

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060042	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 07/15/2026
NAME OF PROVIDER OR SUPPLIER BROOKDALE WEDDINGTON PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 2404 PLANTATION CENTER DRIVE MATTHEWS, NC 28105		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and Mecklenburg County Department of Social Services conducted an annual and follow-up survey from July 14, 2026 to July 15, 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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 4 of 5 sampled residents (#1, #2, #3 & #5) related to medications to treat fluid retention and high blood sugar (#3), hypertension (#1 & #5) vitamin D deficiency (#2) and to reduce the risk of a stroke (#5). The findings are: 1. Review of Resident #3's current FL2 dated 05/01/26 revealed diagnoses included congestive heart failure (CHF), diabetes mellitus type II and chronic kidney disease (CKD). Review of Resident #3's Resident Register revealed an admission date of 03/20/26.	D 358		

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

TITLE

(X6) DATE

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D 358	Continued From page 1 a. Review of Resident #3's signed physician order dated 05/04/26 revealed an order for furosemide (to treat fluid retention) 20mg by mouth in the morning. Review of Resident #3's Nephrologist visit notes dated 06/15/26 revealed: -The purpose of visit was renal (kidney) failure. -There was an order to discontinue furosemide 20mg and check renal panel in two weeks. -His creatinine level was 2.2 (normal result 0.5-1.1) and glomerular filtration rate (GFR) was 22 (normal result 90). Review of Resident #3's June 2026 electronic medication administration record (eMAR) revealed: -There was an entry for furosemide 20mg by mouth in the morning. -Furosemide 20mg was documented as administered from 06/01/26 through 06/30/26 at 8:00am. Review of Resident #3's July 2026 eMAR revealed: -There was an entry for furosemide 20mg by mouth in the morning. -Furosemide 20mg was documented as administered from 07/01/26 through 07/14/26 at 8:00am. Observation of Resident #3's medications on hand on 07/14/26 at 2:54pm revealed furosemide 20mg was available for administration. Review of Resident #3's Primary Care Provider (PCP) progress note dated 07/08/26 revealed: -Resident #3 had a diagnosis of CKD, stage 4. -Nephrology discontinued furosemide and advised follow-up in three months.	D 358			

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D 358	Continued From page 2 -Resident #3's most recent GFR of 22 and creatinine of 2.2. -A renal panel was attempted as requested by nephrology but the resident refused. Telephone interview with a Pharmacist with the facility's contracted pharmacy on 07/15/26 at 8:55am revealed: -Resident #3 had an order for furosemide 20mg by mouth in the morning. -The pharmacy did not receive an order to discontinue Resident #3's furosemide 20mg. -Resident #3 could experience dehydration and develop serious kidney issues from receiving furosemide when not needed. Interview with Resident #3 on 07/15/26 at 11:24am revealed: -Staff administered her medications but she did not know all the medications she was taking. -She did not know furosemide had been discontinued by the Nephrologist. Telephone interview with a Registered Nurse (RN) with Resident #3's Nephrologist's office on 07/15/26 at 10:11am revealed: -Resident #3 had an office visit on 06/15/26. -The Nephrologist discontinued Resident #3's furosemide on 06/15/26. -The Nephrologist documented in Resident #3's visit note on 06/15/26 that her furosemide was discontinued due to the resident being dehydrated. -The Nephrology office did not receive any notification from the facility Resident #3 was still receiving furosemide 20mg. Interview with Resident #3's PCP on 07/15/26 at 12:14pm revealed: -She did not know Resident #3's furosemide	D 358		

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D 358	Continued From page 3 20mg had not been discontinued or that the resident was still being administered furosemide. -Resident #3's furosemide was discontinued to see if her kidney function would improve. Interview with a medication aide (MA) on 07/15/26 at 1:10pm revealed: -She did not know Resident #3 had an order to discontinue furosemide 20mg. -The MAs were responsible for scanning or faxing medication orders to the pharmacy. -After medication orders were sent to the pharmacy, MAs were responsible for entering orders into the eMAR system, including discontinuation orders. Interview with the Resident Care Coordinator (RCC) on 07/15/26 at 3:33pm revealed: -She did not know Resident #3 had an order to discontinue furosemide 20mg until yesterday (07/14/26). -Resident #3's order to discontinue furosemide 20mg was missed and must have been placed in the resident's record. Interview with the Health and Wellness Director (HWD) on 07/15/26 at 4:33pm revealed: -She did not know Resident #3 had an order to discontinue furosemide 20mg until yesterday (07/14/26). -Resident #3's order to discontinue furosemide 20mg was missed. -She should have been ensuring medication orders were placed into the eMAR correctly but she had not. Interview with the Administrator on 07/15/26 at 5:06pm revealed she did not know Resident #3 had an order to discontinue furosemide 20mg until yesterday (07/14/26).	D 358		

