STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034026	A. BUILDING: _____ B. WING _____	R 07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF WINSTON SALEM	2601 REYNOLDA ROAD WINSTON SALEM, NC 27106

(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 conducted and annual and follow-up survey from June 30, 2026 to July 2, 2026.	D 000		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 6 sampled medication aides (MA) (Staff E) had a Clinical Skills Competency Validation Checklist prior to administering medications. The findings are: Review of Staff E's, MA, personnel record revealed: -Staff E was hired as a MA on 03/24/25. -There was documentation Staff E completed the 5-10- 15-hour MA training course on 05/02/25. -Staff E had taken and passed the written MA examination on 04/30/25. -There was no documentation Staff E had a Clinical Skills Competency Validation Checklist completed.	D 125		

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D 125	Continued From page 1 Review of 2 resident's April 2026 electronic medication administration record (eMAR) revealed there was documentation Staff E administered medications 12 days from 04/01/26 to 04/30/26. Review of 2 resident's May 2026 eMAR revealed Staff E administered medications on 11 days from 05/01/26 to 05/31/26. Review of 2 resident's June 2026 eMAR revealed Staff E administered medications on 12 days from 06/01/26 to 06/29/26. Interview with the Business Office Coordinator (BOC) on 07/02/26 at 10:47am revealed: -She kept the training requirements and documents for new hires in her office. -The Resident Care Director (RCD) was responsible for ensuring MA staff qualifications, including Clinical Skills Competency Validation Checklist, were completed and documentation provided for her to file in personnel records. -There was no Clinical Skills Competency Validation Checklist for Staff E available for review. -She was not aware Staff E did not have a Clinical Skills Competency Validation Checklist until yesterday evening (07/01/26) and was not aware of where the previous BOC stored additional documentation prior to her employment date of 4 months ago. Interview with the current RCD on 07/02/26 at 10:50am revealed: -She was aware the MAs were required to have the documentation for completion of the Clinical Skills Competency Validation Checklist prior to administering medications. -The RCD was responsible for completing MAs	D 125		

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D 125	Continued From page 2	D 125		

Clinical Skills Competency Validation Checklist and the BOC was responsible for tracking and filing the completed documentation in personnel records.
-She was not aware Staff E did not have a Clinical Skills Competency Validation Checklist until yesterday evening (07/01/26).
-She was not the RCD when Staff E was hired in March 2025 and she had only been the RCD since December 2025.

Interview with the Corporate Senior RCD on 07/02/26 at 11:03am revealed:
-The RCD was responsible for completing MAs Clinical Skills Competency Validation Checklist and for providing the documentation to the facility's BOC.
-The BOC was responsible for tracking MAs qualifications and ensuring the documentation was stored in the personnel files.
-She was not aware Staff E did not have a Clinical Skills Competency Validation Checklist until yesterday evening (07/01/26) and must have been overlooked by the facility's previous RCD.
-She was aware the MAs were required to have the documentation for completion of the Clinical Skills Competency Validation Checklist prior to administering medications.

Interview with the Administrator on 07/02/26 at 11:10am revealed:
-All MAs were required to have the documentation for completion of the Clinical Skills Competency Validation Checklist prior to administering medications.
-The RCD were responsible for verifying MA staff qualification or completing necessary training and the BOC kept personnel records in her office.
-She was not aware Staff E did not have a Clinical Skills Competency Validation Checklist

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D 125	Continued From page 3 until yesterday evening (07/01/26). -She expected the RCD and the BOC to have all MAs documentation of qualifications completed and filed in the personnel records. Interview with Staff E on 07/02/26 at 11:40am revealed: -The previous RCD had completed her training and her Clinical Skills Competency Validation Checklist a couple of months after she was hired in March 2025. -She was aware she was required to be checked off on Clinical Skills Competency Validation Checklist prior to administering medications. -She was not aware the administration staff did not have her Clinical Skills Competency Validation Checklist and she relied on them to retain her personnel files.	D 125		
D 349	10A NCAC 13F .1002 (f) Medication Orders 10A NCAC 13F .1002 Medication Orders (f) The facility shall assure that all current orders for medications or treatments, including standing orders and orders for self-administration are reviewed and signed by the resident's physician or prescribing practitioner at least every six months. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure that all current orders for self-administration were reviewed and signed by the resident's physician or prescribing practitioner at least every six months for 1 of 7 residents (#4).	D 349		

