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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey from June 30, 2026 through July 2, 2026.	D 000		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to administer medications as ordered for 2 of 5 sampled residents (#1, #2) including one medication used to treat coronary artery disease (CAD), one medication used to treat atrial fibrillation (A-fib) (Resident #1), and a medication used to treat insomnia (Resident #2). The findings are: 1. Review of Resident #1's current FL2 dated 12/01/25 revealed diagnoses included A-fib, CAD and chronic obstructive pulmonary disease (COPD). a. Review of Resident #1's current FL2 dated 12/01/25, there was an order for diltiazem hydrochloride extended release 60 mg 1 capsule daily, hold if systolic blood pressure (SBP) is less than 120.	D 358		

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D 358	Continued From page 1 Review of Resident #1's signed physician orders dated 05/26/26 revealed there was an order for diltiazem hydrochloride extended release 60 mg, give 1 capsule by mouth one time a day for CAD, hold if SBP is less than 120. Review of Resident #1's April 2026 electronic medication administration record (eMAR) revealed: -There was an entry for diltiazem hydrochloride extended release 60 mg, give 1 capsule by mouth one time a day for CAD, hold if SBP is less than 120 scheduled at 04:00pm. -There was documentation that Resident #1's SBP was less than 120 on 3 occasions and the diltiazem hydrochloride was not held with examples as followed; on 04/22/26 at 4:00pm, SBP was 114 and 60mg of diltiazem hydrochloride was administered; on 04/23/26 at 4:00pm, SBP was 119 and 60mg of diltiazem hydrochloride was administered; on 04/27/26 at 4:00pm, SBP was 118 and 60mg of diltiazem hydrochloride was administered. Review of Resident #1's May 2026 eMAR revealed: --There was an entry for diltiazem hydrochloride extended release 60 mg, give 1 capsule by mouth one time a day for CAD, hold if SBP is less than 120 scheduled at 04:00pm. -There was documentation that Resident #1's SBP was less than 120 on 4 occasions and the diltiazem hydrochloride was not held 3 times with examples as followed; on 05/07/26 at 4:00pm, SBP was 119 and 60mg of diltiazem hydrochloride was administered; on 05/25/26 at 4:00pm, SBP was 119 and 60mg of diltiazem hydrochloride was administered; on 05/30/26 at 4:00pm, SBP was 119 and 60mg of diltiazem	D 358		

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hydrochloride was administered.

Review of Resident #1's June 2026 eMAR revealed:
--There was an entry for diltiazem hydrochloride extended release 60 mg, give 1 capsule by mouth one time a day for CAD, hold if SBP is less than 120 scheduled at 04:00pm.
-There was documentation that Resident #1's SBP was less than 120 on 8 occasions and the diltiazem hydrochloride was not held with examples as followed; on 06/07/26 at 4:00pm, SBP was 117 and 60mg of diltiazem hydrochloride was administered; on 06/08/26 at 4:00pm, SBP was 116 and 60mg of diltiazem hydrochloride was administered; on 06/09/26 at 4:00pm, SBP was 118 and 60mg of diltiazem hydrochloride was administered; on 06/17/26 at 4:00pm, SBP was 119 and 60mg of diltiazem hydrochloride was administered; on 06/18/26 at 4:00pm, SBP was 98 and 60mg of diltiazem hydrochloride was administered; on 06/25/26 at 4:00pm, SBP was 119 and 60mg of diltiazem hydrochloride was administered; on 06/28/26 at 4:00pm, SBP was 118 and 60mg of diltiazem hydrochloride was administered; on 06/29/26 at 4:00pm, SBP was 115 and 60mg of diltiazem hydrochloride was administered.

Observation of medications on hand for Resident #1 on 07/02/26 at 10:12am revealed one blister package card of diltiazem hydrochloride 60mg with a dispense date of 06/19/26 with 15 out of 28 capsules remaining.

Interview with Resident #1 on 07/02/26 at 10:39am revealed:
-She reminded staff to take her blood pressure (BP) daily, but they didn't always do so.
-She knew about the medication to treat her CAD.

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-She was aware that her medication was supposed to be held if the top number of her BP was below 120.
-She felt dizzy and lightheaded in the evenings and would lie down in her bed when this happened.