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D 358	Continued From page 4 Refer to the interview with the RCC on 07/15/26 at 3:37pm. Refer to the interview with the HWD on 07/15/26 at 4:32pm. Refer to the interview with the Administrator on 07/15/26 at 5:07pm. b. Review of Resident #3's signed physician order dated 06/04/26 revealed an order for insulin Lispro (insulin used to lower blood sugar) 100units/ml, inject 6 units three times daily before meals; hold if blood sugar (BS) reading is less than 150. Review of Resident #3's June 2026 eMAR revealed: -There was an entry for Lispro 100units/ml, 6 units three times daily before meals; hold if BS reading is less than 150. -There was an entry for blood sugar checks before each meal. -On 06/14/26 at 8:00am, there was a BS reading of 145 documented and Lispro 100units/ml, 6 units was documented as administered. -On 06/18/26 at 12:00pm, there was a BS reading of 134 documented and Lispro 100units/ml, 6 units was documented as administered. -On 06/30/26 at 5:00pm, there was a BS reading of 139 documented and Lispro 100units/ml, 6 units was documented as administered. -Lispro 100units/ml 6 units was administered on three occasions when Resident #3's BS was less than 150. Review of Resident #3's July 2026 eMAR revealed: -There was an entry for Lispro 100units/ml, 6	D 358		

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D 358	Continued From page 5 units three times daily before meals; hold if BS reading is less than 150. -There was an entry for blood sugar checks before each meal. -On 07/02/26 at 8:00am, there was a BS reading of 143 documented and Lispro 100units/ml, 6 units was documented as administered. -On 07/08/26 at 8:00am, there was a BS reading of 146 documented and Lispro 100units/ml, 6 units was documented as administered. -On 07/08/26 at 12:00pm, there was a BS reading of 143 documented and Lispro 100units/ml, 6 units was documented as administered. -On 07/09/26 at 8:00am, there was a BS reading of 142 documented and Lispro 100units/ml, 6 units was documented as administered. -Lispro 100units/ml 6 units was administered on four occasions when Resident #3's BS was less than 150. Observation of Resident #3's medications on hand on 07/14/26 at 2:54pm revealed Lispro 100 unit/ml was available for administration. Interview with Resident #3 on 07/15/26 at 11:24am revealed: -She knew she was not to have insulin if her BS was less than 150. -Staff usually told her what her BS reading was. -She did not know she had received insulin when she should not have. Interview with a medication aide (MA) on 07/15/26 at 1:10pm revealed: -She knew Resident #3 was not to receive Lispro if his BS was less than 150. -She did not administer Lispro to Resident #3 when his BS was less than 150 although the eMAR indicated she did administer his insulin. -She incorrectly documented in the eMAR	D 358			

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D 358	Continued From page 6 system. -There was no documentation available in the eMAR system stating resident Lispro was not administered. Interview with the Resident Care Coordinator (RCC) on 07/15/26 at 3:33pm revealed: -She did not know Resident #3 had received Lispro when outside of parameters. -The MAs were responsible for following all physician orders. -If Resident #3's BS were outside of parameters, MAs were responsible for entering a note into the eMAR with documentation of the residents BS reading and that insulin was not administered. -There were no audits completed to ensure medications were administered according to ordered parameters. Interview with the Administrator on 07/15/26 at 5:06pm revealed: -She did not know Resident #3 had received Lispro when her BS readings were outside of parameters until yesterday (07/14/26). -There were no audits completed to ensure medications were administered according to ordered parameters. Telephone interview with a Pharmacist with the facility's contracted pharmacy on 07/15/26 at 8:55am revealed Resident #3 receiving insulin when not indicated could cause the resident to experience dizziness, lightheadedness and be at risk of falling. Interview with Resident #3's PCP on 07/15/26 at 12:17pm revealed: -She did not know Resident #3 received Lispro when her BS reading was less than 150. -She expected the MAs to follow orders and	D 358		

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D 358	Continued From page 7 parameters. -Resident #3 could experience hypoglycemic (when BS drops below a safe level) episodes, especially if the resident did not eat all of her meal after receiving insulin. Refer to the interview with the RCC on 07/15/26 at 3:37pm. Refer to the interview with the HWD on 07/15/26 at 4:32pm. Refer to the interview with the Administrator on 07/15/26 at 5:07pm. 2. Review of Resident #5's current FL2 dated 11/26/25 revealed diagnoses included atrial fibrillation and transient cerebral ischemic attack (mini-stroke). a. Review of Resident #5's current FL2 dated 11/26/25 revealed: -There was an order for warfarin 3mg (a medication to decrease blood clotting time), one tablet on Mondays, Wednesdays and Fridays. -There was an order for warfarin 1.5mg, give 1.5mg on Tuesdays, Thursdays, Saturdays, and Sundays. Review of Resident #5's signed Nurse Practitioner's (NP) orders dated 03/18/26 revealed: -There was an order for warfarin 3mg, one tablet on Mondays, Wednesdays and Fridays. -There was an order for warfarin 1.5mg, give 1.5mg on Tuesdays, Thursdays, Saturdays, and Sundays. Review of Resident #5's NP order dated 07/05/26 revealed there was an order to hold Resident #5's	D 358		