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D 349	Continued From page 4 The findings are: Review of Resident #4's current FL-2 dated 02/17/26 revealed: -Diagnoses included quadriplegia, hypothyroidism, hyperlipidemia, lymphedema, vitamin D deficiency, and type 2 diabetes. -There was an order for tizanidine 10mg (used to treat muscle spasms) 1 tablet every 8 hours as needed for muscle spasms. -There was an order for aspirin 81mg (used to treat prevent heart attacks) 1 tablet daily. -There was an order for furosemide 20mg (used to treat fluid retention and hypertension) 1 tablet daily. -There was an order for miralax 17gm (used to treat constipation) 1 capful daily. -There was an order for potassium chloride 10mEq (used to treat and prevent low blood levels of potassium) 1 tablet daily. -There was an order for senna 8.6mg (used to treat constipation) 2 tablets daily. -There was an order for acetaminophen 325mg (used to treat pain) 2 tablets every 6 hours as needed for pain and fever. -There was an order for albuterol 90mcg (used to treat wheezing and shortness of breath) 2 puffs every 6 hours as needed for wheezing. -There was an order for baclofen 10mg (used to treat muscle spasticity, stiffness, and spasms) 1 tablet twice daily. -There was an order for vitamin D3 (used to treat vitamin D deficiency) 1 tablet daily. -There was an order for bisacodyl suppository 10mg (used to treat constipation) insert 10mg daily as needed for constipation. -There was an order for vitamin B12 1000mcg (used to treat vitamin B12 deficiency) 1 tablet daily. -There was an order for ferrous sulfate 45mg	D 349		

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(used to treat iron deficiency) 1 tablet daily.
-There was an order for famotidine 20mg (used to treat acid reflux) 1 tablet daily.
-There was an order for ketoconazole 2% cream (used to treat rash) apply every 12 hours as needed.
-There was an order for levothyroxine 125mcg (used to treat hypothyroidism) 1 tablet every morning.
-There was an order for magnesium oxide 400mg (used to treat constipation, heartburn, indigestion, and to supplement magnesium) 1 tablet twice daily.
-There was an order for melatonin 3mg (used to treat insomnia) 1 tablet every night.
-There was an order for multivitamin (used to treat vitamin deficiency) 1 tablet daily.
-There was an order for omega 3 fish oil 1000mg (used to support heart, brain, joint, and overall cellular health) 1 capsule twice daily.
-There was an order for pentoxifylline 400mg (used to improve blood flow and reduce leg pain) 1 tablet twice daily.
-There was an order for furosemide 20mg (a medication used to treat fluid retention and hypertension) 1 tablet daily as needed for swelling.
-There was an order for geri-tussin 15mL (a medication used to treat cough) 15mL every 8 hours as needed.
-There was an order for mupirocin 2% (used to treat bacterial skin infections) apply between legs every shift until healed.

Review of Resident #4's record revealed:
-There was a physician's order for self-administration dated 03/31/25.
-There was no current six-month signed medication self-administration physician's orders for review.

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D 349	Continued From page 6 Review of Resident #4's June electronic medication administration record (eMAR) revealed there was documentation Resident #4 self-administered all of her medications from 06/17/26 to 06/30/26. Interview with Resident #4 on 07/01/26 at 2:07pm revealed: -She had her medication self-administration privileges revoked in August or September of 2025 because the facility feared she was not taking her medications as ordered. -She received her medication self-administration privileges back a few weeks ago. -She thought the facility did everything they needed to do on their end so she could self-administer her medications. -She was not aware that there was no current six-month signed medication self-administration physician's orders. Telephone interview with Resident #4's PCP on 06/30/26 at 2:50pm revealed she did not recall signing 6 months self-administration orders for Resident #4 until that day, 06/30/26. Interview with the Resident Care Director (RCD) on 07/02/26 at 11:09am revealed: -She was not aware Resident #4 did not have current six-month signed medication self-administration physician's orders. -She was aware residents who self-administered their medications were required to have signed medication self-administration physician's orders every 6 months or upon a significant change. -The Corporate Senior Resident Care Director (RCD) was in charge of obtaining medication self-administration orders from residents' providers.	D 349		

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D 349	Continued From page 7 -There was no system in place to remind staff when 6-month medication self-administration orders were due. -She expected all residents who self-administer medication to have current self-administration physician's orders every 6 months or upon a significant change. Interview with the Corporate Senior RCD on 07/02/26 at 11:25am revealed: -She was aware residents who self-administered their medications were required to have signed medication self-administration physician's orders every 6 months or upon a significant change. -There was a delay in obtaining Resident #4's signed medication self-administration orders because she saw an outside provider. -She was aware Resident #4 should not have self-administered her medications until the signed physicians order was received. -She expected all residents who self-administer medication to have current self-administration physician's orders every 6 months or upon a significant change. Interview with the Administrator on 07/02/26 at 11:55am revealed: -She was aware residents who self-administered their medications were required to have signed medication self-administration physician's orders every 6 months or upon a significant change. -She expected all residents who self-administer medication to have current self-administration physician's orders every 6 months or upon a significant change.	D 349		
D 358	10A NCAC 13F .1004 (a) Medication Administration	D 358		