Telephone interview with a representative from the facility's contracted pharmacy on 07/02/26 at 11:00am revealed:
-Resident #1 had an active order for diltiazem hydrochloride extended release 60 mg, give 1 capsule by mouth one time a day for CAD, hold if SBP is less than 120.
-The last 3 dispense dates for the diltiazem hydrochloride were 04/17/26 (quantity of 28), 05/15/26 (quantity of 30) and 06/12/26 (quantity of 28).
-If Resident #1 was administered diltiazem hydrochloride when her SBP was below 120, her BP could drop lower and adversely affect her heart rate and cause circulatory issues, dizziness, lightheadedness and potentially increase her risk for falls.

Interview with a medication aide (MA) on 07/02/26 at 2:09pm revealed:
-She was aware of Resident #1's diltiazem hydrochloride order.
-She was aware that she was supposed to take Resident #1's BP before administration of this medication and to hold it if the SBP was less than 120.
-She did not remember whether she held Resident #1's diltiazem hydrochloride on 06/08/26, 06/17/26, 06/18/26 and 06/25/26
-A nurse completed eMAR audits, but she did not know how often.

Interview with a second MA on 07/02/26 at

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D 358	Continued From page 4 2:30pm revealed: -She was aware of Resident #1's diltiazem hydrochloride order. -She was aware that she was supposed to take Resident #1's BP before administration of this medication and to hold it if the SBP was less than 120. -Resident #1 would count her medications when administered but could not tell which one(s) were missing. -When Resident #1 was told her diltiazem hydrochloride was being held, she would become argumentative and threaten to report the MA to administration. -She would give Resident #1 her medication despite the order to hold it, for fear of being reported and losing her job. -She had reported Resident #1's insistence on taking her medication despite her SBP reading to a previous Health and Wellness Director (HWD), but not to the current HWD. -The HWD and Resident Care Coordinator (RCC) completed eMAR audits, but she did not know how often. -She was aware that she did not hold Resident #1's diltiazem hydrochloride on several occasions but could not recall the dates. Interview with the RCC on 07/02/26 at 2:42pm revealed: -She was not aware of Resident #1's order for diltiazem hydrochloride. -She was not aware that the medication was not held as ordered. -Resident #1's primary care provider (PCP) wrote orders and sent them directly to the pharmacy. -She did not complete eMAR audits. -MAs were responsible for taking residents' BPs and administering medications as ordered.	D 358		

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D 358	Continued From page 5 Interview with the HWD on 07/02/26 at 3:16pm revealed: -She was aware of Resident #1's orders for diltiazem hydrochloride and that the medication had parameters to hold if Resident #1's SBP was less than 120. -She was not aware that this medication was not held as ordered in April, May and June 2026. -She had been conducting eMAR audits every 1-2 weeks since January 2026, for late administrations and medications not being administered. -MAs on 3rd shift completed medication card audits weekly. -No staff had reported Resident #1 insisting on taking her diltiazem hydrochloride despite her BP readings. -MAs were responsible for administering medications as ordered. Interview with the Administrator on 07/02/26 at 3:49pm revealed: -She was aware of Resident #1's diltiazem hydrochloride order and assumed there were parameters for the medication. -She was not aware that Resident #1's medication was not being held as ordered. -She expected the RCC to complete eMAR audits and medication cart audits weekly and the HWD to complete eMAR audits daily or every other day. -She expected MAs to administer medications as ordered and hold them based on parameters. Attempted telephone interview with Resident #1's PCP on 07/02/26 at 1:35pm was unsuccessful. b. Review of Resident #1's signed physician orders dated 05/26/26 revealed there was an order for losartan potassium 25 mg, give one tablet by mouth one time a day for A-fib, please	D 358		

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D 358	Continued From page 6 hold for SBP less than 120. Review of Resident #1's April 2026 eMAR revealed: -There was an entry for losartan potassium 25 mg for A-fib, give one tablet by mouth one time a day for A-fib, please hold for SBP less than 120 scheduled at 04:00pm. -There was documentation that Resident #1's SBP was less than 120 on 3 occasions and the losartan potassium was not held with examples as followed; on 04/22/26 at 4:00pm, SBP was 114 and 25mg of losartan potassium was administered; on 04/23/26 at 4:00pm, SBP was 119 and 25mg of losartan potassium was administered; on 04/27/26 at 4:00pm, SBP was 118 and 25mg of losartan potassium was administered. Review of Resident #1's May 2026 eMAR revealed: -There was an entry for losartan potassium 25 mg for A-fib, give one tablet by mouth one time a day for A-fib, please hold for SBP less than 120 scheduled at 04:00pm. -There was documentation that Resident #1's SBP was less than 120 on 4 occasions and the losartan potassium was not held with examples as followed; on 05/07/26 at 4:00pm, SBP was 119 and 25mg of losartan potassium was administered; on 05/16/26 at 4:00pm, SBP was 119 and 25mg of losartan potassium was administered; on 05/25/26 at 4:00pm, SBP was 119 and 25mg of losartan potassium was administered; on 05/30/26 at 4:00pm, SBP was 119 and 25mg of losartan potassium was administered. Review of Resident #1's June 2026 eMAR from revealed:	D 358		