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D 358	Continued From page 8 warfarin starting 07/06/26 for 48 hours and then resume the resident's normal dosing. Review of Resident #5's July 2026 electronic medication administration record (eMAR) revealed: -There was an entry for warfarin 3mg on Mondays, Wednesdays and Fridays with a start date of 11/16/25 and a discontinue date of 07/05/26 with administration documented on 07/01/26 and 07/03/26. -There was an entry for warfarin 1.5mg on Tuesdays, Thursdays, Saturdays, and Sundays with a start date of 11/16/25 and a discontinue date of 07/05/26 with administration documented on 07/02/26, 07/04/26 and 07/05/26. -There was an entry for warfarin 3mg, one-half tablet (1.5mg) on Tuesdays, Thursdays, Saturdays and Sundays with a start date of 07/12/26 with administration documented on 07/12/26. -There was an entry for warfarin 3mg, one tablet on Mondays, Wednesdays and Fridays with a start date of 07/13/26 with administration documented on 07/13/26. -Warfarin was not documented as administered from 07/08/26 through 07/11/26. Observation of Resident #5's medications on hand on 07/15/26 at 11:08am revealed: -There was a bubble pack containing warfarin 3mg, 24 tablets available for administration for Resident #5 with a "start date" of 07/08/26. -There was a bubble pack containing warfarin 3mg, 13 half tablets (1.5mg) available for administration for Resident #5 with a "start date" of 07/08/26. Interview with Resident #5 on 07/15/26 at 9:55am revealed:	D 358		

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D 358	Continued From page 9 -She was prescribed warfarin because she had a stroke in 2013. -She did not know if there was a time she did not receive her warfarin. -The medication aides (MA) brought her the medications she was to take. Telephone interview with a Pharmacist with the facility's contracted pharmacy on 07/15/26 at 8:36am revealed: -Resident #5 had two current orders for warfarin. -Resident #5 had an order dated 07/08/26 for warfarin 3mg, one tablet on Mondays, Wednesdays and Fridays. -Resident #5 had a second order dated 07/08/26 for warfarin 3mg, one-half tablet (1.5mg) on Tuesdays Thursdays, Saturdays and Sundays. -If Resident #5 did not receive warfarin as ordered she could experience a stroke or a pulmonary embolism (blood clot in the lung). Interview with a MA on 07/15/26 at 11:20am revealed: -The Health and Wellness Director (HWD) or the Resident Care Coordinators (RCC) usually entered resident medication orders in the eMAR, but MAs were able to enter them if the HWD or RCCs were not available, like on weekends. -If a MA received an order, they were responsible for entering it into the eMAR system, scanning the order to the pharmacy and placing a copy of the order in a folder for the HWD or RCCs to review for accuracy. -She did not know why Resident #5's warfarin was not restarted as ordered. Interview with Resident #5's NP on 07/15/26 at 12:20pm revealed: -Resident #5 was prescribed warfarin because she was diagnosed with atrial fibrillation and was	D 358		

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D 358	Continued From page 10 at risk for blood clots. -She placed Resident #5's warfarin on hold for 48 hours on 07/05/26 because her blood was supratherapeutic (too thin). -Resident #5's warfarin did not start after 48 hours (on 07/08/26) as was ordered. -She was notified on 07/12/26 by a RCC that Resident #5's warfarin was not re-started on 07/08/26. -Resident #5's warfarin was restarted on 07/12/26. -Resident #5 was at risk of having a stroke if she was not administered her warfarin as ordered. Interview with a RCC on 07/15/26 at 3:33pm revealed: -The MAs were responsible for entering medication orders into the eMAR system and scanning the order to the clinical managers and pharmacy. -The MAs were to put a copy of all orders entered into the eMAR in a "box" in the medication room. -The RCCs or HWD were responsible for reviewing the orders entered for accuracy. -She discovered Resident #5's warfarin order had not been restarted as ordered during an audit on 07/11/26 and contacted the NP for guidance. Interview with the HWD on 07/15/26 at 4:32pm revealed: -During an audit, a RCC identified Resident #5's warfarin had not been restarted as ordered. -She thought the MA that entered the order to hold Resident #5's warfarin in the eMAR system probably did not know how to place the warfarin on hold and just discontinued the warfarin orders. Interview with the Administrator on 07/15/26 at 5:06pm revealed: -It was discovered during an audit by a RCC that	D 358		

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D 358	Continued From page 11 Resident #5's warfarin was not restarted as ordered. -The RCC informed her and the resident's NP when she discovered the error. Refer to the interview with the RCC on 07/15/26 at 3:37pm. Refer to the interview with the HWD on 07/15/26 at 4:32pm. Refer to the interview with the Administrator on 07/15/26 at 5:07pm. b. Review of Resident #5's signed Nurse Practitioner's (NP) orders dated 06/01/26 revealed: -There was an order for carvedilol (a medication to treat high blood pressure) 25mg, one tablet twice daily. -Resident #5's carvedilol 25mg, one tablet was to be held for heart rate less than 60 or systolic blood pressure less than 110. Review of Resident #5's June 2026 electronic medication administration record (eMAR) revealed: -There was an entry for carvedilol 25mg, one tablet twice daily scheduled at 9:00am and 9:00pm and hold if heart rate was less than 60 or systolic blood pressure was less than 110. -There were three of 60 opportunities when carvedilol 25mg, one tablet was administered to Resident #5 when her heart rate was less than 60 or her systolic blood pressure was less than 110. -There was documentation carvedilol 25mg, one tablet was administered to Resident #5 on 06/05/26 at 9:00am when her heart rate was 59. -There was documentation carvedilol 25mg, one tablet was administered to Resident #5 on	D 358		