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D 358	Continued From page 8 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 1 of 7 sampled residents including a resident with an order for a blood pressure medication with parameters to hold if blood pressure or pulse rate was outside the parameters (#2). The findings are: Review of Resident #2's current FL2 dated 11/13/25 revealed: -Diagnoses included chronic kidney disease, and essential primary hypertension. -There was an order for metoprolol tartrate (used to treat hypertension) 25mg twice a day.-Resident #2 was non-ambulatory Review of Resident #2's current signed physician's orders dated 06/30/2601/13/26 revealed an order for metoprolol tartrate 25mg twice a day for essential primary hypertension. Review of Resident #2's physician order dated 03/31/26 revealed an order for metoprolol 25mg twice a day. Hold for systolic blood pressure (SBP) less than 110 or pulse rate less than 65. Review of Resident #2's current signed	D 358		

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physician's orders dated 06/30/26 revealed an order for metoprolol 25mg twice a day. Hold for systolic blood pressure (SBP) less than 110 or pulse rate less than 65.

Review of Resident #2's April 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for metoprolol 25mg two times a day related to essential primary hypertension. Hold for systolic blood pressure (SBP) less than (<)110 or pulse rate < 65 scheduled for administration 7:00-9:00am and 7:00-9:00pm.
-There was an entry for blood pressure (BP) results and pulse rate documentation scheduled for administration 7:00-9:00am and 7:00-9:00pm.
-The range for systolic blood pressure values documented from 04/01/26 to 04/30/26 was 90 to 132 at 7:00-9:00am; and from 101 to 151 at 7:00-9:00pm.
-The range for the pulse rate documented from 04/01/26 to 04/30/26 was 74 to 90 at 7:00-9:00am; and from 64 to 102 at 7:00-9:00pm.
-Metoprolol 25mg was documented as held and should have been administered on 04/21/26 at 7:00-9:00am with SBP of 124 and pulse of 70, and on 04/22/26 with SBP of 127 and pulse rate of 84.
-Metoprolol 25mg was administered and should have been held 7 days at 7:00-9:00pm as follows: on 04/06/26, 04/18/26, 04/20/26 the SBP was less than 110; and on 04/09/26, 04/16/26, 04/21/26, and 04/22/26 the pulse rate was 64.

Review of Resident #2's May 2026 eMAR revealed:
-There was an entry for metoprolol 25mg two times a day related to essential primary hypertension. Hold for systolic blood pressure

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(SBP) less than (<)110 or pulse rate < 65 scheduled for administration 7:00-9:00am and 7:00-9:00pm.
-There was an entry for blood pressure (BP) results and pulse rate documentation scheduled for administration 7:00-9:00am and 7:00-9:00pm.
-The range for systolic blood pressure values documented from 05/01/26 to 05/31/26 was 97 to 132 at 7:00-9:00am; and from 101 to 151 at 7:00-9:00pm.
-The range for the pulse rate documented from 05/01/26 to 05/31/26 was 60 to 78 at 7:00-9:00am; and from 62 to 87 at 7:00-9:00pm.
-Metoprolol 25mg was documented as held and should have been administered at 7:00-9:00am on 05/12/26 with SBP of 125 and pulse rate 76, on 05/13/26 with SBP of 126 and pulse rate of 72 and on 05/24/26 with SBP of 116 and pulse rate of 66; and at 7:00-9:00pm on 05/24/26 with SBP of 117 and pulse rate of 67.
-Metoprolol 25mg was administered and should have been held on days at 7:00-9:00pm as follows: on 05/04/26 pulse rate was 62, on 05/09/26 SBP was 108, and on 05/20/26 pulse rate was 62.

