am revealed: -He received insulin injections twice daily. -He did not know what his FSBS readings were. -He did not know if there were any hold parameters with his insulin. -He did not recall his insulin injections ever being held. Interview with the HWD on 09/23/26 at 2:41pm revealed: -She started working at the facility on 07/13/26. -She had requested parameters for Resident #4's FSBS because she had noted there were no parameters ordered. -If Resident #4's FSBS reading was less than 120, his insulin should be held. -She was concerned Resident #4's Humulin had been administered when his FSBS reading was outside of the ordered parameter. Interview with the facility's Corporate Clinical Nurse Specialist on 09/23/26 at 3:36pm revealed: -If Resident #4's insulin was administered when it should have been held based on his parameters, his FSBS could have bottomed out and resulted in an emergency. -She expected the MAs to follow the parameters ordered. Based on observations and interviews, the Administrator was not available at the time of the survey.	{D 358}		

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{D 358}	Continued From page 28 2. Review of Resident #2's current FL2 dated 03/23/26 revealed: -Diagnoses included senile dementia of the brain, frailty, and hypertension. -There was an order for Biofreeze gel (a topical gel that was used for joint discomfort) to be applied to the shoulder, back, or neck for pain as needed (PRN). Review of a physician's order dated 09/10/26 revealed an order for Biofreeze 4% topical gel, apply one application to the left shoulder at bedtime. Review of Resident #2's September 2026 electronic medication administration record (eMAR) from 09/01/26-09/22/26 revealed: -There was an entry for Biofreeze gel 4%, apply one application to the left shoulder at bedtime; it was not scheduled and was labeled as PRN. -There was documentation that Biofreeze was applied once on 09/10/26 and 09/20/26. Observation of Resident #2's medications on hand on 09/22/26 at 11:28am revealed: -There was a large, opened bottle of Biofreeze gel with Resident #2's room number written on the bottle. -The bottle did not have a pharmacy label. Telephone interview with a representative from the facility's contracted pharmacy on 09/22/26 at 2:15pm revealed: -Resident #2's current order was for Biofreeze gel 4%, apply one application to the left shoulder at bedtime. -The pharmacy put the order into the eMAR system, and it had to be approved by a staff member at the facility. -She could see where a staff member had	{D 358}		

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{D 358}	Continued From page 29 accepted the order but had changed it to PRN. Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/22/26 at 3:36pm revealed: -Biofreeze was used to treat joint and muscle pain. -If the Biofreeze was not applied as ordered, the resident could continue to have discomfort. Interview with Resident #2 on 09/22/26 at 3:09pm revealed: -He had arthritis in his left shoulder. -He had a hard time applying the Biofreeze himself, so the staff did it for him. -Staff did not apply the Biofreeze every night. -He had woken up at night with his shoulder hurting so badly that he could not go back to sleep. Telephone interview with Resident #2's primary care provider's (PCP) nurse on 09/22/26 at 5:35pm revealed: -The PCP had received a message from Resident #2's family member requesting that the Biofreeze order be administered every night, as the resident did not consistently remember to request it. -Resident #2 had reported shoulder pain that woke him during the night and prevented him from returning to sleep. -Staff were expected to follow the PCP's orders as written. Telephone interview with Resident #2's family member on 09/23/26 at 9:00am revealed: -Resident #2 told her he was having pain. -The pain would wake him up at night; he complained about the pain a lot. -His Physical Therapist (PT) recommended	{D 358}		

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{D 358}	Continued From page 30 changing the Biofreeze from PRN to scheduled. -She requested that Resident #2's Biofreeze be changed to scheduled, because he did not ask for it. Telephone interview with Resident #2's PT on 09/23/26 at 10:05am revealed: -Resident #2 had complained to her about his shoulder pain. -She suggested that the order for the Biofreeze be scheduled instead of PRN because he was not going to ask for it. -It would be good for Resident #2 to have the Biofreeze as ordered nightly because that was when he was in pain. Interview with the Resident Care Coordinator (RCC) on 09/23/26 at 2:18pm revealed he had not seen the order for Resident #2's Biofreeze to be changed to scheduled. Interview with the Health and Wellness Director (HWD) on 09/23/26 at 2:41pm revealed: -She had not seen the order for Resident #2's Biofreeze to be changed from PRN to scheduled. -The MAs approved orders once the medication was received at the facility. -If someone had told her Resident #2 was having pain, she could have looked into it and seen that the Biofreeze was not being utilized. Interview with the facility's Corporate Clinical Nurse Specialist on 09/23/26 at 3:36pm revealed: -She could see where the pharmacy entered Resident #2's Biofreeze order as scheduled and it was approved, but the MA who approved it accidentally attached it to the existing PRN order when it should have been entered as a new order. -If the Biofreeze was not administered as	{D 358}			