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D 358	Continued From page 12 06/08/26 at 9:00pm when her systolic blood pressure was 104. -There was document carvedilol 25mg, one tablet was administered to Resident #5 on 06/24/26 at 9:00am when her systolic blood pressure was 108. Observation of Resident #5's medications on hand on 07/15/26 at 11:08am revealed: -There was a bubble pack containing carvedilol 25mg, 13 tablets available for administration for Resident #5 with a "start date" of 07/08/26. -There was a second bubble pack containing carvedilol 25mg, 26 tablets available for administration for Resident #5 with a "start date" of 07/08/26. -The medication label on both carvedilol 25mg bubble packs for Resident #5 indicated the medication was to be held for heart rate less than 60 or systolic blood pressure less than 110. Interview with Resident #5 on 07/15/26 at 9:55am revealed: -She did not know when her carvedilol 25mg, one tablet was to be held. -The medication aides (MA) brought her the medications she was to take. Telephone interview with a Pharmacist with the facility's contracted pharmacy on 07/15/26 at 8:36am revealed: -Resident #5 had a current order for carvedilol 25mg, one tablet twice daily. -Resident #5's carvedilol 25mg, one tablet twice daily was to be held for heart rate less than 60 or systolic blood pressure less than 110. -If Resident #5 received carvedilol 25mg, one tablet when her heart rate was less than 60 or her systolic blood pressure was less than 110 she could experience orthostatic hypotension (a	D 358		

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NAME OF PROVIDER OR SUPPLIER BROOKDALE WEDDINGTON PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 2404 PLANTATION CENTER DRIVE MATTHEWS, NC 28105		
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D 358	Continued From page 13 sudden drop in blood pressure when standing up) or dizziness which could lead to falls. Interview with a MA on 07/15/26 at 11:20am revealed: -The MAs were responsible for administering medications as ordered to the residents. -Resident #5's carvedilol 25mg, one tablet was not to be administered when her blood pressure or heart rate was outside of the ordered parameters. -She did not know why she documented she administered Resident #5's carvedilol at 9:00am on 06/05/26 and 06/24/26. -She thought she may have accidentally documented she administered Resident #5's carvedilol 25mg, one tablet at 9:00am on 06/05/26 and 06/24/26 because she was very careful to hold the resident's medication when her pulse and or heart rate were outside of parameters. Interview with Resident #5's NP on 07/15/26 at 12:20pm revealed: -She placed parameters on the resident's carvedilol 25mg, one tablet twice daily order as a "safety net" so her blood pressure or heart rate did not drop too low. -The MAs needed to hold Resident #5's carvedilol 25mg, one tablet twice daily if her blood pressure or pulse was outside of parameters. -Resident #5 could experience dizziness which could lead to falls if her heart rate or blood pressure dropped too low. Interview with a RCC on 07/15/26 at 3:33pm revealed: -The MAs were responsible for administering medications as ordered. -The MAs should pay close attention to orders	D 358			

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D 358	Continued From page 14 containing parameters. -There were no audits completed to ensure medications were administered according to ordered parameters. Interview with the HWD on 07/15/26 at 4:32pm revealed: -The MAs were responsible for administering medications as ordered, including ordered parameters. -She completed training approximately a month ago with all MAs regarding parameters because she had found some issues with medications being administered outside of parameters. -There were no audits completed to ensure medications were administered according to ordered parameters. Interview with the Administrator on 07/15/26 at 5:06pm revealed: -The MAs were responsible for administering medications as ordered, including ordered parameters. -There were no audits completed to ensure medications were administered according to ordered parameters. Refer to the interview with the RCC on 07/15/26 at 3:37pm. Refer to the interview with the HWD on 07/15/26 at 4:32pm. Refer to the interview with the Administrator on 07/15/26 at 5:07pm. 3. Review of Resident #1's current FL2 dated 03/13/26 revealed: -Diagnoses included hypertension and dementia. -There was an order for carvedilol 25mg one	D 358		

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D 358	Continued From page 15 tablet daily, hold if heart rate was less than 70 or systolic blood pressure blood pressure was less than 110. Review of Resident #1's Nurse Practitioner's (NP) order dated 10/03/25 revealed there was an order for carvedilol 25mg, one tablet daily for hypertension. Review of Resident #1's May 2026 electronic medication administration record (eMAR) revealed: -There was an entry for carvedilol tablet 25mg daily for hypertension, hold if heart rate was less than 70 or systolic blood pressure was less than 110. -There were 10 out of 31 opportunities that carvedilol 25 mg, one tablet was documented as administered to Resident #1 when her heart rate was less than 70. -For example, on 05/07/26 and 05/28/26 at 9:00am Resident #1's heart rate was 64 and carvedilol 25mg, one tablet was documented as administered. -For example, on 05/14/26 at 9:00am Resident #1's heart rate was 62 and carvedilol 25mg, one tablet was documented as administered. Review of Resident #1's June 2026 eMAR revealed: -There was an entry for carvedilol tablet 25mg, give one tablet daily for hypertension, hold if heart rate was less than 70 or systolic blood pressure was less than 110. -There were 12 out of 30 opportunities that carvedilol 25 mg, one tablet was documented as being administered to Resident #1 when her heart rate was less than 70. -For example, on 06/11/26 at 9:00am Resident #1's heart rate was 64 and carvedilol 25mg, one	D 358			