Review of Resident #2's June 2026 eMAR revealed:
-There was an entry for metoprolol 25mg two times a day related to essential primary hypertension. Hold for systolic blood pressure (SBP) less than (<)110 or pulse rate < 65 scheduled for administration 7:00-9:00am and 7:00-9:00pm.
-There was an entry for blood pressure (BP) results and pulse rate documentation scheduled for administration 7:00-9:00am and 7:00-9:00pm.
-The range for systolic blood pressure values documented from 06/01/26 to 06/30/26 was 99 to 138 at 7:00-9:00am; and from 94 to 154 at

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D 358	Continued From page 11 7:00-9:00pm. -The range for the pulse rate documented from 06/01/26 to 06/30/26 was 60 to 85 at 7:00-9:00am; and from 66 to 105 at 7:00-9:00pm. -Metoprolol 25mg was documented as held and should have been administered at 7:00-9:00am on 06/16/26 with SBP of 112 and pulse rate 75. -Metoprolol 25mg was administered and should have been held at 7:00-9:00pm on 06/26/26 with SBP of 94. Observation of Resident #2's metoprolol 25mg available for administration on 07/01/26 at 3:35pm revealed: -There were 2 bingo card of 28 on each card dispensed on 06/23/26 for 56 tablets with 49 tablets remaining. -The metoprolol 25mg was labeled for one tablet twice a day. -There were no parameters for administration on the medication dispensed label from the contracted pharmacy. Interview with a medication aide (MA) on 07/01/26 at 1:45pm revealed: -She was aware Resident #2 had parameters to hold her metoprolol 25mg. -The medication aides were supposed to read the eMAR completely when administering medication paying attention to medications that had administration parameters. -If she was hurried or interrupted, she must have misread the parameters to hold the metoprolol 25mg for pulse less than 65 and held the medication for diastolic BP less than 65. Interview with a second MA on 07/01/26 at 3:50pm revealed: -She was aware Resident #2 had parameters to hold her metoprolol 25mg.	D 358		

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D 358	Continued From page 12 -She administered medications using the medication label and the eMAR. -The medication aides were supposed to read the eMAR completely when administering medication paying attention to medications that had administration parameters. -She had not seen the parameters for administration of Resident #2's metoprolol 25mg. -The parameters did not appear on the medication label sent by the facility's contracted pharmacy. Telephone interview with Resident #2's primary care provider (PCP) on 07/02/26 at 9:15am revealed: -Resident #2 had parameters for administering metoprolol 25mg due to the medication slowing heart rate as well as lowering BP. -Slow heart rate (bradycardia) and low blood pressure could cause dizziness, or lightheadedness and possibility increase the risk for falls or malaise. -She would expect the MAs to administer medications according to the parameters she had specified. -The facility had not made her aware of any negative side effects for Resident #2. -She had not had any complaints from the resident. Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/02/26 at 9:30am revealed: -The facility was responsible for sending all orders to the pharmacy for preparing medications. -The facility staff entered the residents' medication orders into the facility's eMAR system. -The pharmacy computer system did not communicate with the facility's computer system.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034026	A. BUILDING: _____ B. WING _____	R 07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF WINSTON SALEM	2601 REYNOLDA ROAD WINSTON SALEM, NC 27106

(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 -There was no documentation for the order dated 03/31/26 for metoprolol 25mg parameters available for review at the pharmacy. -Resident #2's metoprolol 25mg was filled on 28 days cycle fill beginning 11/20/25 for 56 tablets labeled one tablet twice a day per the original FL2 order. -The facility was responsible for notifying the pharmacy if there were contradicting or incomplete orders since the facility managed their own eMARS. Interview with Resident #2 on 07/02/26 at 10:55am revealed: -She was non-ambulatory due to health-related issues. -Staff assisted her with bathing and attended her catheter care. -Staff managed her medications. -She did not have any issues with her medications. Interview with the Resident Care Director (RCD) on 07/02/26 at 11:05am revealed: -The facility generated residents' eMARs. -Medication orders were entered by the in the medication room by the Wellness Nurse (WN) and she was responsible for faxing orders to the facility's contracted pharmacy and ensuring medication orders were current and correct. The the RCD and the Memory Care Director (MCD) routinely checked the orders and the eMAR for a second check for accuracy and completeness. -The MAs could fax orders to the pharmacy. -The facility did not have a system in place to routinely audit eMARS for accuracy of medication administration. -She did not know Resident #2's metoprolol 25mg was incorrectly administered according to the parameters since she had not been auditing the	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BRIGHTON GARDENS OF WINSTON SALEM	2601 REYNOLDA ROAD WINSTON SALEM, NC 27106

(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 14 eMARs. Interview with the Corporate Senior Resident Care Director on 07/02/2026 at 11:25am revealed: -The Wellness Nurse enters the residents' medication orders in the facility's eMAR system. -There should be a second look by the RCD, or MCD for check of accuracy. -The RCD was responsible for auditing the eMARs for documentation related to accuracy and completeness of medication administration. Interview with the Administrator on 07/02/26 at 11:55am revealed: -The RCD was responsible to ensure medication is administered as ordered. -The RCD was responsible for performing routine audits for medication administration to ensure the residents were receiving medications as ordered. -She had not been made aware of Resident #2's metoprolol 25mg administration errors.	D 358		