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{D 358}	Continued From page 31 ordered, the resident could continue to be in pain. Based on observations and interviews, the Administrator was not available at the time of the survey. Attempted telephone interview with a second MA on 09/23/26 at 1:58pm was unsuccessful. The facility failed to administer medications as ordered by not holding a resident's Humulin insulin based on the FSBS parameters, resulting in the resident being administered insulin 19 times in less than a two-month period when it should have been held. Due to his age, he was at increased risk for unconsciousness, hypoglycemia, and falls if his FSBS dropped too low (#4). Resident #2 experienced shoulder pain that, at times, prevented him from sleeping. His topical pain gel was not applied nightly as ordered, resulting in ongoing pain. These failures were detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on September 23, 2026, for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 7, 2026.	{D 358}		
{D 371}	10A NCAC 13F .1004 (n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control	{D 371}		

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{D 371}	Continued From page 32 measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure a medication was administered in accordance with infection control measures during the morning medication pass by the medication aide (MA) who did not clean the durable medical equipment (DME) nebulizer following the aerosol treatment. The findings are: Request for the facility's policy on medication administration infection control revealed there was no policy available for review. Observation of the MA during the morning medication pass on 09/23/26 at 8:42 am revealed: -The MA reviewed a resident's electronic medication administration record (eMAR). -He removed 1 ipratropium solution vial (a bronchodilator medication used to prevent narrowing of the airways), from its container. -He removed a mask, tubing, and chamber from a clear plastic bag and poured the medication into the nebulizer chamber. -He placed the mask with the connected tubing and chamber on the face of the resident and turned the nebulizer machine on. -The nebulizer breathing treatment lasted 10 minutes. -He removed the mask with tubing, the chamber and nebulizer after the treatment was completed.	{D 371}		

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{D 371}	Continued From page 33 -He returned the mask, tubing and chamber to the plastic bag and placed the nebulizer machine in the locked medication cart. -He did not wash the nebulizer chamber, or mask. Interview with the MA on 09/23/26 at 8:55am revealed: -He never washed the mask or chamber. -He did not know to wash the mask and chamber after each use and allow them to air dry completely. -He did not know the mask and tubing needed to be changed. Review of The Center of Medicare and Medicaid services (CMS) guidelines for nebulizer cleaning revealed: -The nebulizer mask and medicine chamber should be washed in warm soapy water after each use and left out to air dry completely and disinfected weekly. -The mask and medicine chamber should be disassembled and set aside from the tubing. -The mask and tubing should be changed every 3-6 months. Interview with a representative from the facility's contracted pharmacy on 09/23/26 revealed: -The facility was responsible for entering care of the nebulizer and parts on the eMAR. -The facility should follow their policy or the manufacture's policy for care of the DME. -The lack of care for any DME could lead to infections. Interview with the Resident Care Coordinator (RCC) on 09/23/26 at 6:00pm revealed: -He did not know the nebulizer and equipment was not cleaned after each use.	{D 371}		

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{D 371}	Continued From page 34 -He did not know the nebulizer and equipment should be cleaned after each use and left out to air dry. Telephone interview with the facility's contracted primary care provider (PCP) on 09/23/26 at 11:37am revealed: -The mask had germs, especially with the resident coughing during the administration of the nebulizer medication. -She was concerned about respiratory infections and fungal infection with the lack of cleaning the nebulizer, mask and chamber. -She was concerned about the resident's weakened immune system and exposure to germs from the DME. Interview with the Health and Wellness Director (HWD) on 09/23/26 at 3:00pm revealed: -She did not know the nebulizer was not cleaned after each use. -She was concerned that the resident could get an infection and become very sick. -The MAs were responsible for cleaning the mask, chamber and nebulizer after each use. Interview with the facility's Corporate Clinical Nurse Specialist on 09/23/26 at 7:02 pm revealed: -She was not aware there was not a policy for maintaining nebulizers. -She was concerned that the resident could get a respiratory infection. -The MAs were responsible for cleaning the mask, chamber and nebulizer after each use. -The HWD is responsible for training the MAs on the care of the nebulizer. Based on observations and record reviews, it was determined the resident was not interviewable.	{D 371}		

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{D 371}	Continued From page 35 Based on observations and interviews, the Administrator was not available at the time of the survey.	{D 371}			