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D 358	Continued From page 16 tablet was documented as administered. -For example, on 06/29/26 at 9:00pm Resident #1's heart rate was 58 and carvedilol 25mg, one tablet was documented as administered. Review of Resident #1's July 2026 eMAR revealed: -There was an entry for carvedilol tablet 25mg, give one tablet daily for hypertension, hold if heart rate was less than 70 or systolic blood pressure was less than 110. -There were 7 out of 14 opportunities that carvedilol 25 mg, one tablet was documented as administered to Resident #1 when her heart rate was less than 70. -There were 1 out of 14 opportunities that carvedilol 25 mg, one tablet was documented as administered to Resident #1 when her systolic blood pressure was less than 110. -For example, on 07/10/26 at 9:00am Resident #1's heart rate was 61 and carvedilol 25mg, one tablet was documented as administered. -For example, on 07/02/26 at 9:00am Resident #1's systolic blood pressure was 101 and carvedilol 25mg, one tablet was documented as administered. Observation of medication on hand for Resident #1 on 07/14/26 at 4:40pm revealed there was a bubble pack containing carvedilol 25mg, available for administration. Interview with a medication aide (MA) on 07/15/26 at 1:10pm revealed: -The MAs were responsible for reading each order on the residents' eMARs and administering medications according to the order and all parameters. -She did not know how to look up the vitals for Resident #1 on the computer to confirm if the	D 358			

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D 358	Continued From page 17 medication was administered outside the parameters. Telephone interview with facility's contracted pharmacy on 07/15/26 at 10:40am revealed: -Resident #1 had a current order dated 07/08/26 for carvedilol 25mg, one tablet every morning and hold if heart rate was less than 70 or systolic blood pressure was less than 110. -Carvedilol 25mg, 56 tablets were dispensed on 05/08/26, 06/03/26, and 07/01/26. Interview with Resident #1's NP on 07/15/26 at 12:35 revealed: -Resident's #1's carvedilol 25 mg was to be held if her heart rate was less than 70, or her systolic blood pressure was less than 110. -If carvedilol 25 mg was administered when her heart rate was less than 70, or her systolic blood pressure was less than 110, it could have resulted in falls, dizziness, and decreased heart rate. Refer to the interview with the RCC on 07/15/26 at 3:37pm. Refer to the interview with the HWD on 07/15/26 at 4:32pm. Refer to the interview with the Administrator on 07/15/26 at 5:07pm. 4. Review of Resident #2's current FL2 dated 04/14/26 revealed: -Diagnoses included fracture of right femur, protein calorie malnutrition, unsteadiness on feet, muscle weakness, acute kidney failure, cardiac pacemaker, sick sinus syndrome, and a-fibrillation. -There was an order for cholecalciferol (used to	D 358		

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D 358	Continued From page 18 treat vitamin D deficiency) 50mcg one capsule once daily on Mondays. Review of Resident #2's Resident Register revealed an admission date of 04/25/25. Review of Resident #2's May 2026 electronic medication administration record (eMAR) revealed there was no entry for cholecalciferol 50mcg one capsule once daily on Mondays. Review of Resident #2's June 2026 eMAR revealed there was no entry for cholecalciferol 50mcg one capsule once daily on Mondays. Review of Resident #2's July 2026 eMAR revealed there was no entry for cholecalciferol 50mcg one capsule once daily on Mondays. Observation of medications on hand on 07/14/26 at 4:30pm for Resident #2 revealed: -There were two bubble packs of cholecalciferol 50mcg one capsule once daily on Mondays for June and July with five tablets each in both packs. -The June bubble pack was dispensed 06/03/26 with five capsules. -The July bubble pack was dispensed on 07/01/26 with five capsules. Telephone interview with the facility's contracted pharmacy on 07/15/26 at 10:36am revealed: -The pharmacy received the FL2 order for Resident #2 dated 04/14/26 for cholecalciferol 50mcg one capsule daily on Mondays. -The facility told the pharmacy not to administer the medication until the next cycle fill because they already had the medication on hand to administer. -The first dispense date was 05/06/26 with five	D 358		

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D 358	Continued From page 19 capsules. -The cholecalciferol 50mcg was returned back to the pharmacy from the facility on 06/03/26 with four capsules returned. -The second dispense date was on 06/03/26 with five capsules. -The third dispense date was on 07/01/26 with five capsules. -June and July bubble packs of cholecalciferol 50mcg were returned to the pharmacy from the facility last night (07/14/26) with five capsules returned in each pack. -The facility staff added medications into the eMAR system. Interview with Resident #2 on 07/14/26 at 9:44am and on 07/15/26 at 2:44pm revealed: -She thought she always received the medications she was supposed to receive. -She did not know she was not getting cholecalciferol 50mcg. -She complained of feeling tired and wondered if that was a symptom of not receiving that medication. Interview with a medication aide (MA) on 07/15/26 at 11:07am revealed: -She had never administered cholecalciferol 50mcg to Resident #2. -She thought she had seen the medication on the cart but never administered it because it was not on the eMAR. -She never gave medications if they were not on the eMAR. -If she found a medication that was not on the eMAR, she should ask upper management about it. -She had not asked anyone about cholecalciferol before, she had just never administered it. -When medication orders came in, she would fax	D 358		