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D 358	Continued From page 7 -There was an entry for losartan potassium 25 mg for A-fib, give one tablet by mouth one time a day for A-fib, please hold for SBP less than 120 scheduled at 04:00pm. -There was documentation that Resident #1's SBP was less than 120 on 8 occasions and the losartan potassium was not held with examples as followed; on 06/07/26 at 4:00pm, SBP was 117 and 25mg of losartan potassium was administered; on 06/08/26 at 4:00pm, SBP was 116 and 25mg of losartan potassium was administered; on 06/09/26 at 4:00pm, SBP was 118 and 25mg of losartan potassium was administered; on 06/17/26 at 4:00pm, SBP was 119 and 25mg of losartan potassium was administered; on 06/18/26 at 4:00pm, SBP was 98 and 25mg of losartan potassium was administered; on 06/25/26 at 4:00pm, SBP was 119 and 25mg of losartan potassium was administered; on 06/28/26 at 4:00pm, SBP was 118 and 25mg of losartan potassium was administered; on 06/29/26 at 4:00pm, SBP was 115 and 25mg of losartan potassium was administered. Observation of medications on hand for Resident #1 on 07/02/26 at 10:12am revealed one blister package card of losartan potassium 25mg with a dispense date of 06/19/26 with 15 out of 28 capsules remaining. Interview with Resident #1 on 07/02/26 at 10:39am revealed: -She reminded staff to take her blood pressure (BP) daily, but they didn't always do so. -She did not know about the medication to treat her A-fib. -She was aware that at least one of her medications was supposed to be held if the top number of her BP was below 120.	D 358		

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D 358	Continued From page 8 -She felt dizzy and lightheaded in the evenings and would lie down in her bed when this happened. Telephone interview with a representative from the facility's contracted pharmacy on 07/02/26 at 11:00am revealed: -Resident #1 had an active order for losartan potassium 25 mg, give one tablet by mouth one time a day for A-fib, please hold for SBP less than 120. -The last 3 dispense dates for the losartan potassium were 04/17/26 (quantity of 28), 05/15/26 (quantity of 28) and 06/12/26 (quantity of 28). -If Resident #1 was administered losartan potassium when her SBP was below 120, her BP could drop lower and adversely affect her heart rate and cause circulatory issues, dizziness, lightheadedness and potentially increase her risk for falls. Interview with an MA on 07/02/26 at 2:09pm revealed: -She was aware of Resident #1's losartan potassium order. -She was aware that she was supposed to take Resident #1's BP before administration of this medication and to hold it if the SBP was less than 120. -She did not remember whether she held Resident #1's losartan potassium on 06/08/26, 06/17/26, 06/18/26 and 06/25/26. -A nurse completed eMAR audits, but she did not know how often. Interview with a second MA on 07/02/26 at 2:30pm revealed: -She was aware of Resident #1's losartan potassium order.	D 358		

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-She was aware that she was supposed to take Resident #1's BP before administration of this medication and to hold it if the SBP was less than 120.
-Resident #1 would count her medications when administered but could not tell which one(s) were missing.
-When Resident #1 was told her losartan potassium was being held, she would become argumentative and threaten to report the MA to administration.
-She would give Resident #1 her medication despite the order to hold it, for fear of being reported and losing her job.
-She had reported Resident #1's insistence on taking her medication despite her SBP reading to a previous HWD, but not to the current HWD.
-The HWD and RCC completed eMAR audits, but she did not know how often.
-She was aware that she did not hold Resident #1's losartan potassium on several occasions but could not recall the dates.

Interview with the RCC on 07/02/26 at 2:42pm revealed:
-She was not aware of Resident #1's order for losartan potassium.
-She was not aware that the medication was not held as ordered.
-Resident #1's PCP wrote orders and sent them directly to the pharmacy.
-She did not complete eMAR audits.
-MAs were responsible for taking residents' BPs and administering medications as ordered.