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D 358	Continued From page 20 or scan the order to the pharmacy. -If she faxed the order, she would also make a copy of the order and place the order in the "tracking box" so the resident care coordinator (RCC), Health and Wellness Director (HWD), and the Administrator would see the order. -When orders were scanned, an automatic email would get sent to the RCC, HWD, Administrator, and the Pharmacy. -After orders were sent to the Pharmacy, the MAs would put the order into the eMAR. -She did not remember seeing the order for cholecalciferol 50mcg. -She did not know why the medication never got entered into the eMAR. -She thought it must have gotten missed some way but did know how. Interview with another MA on 07/15/26 at 3:27pm revealed: -She never administered cholecalciferol 50mcg to Resident #2. -She returned the medication to pharmacy last night (07/14/26) because she thought it had been discontinued since it was not on the eMAR. -She worked second shift and would not have administered that medication because first shift would have administered it. -She did medication cart audits once a month but never noticed that medication on the cart. -She never saw the order for cholecalciferol 50mcg and she never processed it. -If she ever found a medication on the medication cart that was not on the eMAR, she would send it back to Pharmacy. -When new orders were sent to the facility and she received them, she would scan or fax to the pharmacy and called pharmacy to make sure they received it. -She would enter the medication on the eMAR	D 358		

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D 358	Continued From page 21 after it was scanned or faxed. -If she had any questions about medications, she would ask the HWD or the RCC. Interview with the facility's contracted nurse practitioner (NP) on 07/15/26 at 12:15pm revealed: -She prescribed cholecalciferol 50mcg to Resident #2 due to the resident having vitamin D deficiency. -She did not think Resident #2 suffered any negative impact from not receiving cholecalciferol. -Resident #2's vitamin D would continue to be deficient, but no other negative impact. -She did not know until yesterday (07/14/26) that Resident #2 had not been receiving cholecalciferol. Interview with the RCC on 07/15/26 at 3:37pm revealed: -She just started auditing charts and had not gotten to Resident #2's chart yet. -She did not know Resident #2 had not been receiving cholecalciferol 50mcg once weekly. -She thought it was an oversight. Interview with the HWD on 07/15/26 at 4:32pm revealed: -She did not know Resident #2 had not been getting cholecalciferol 50mcg once weekly. -She did not know how the medication for Resident #2 got missed. Interview with the Administrator on 07/15/26 at 5:07pm revealed: -She did not know Resident #2 had not been receiving cholecalciferol 50mcg once weekly. -She was not sure how the medication for Resident #2 got missed.	D 358			

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D 358	Continued From page 22 Refer to the interview with the RCC on 07/15/26 at 3:37pm. Refer to the interview with the HWD on 07/15/26 at 4:32pm. Refer to the interview with the Administrator on 07/15/26 at 5:07pm. Interview with the RCC on 07/15/26 at 3:37pm revealed: -She had been the RCC at the facility since 2017. -They had issues in the past with medications orders getting processed. -Within the last three months, they had began a new system with scanning orders and it would automatically email the pharmacy and all the clinical staff. -When orders were faxed in the past, the MAs would sometimes forget to place the order sheet in the "tracking box" and orders would get missed by clinical staff and they would not find out about the medications. -She expected MAs to do medication cart audits weekly and to compare medications to the eMAR. -She was not sure if medication cart audits were happening weekly because the MAs did not always document medication cart audits. -She did not think audits were being done consistently. -She just recently started full auditing where she would audit the eMAR to the cart and then look at the charts. Interview with the HWD on 07/15/26 at 4:32pm revealed: -Orders would come three different ways; by fax, walk-ins through doctor appointments, and email. -Once the orders were received, the MA would	D 358		

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D 358	Continued From page 23 scan orders and it would automatically email the clinical team and pharmacy. -She expected MAs to compare the order to what was entered in the eMAR. -She thought some things with orders got overlooked and the system had been "slack." -Orders sometimes got overlooked if the staff did not notify the RCC and HWD and medications got missed. -Audits had not been done consistently. -If medications were on the medication cart, but not entered into the eMAR, the MAs should check with clinical team, call pharmacy, and call the Primary Care Physician (PCP) to verify if the order was still active. -She expected MAs to compare all medications with the the eMAR. -She expected MAs to do weekly cart audits. -She and the HWD were to check behind MAs monthly. -Documentation of medication cart audits had not been consistent. Interview with the Administrator on 07/15/26 at 5:07pm revealed: -She expected the MAs to compare the medication to the eMAR before administration. -If something did not match up, the MAs should report to clinical staff. -If a medication was found on the cart that was not on the eMAR, they should report it to clinical staff. -MAs entered orders into the eMAR after they were faxed or scanned to pharmacy. -Copies would be placed in the "tracking folder" by MAs. -Sometimes MAs would forget to place copies in the "tracking folder," and medications got missed. -Audits were not happening consistently. -She expected MAs, RCC, and HWD to do audits	D 358		

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D 358	Continued From page 24 weekly. -She did not think documentation of audits were happening consistently. The facility failed to ensure medications were administered as ordered for Resident #3 who had diagnoses of kidney failure and diabetes when she received a medication discontinued by her Nephrologist for fluid retention in order to improve her kidney function, and was administered insulin when not indicated placing her at risk for hypoglycemia, Resident #5 who was not administered a medication to decrease blood clotting time placing the resident at risk for a stroke or pulmonary embolism, and Resident #1 & #5 were administered a medication to lower blood pressure when their heart rate and blood pressure were outside of parameters placing them at risk for dizziness and risk of falling. This failure was 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 07/15/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 29, 2026.	D 358		
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name;	D 367		

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NAME OF PROVIDER OR SUPPLIER BROOKDALE WEDDINGTON PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 2404 PLANTATION CENTER DRIVE MATTHEWS, NC 28105		
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D 367	Continued From page 25 (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure medication administration records were accurate for 2 of 5 residents (#2 & #5) related to documentation of medications to treat shortness of breath (#5) and vitamin D deficiency (#2). The findings are: 1. Review of Resident #5's current FL2 dated 11/26/25 revealed diagnoses included anxiety disorder, hypertension and atrial fibrillation. Review of Resident #5's Nurse Practitioner's (NP) order dated 05/11/26 revealed there was an order for albuterol inhaler (a medication that opens airways and improves breathing) 90mcg/act, 2	D 367		

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D 367	Continued From page 26 inhalations every 8 hours for 3 days for an upper respiratory infection. Review of Resident #5's NP order dated 05/13/26 revealed the resident's albuterol inhaler administration was to be extended for another 2 days (total of 5 days). Review of Resident #5's May 2026 electronic medication administration record (eMAR) revealed: -There was entry for albuterol-budesonide (a combination medication that opens airways and reduces swelling in the airways) 90-80mcg/act, 2 inhalations every 8 hours for 3 days with a start date of 05/12/26 and a discontinue date of 05/13/26. -Albuterol-budesonide 90-80mcg/act 2 inhalations was documented administered at 6:00am, 2:00pm and 10:00pm on 05/12/26 and at 6:00am on 05/13/26. -There was a second entry for albuterol-budesonide 90-80mcg/act, 2 inhalations every 8 hours for 4 days with a start date of 05/13/26. -The second entry had documentation albuterol-budesonide 90-80mcg/act 2 inhalations was administered at 6:00am, 2:00pm and 10:00pm from 2:00pm on 05/13/26 through 6:00am on 05/17/26. Observation of Resident #5's medications on hand on 07/15/26 at 11:08am revealed there was no albuterol 90mcg/actuation inhaler or albuterol-budesonide 90-80mcg/act inhaler for Resident #5. Telephone interview with a Pharmacist with the facility's contracted pharmacy on 07/15/26 at 8:36am revealed:	D 367		

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D 367	Continued From page 27 -Resident #5 had an order dated 05/11/26 for albuterol 90mcg/act, inhale 2 puffs every 8 hours for 3 days. -Resident #5 had a second order dated 05/13/26 for albuterol 90mcg/act, inhale 2 puffs every 8 hours for 3 days. -The pharmacy dispensed one albuterol 90mcg/act inhaler containing 120 metered doses on 05/11/26. Telephone interview with a representative at the facility's contracted pharmacy on 07/15/26 at 2:58pm revealed: -Albuterol-budesonide 90-80mcg/act inhalation medication was never dispensed for Resident #5. -The pharmacy posted a return of a partial albuterol 90mcg/act for Resident #5 on 05/20/26. Interview with a MA on 07/15/26 at 11:20am revealed: -The Health and Wellness Director (HWD) or the Resident Care Coordinators (RCC) usually entered resident medication orders in the eMAR, but MAs were able to enter them if the HWD or RCCs were not available, like on weekends. -If a MA received an order they were responsible for entering it into the eMAR system, scanning the order to the pharmacy and placing a copy of the order in a folder for the HWD or RCCs to review for accuracy. Interview with a RCC on 07/15/26 at 3:33pm revealed: -The MAs were responsible for entering medication orders into the eMAR system and scanning the order to the clinical managers and pharmacy. -The MAs were to put a copy of all orders entered into the eMAR system in a "box" in the medication room, but this was not being done consistently.	D 367		

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D 367	Continued From page 28 -The RCCs or HWD were responsible for comparing the orders placed in the "box" in the med room with the order entered in the eMAR system for accuracy. -The RCCs or HWD should have identified Resident #5's albuterol 90mcg order was entered into the eMAR system incorrectly if the order was in the "box" and reviewed. -The MAs should have identified the albuterol 90mcg/act inhaler on the medication cart for Resident #5 did not match the order on the resident's eMAR each time it was administered to the resident. Interview with the HWD on 07/15/26 at 4:32pm revealed: -She completed training approximately a month ago with all MAs on medication administration and accurate documentation. -She instructed the MAs to read the label and the eMAR, if the two orders did not match they were to not administer the medication and notify a member of the clinical team, check the chart or call the pharmacy. Refer to the interview with the RCC on 07/15/26 at 3:37pm. Refer to the interview with the HWD on 07/15/26 at 4:32pm. Refer to the interview with the Administrator on 07/15/26 at 5:07pm. 2. Review of Resident #2's current FL2 dated 04/14/26 revealed: -Diagnoses included fracture of right femur, protein calorie malnutrition, unsteadiness on feet, muscle weakness, acute kidney failure, cardiac	D 367		

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D 367	Continued From page 29 pacemaker, sick sinus syndrome, and a-fibrillation. -There was an order for cholecalciferol (used to treat vitamin D deficiency) 50mcg one capsule once daily on Mondays. Review of Resident #2's May 2026 electronic medication administration record (eMAR) revealed there was no entry for cholecalciferol 50mcg one capsule once daily on Mondays. Review of Resident #2's June 2026 eMAR revealed there was no entry for cholecalciferol 50mcg one capsule once daily on Mondays. Review of Resident #2's July 2026 eMAR revealed there was no entry for cholecalciferol 50mcg one capsule once daily on Mondays. Observation of medications on hand on 07/14/26 at 4:30pm for Resident #2 revealed there were two bubble packs of cholecalciferol 50mcg one capsule once daily on Mondays for June and July with five tablets each in both bubble packs. Telephone interview with the facility's contracted pharmacy on 07/15/26 at 10:36am revealed: -The pharmacy received the FL2 order dated 04/14/26 for cholecalciferol 50mcg one capsule daily on Mondays. -The facility told the pharmacy not to administer the medication until the next cycle fill because they already had the medication on hand to administer. -The first dispense date was 05/06/26 with five capsules. -The cholecalciferol 50mcg was returned back to the pharmacy from the facility on 07/03/26 with four capsules returned. -The second dispense date was on 06/03/26 with	D 367		