Interview with the HWD on 07/02/26 at 3:16pm revealed:
-She was aware of Resident #1's orders for losartan potassium and that the medication had parameters to hold if Resident #1's SBP was less

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than 120.
-She was not aware that this medication was not held as ordered in April, May and June 2026.
-She had been conducting eMAR audits every 1-2 weeks since January 2026, for late administrations and medications not being administered.
-MAs on 3rd shift completed medication card audits weekly.
-No staff had reported Resident #1 insisting on taking her losartan potassium despite her BP readings.
-MAs were responsible for administering medications as ordered.

Interview with the Administrator on 07/02/26 at 3:49pm revealed:
-She was aware of Resident #1's losartan potassium order and assumed there were parameters for the medication.
-She was not aware that Resident #1's medication was not being held as ordered.
-She expected the RCC to complete eMAR audits and medication cart audits weekly and the HWD to complete eMAR audits daily or every other day.
-She expected MAs to administer medications as ordered and hold them based on parameters.

Attempted telephone interview with Resident #1's PCP on 07/02/26 at 1:35pm was unsuccessful.

2. Review of Resident #2's current FL2 dated 04/28/26 revealed:
-Diagnoses included gait difficulty and osteoarthritis.
-She was intermittently confused.

Review of Resident #2's signed provider order dated 06/23/26 revealed there was an order for quetiapine (a medication used to treat insomnia)

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D 358	Continued From page 11 25 mg take 1 tablet at bedtime for insomnia. Review of Resident #2's June 2026 electronic medication administration record (eMAR) revealed: -There was an entry for quetiapine 25 mg take 1 tablet at bedtime for insomnia scheduled for administration at 8:00pm. -There was documentation quetiapine was administered from 06/24/26 to 06/29/26. Observation of the medications on hand for Resident #2 on 07/02/26 at 11:20am revealed there was no quetiapine 25mg available for administration on the medication cart. Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/02/26 at 2:09pm revealed: -Resident #2 had a current order on file for quetiapine 25mg take 1 tablet at bedtime. -Quetiapine 25mg was dispensed on 06/23/26 for a quantity of 3 tablets which was a 3-day supply. -The medication was also filled by a different pharmacy on 06/23/26 which was why the pharmacy only dispensed a 3-day supply. -The medication would have run out on 06/26/26. Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable. Interview with a medication aide (MA) on 07/02/26 at 2:32pm revealed: -She administered medications to Resident #2. -She administered the last dose of quetiapine to Resident #2 last night on 07/01/26. Interview with the Resident Care Coordinator (RCC) on 07/02/26 at 2:44pm revealed:	D 358		

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D 358	Continued From page 12 -She knew Resident #2 had an order for quetiapine 25mg take one tablet at bedtime. -She did not know Resident #2 missed five doses of quetiapine between 06/24/26 and 07/01/26. -The MAs normally sent medication refill requests to the pharmacy and reordered residents' medications. Interview with the Health and Wellness Director (HWD) on 07/02/26 at 3:14pm revealed: -She did not know Resident #2 had an order for quetiapine 25mg at bedtime until 07/02/26. -She did not know only 3 doses of Resident #2's quetiapine were dispensed from the pharmacy on 06/23/26. -She did not know Resident #2 would have run out of quetiapine on 06/26/26 if Resident #2's quetiapine was administered as ordered. -The staff on the medication cart was responsible to administer medications as ordered. -If a medication was not available on the medication cart, she expected staff to document in a progress note, call the pharmacy and let the RCC know. Interview with the Administrator on 07/02/26 at 3:53pm revealed: -She did not know Resident #2 had an order for quetiapine 25mg at bedtime. -She did not know only 3 doses of Resident #2's quetiapine were dispensed from the pharmacy on 06/23/26. -She did not know Resident #2 would have run out of quetiapine on 06/26/26 if Resident #2's quetiapine was administered as ordered. -She expected the RCC to complete weekly audits and the HWD to complete audits daily or every other day. -MAs were responsible to administer medications as ordered.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080014	A. BUILDING: _____ B. WING _____	R 07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE SALISBURY	2201 STATESVILLE BOULEVARD SALISBURY, NC 28147

(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 358	Continued From page 13 Attempted telephone interview with Resident #2's primary care provider (PCP) on 07/02/26 at 1:35pm was unsuccessful.	D 358		