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D 367	Continued From page 30 five capsules. -The third dispense date was on 07/01/26 with five capsules. -June and July bubble packs of cholecalciferol 50mcg were returned to the pharmacy from the facility last night (07/14/26) with five capsules returned in each pack. -The facility added medications into the eMAR system. Interview with a medication aide (MA) on 07/15/26 at 11:07am revealed: -She thought she had seen the Resident #2's cholecalciferol on the cart but never administered it because it was not on the eMAR. -She never gave medication if it was not on the eMAR. -If she found a medication that was not on the eMAR, she should ask upper management about it. -She had not asked anyone about cholecalciferol before, she had just never administered it. -When medication orders came in, she would fax or scan the order to the pharmacy. -After orders were sent to the Pharmacy, the MAs would put the order into the eMAR. -She did not remember seeing the order for cholecalciferol 50mcg. -She did not know why cholecalciferol never got entered into the eMAR. -She did not know how it got missed. Interview with another MA on 07/15/26 at 3:27pm revealed: -If she ever found a medication on the medication cart that was not on the eMAR, she would send back to pharmacy. -When new orders were sent to the facility and she received them, she would scan or fax to the pharmacy and called pharmacy to make sure	D 367		

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D 367	Continued From page 31 they received it. -She would enter the medication on the eMAR after it was scanned or faxed. -She returned the medication to pharmacy last night (07/14/26) because she thought it had been discontinued since it was not on the eMAR. -She did not know how cholecalciferol did not get entered into the eMAR. Interview with the RCC on 07/15/26 at 3:37pm revealed: -She did not know Resident #2's cholecalciferol never got entered into the eMAR. -She did not think they had been doing audits consistently and that is a possibility of why no one caught it. -She thought it was an oversight. Interview with the HWD on 07/15/26 at 4:32pm revealed: -She did not know Resident #2's cholecalciferol never got entered into the eMAR. -She knew they had issues in the past with processing orders and thought maybe that is why it got overlooked. -If medications were on the medication cart, but not entered into the eMAR, the MAs should check with clinical team, call pharmacy, and call the Primary Care Physician (PCP) to verify if the order was still active. Interview with the Administrator on 07/15/26 at 5:07pm revealed: -She did not know Resident #2's cholecalciferol never got entered into the eMAR. -She did not know why Resident #2's cholecalciferol did not get entered into the eMAR. - If a medication was found on the cart that was not on the eMAR, they should report it to clinical staff.	D 367		

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D 367	Continued From page 32 Refer to the interview with the RCC on 07/15/26 at 3:37pm. Refer to the interview with the HWD on 07/15/26 at 4:32pm. Refer to the interview with the Administrator on 07/15/26 at 5:07pm. Interview with the RCC on 07/15/26 at 3:37pm revealed: -She had been the RCC at the facility since 2017. -They had issues in the past with medications orders getting processed. -Within the last three months, they had begun a new system with scanning orders, and it would automatically email the pharmacy and all the clinical staff. -When orders were faxed in the past, the MAs would sometimes forget to place the order sheet in the "tracking box" and orders would get missed by clinical staff and they would not find out about the medications. -She expected MAs to do medication cart audits weekly and to compare medications to the eMAR. -She was not sure if medication cart audits were happening weekly because the MAs did not always document medication cart audits. -She did not think audits were being done consistently. -She just recently started full auditing where she would audit the eMAR to the cart and then look at the charts. Interview with the HWD on 07/15/26 at 4:32pm revealed: -Orders would come three different ways, by fax, walk-ins through doctor appointments, and email. -Once the orders were received, the MAs would	D 367		

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D 367	Continued From page 33 scan orders and it would automatically email the clinical team and pharmacy. -She expected MAs to compare the order to what was entered in the eMAR. -She thought some things with orders got overlooked and their system had been "slack." -Orders sometimes got overlooked if the staff did not notify the RCC and HWD and medications got missed. -Audits had not been done consistently. -She expected MAs to enter orders into the eMAR after it was faxed or scanned to the pharmacy. -She expected MAs to compare all medication with the eMAR. -She expected MAs to do weekly medication cart audits. -She and the HWD were to check behind MAs monthly. -Documentation of medication cart audits had not been consistent. Interview with the Administrator on 07/15/26 at 5:07pm revealed: -She expected the MAs to compare the medication to the eMAR before administration. -If something did not match up, the MAs should report to clinical staff. -MAs entered orders into the eMAR after they were faxed or scanned to pharmacy. -Copies would be placed in the "tracking folder" by the MAs, but sometimes that had not happened and medications got missed. -Audits were not happening consistently. -She expected MAs, RCC, and HWD to do audits weekly. -She did not think documentation of audits were happening consistently.	D 367		