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 05/21/2025

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

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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 05/20/25 and 05/21/25.	D 000		
D 375	10A NCAC 13F .1005 (a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure 1 of 1 sampled resident (#1) had a physician's order and assessment completed to self-administer medications related to a cough medicine, a stool softener, a medication used to treat temporary stomach discomfort, and a medication used to treat diarrhea. The findings are: Review of the facility's Resident Self-Administration policy dated April 2023 revealed: -There must be a physician's order and a nursing	D 375		

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D 375	Continued From page 1	D 375		

assessment to indicate that a resident could safely administer his/her medications.
-Nothing should be at the resident's bedside unless they could self-administer.
-Residents should not be on a combination of some self-administered and some not self-administered.
-The resident's ability to self-administer safely and correctly would be evaluated and validated monthly during the wellness visit.

Review of Resident #1's current FL-2 dated 02/26/25 revealed diagnoses included anxiety, hyperlipidemia, and cerebral infarction.

Review of Resident #1's pre-admission assessment form dated 02/26/25 revealed the resident was not capable of self-administering her medication and was signed by the resident's primary care provider (PCP).

Review of Resident #1's service plan dated 03/01/25 revealed Resident #1 was not able to self-administer medications.

Review of Resident #1's record revealed there was no self-administration assessment completed for Resident #1.

a. Review of Resident #1's signed physician's orders dated 03/18/25 revealed no order for bismuth subsalicylate (used to treat temporary discomfort of the stomach).

Observation of Resident #1's room on 05/20/25 at 9:28am revealed:
-There was a bottle of bismuth subsalicylate on the resident's bedside table.
-The bottle was 75% full.
-The top to the bismuth subsalicylate was

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D 375	Continued From page 2 secured. Second observation of Resident #1's room on 05/20/25 at 4:15pm revealed: -There was a bottle of bismuth subsalicylate on the resident's bedside table. -The bottle was 65% full. -The top of the bismuth subsalicylate was not securely on the bottle. Interview with Resident #1 on 05/20/25 at 9:28am revealed she took one tablespoon of bismuth subsalicylate yesterday, 05/19/25 because her stomach was hurting. Attempted telephone interview with Resident #1's family member on 05/21/25 at 9:42am was unsuccessful. Refer to the interview with a medication aide (MA) on 05/20/25 at 4:23pm. Refer to the interview with a personal care aide (PCA) on 05/21/25 at 9:26am. Refer to the interview with a second MA on 05/21/25 at 9:28am. Refer to the interview with the facility's Registered Nurse (RN)/Interim Administrator on 05/21/25 at 10:07am. Refer to the telephone interview with a representative from Resident #1's PCP's office on 05/21/25 at 12:23pm. b. Review of Resident #1's signed physician's orders dated 03/18/25 revealed an order for loperamide 2mg (used to treat diarrhea) give 1 tablet every 6 hours as needed (PRN).	D 375		

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D 375	Continued From page 3 Observation of Resident #1's room on 05/20/25 at 9:28am revealed: -There was a bottle of loperamide liquid on the resident's bedside table. -There was 25% of the liquid remaining in the bottle. Interview with Resident #1 on 05/20/25 at 9:28am revealed she took one tablespoon of loperamide yesterday, 05/19/25, because her stools were loose. Observation of Resident #1's room on 05/21/25 at 9:27am revealed the bottle of loperamide liquid was not on the resident's bedside table. Interview with Resident #1 on 05/21/25 at 9:27am revealed she did not know where the bottle of loperamide liquid was. Interview with a MA on 05/21/25 at 9:28am revealed: -Resident #1 asked for loperamide "about every day" and then the next day she would ask for a stool softener. -She did not think Resident #1 understood how her medications worked. Attempted telephone interview with Resident #1's family member on 05/21/25 at 9:42am was unsuccessful. Refer to the interview with a medication aide (MA) on 05/20/25 at 4:23pm. Refer to the interview with a PCA on 05/21/25 at 9:26am. Refer to the interview with a second MA on	D 375		

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D 375	Continued From page 4 05/21/25 at 9:28am. Refer to the interview with the facility's Registered Nurse (RN)/Interim Administrator on 05/21/25 at 10:07am. Refer to the telephone interview with a representative from Resident #1's PCP's office on 05/21/25 at 12:23pm. c. Review of Resident #1's signed physician's orders dated 03/18/25 revealed an order for sennosides and docusate sodium (used to treat constipation) 8.5-50mg give 1 tablet every 24 hours PRN. Observation of Resident #1's room on 05/20/25 at 9:28am revealed: -There was a bottle of docusate sodium (stool softener) on the resident's bedside table. -There was an undetermined number of tablets in the bottle. Interview with Resident #1 on 05/20/25 at 9:28am revealed she took 3 tablets of docusate sodium on Saturday, 05/17/25, because she had not gone to the bathroom in a long time. Observation of Resident #1's room on 05/21/25 at 9:27am revealed the bottle of docusate sodium was not on the resident's bedside table. Interview with Resident #1 on 05/21/25 at 9:27am revealed she did not know where the bottle of docusate sodium was. Interview with a MA on 05/21/25 at 9:28am revealed Resident #1 asked for a stool softener today, 05/21/25.	D 375		

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D 375	Continued From page 5 Attempted telephone interview with Resident #1's family member on 05/21/25 at 9:42am was unsuccessful. Refer to the interview with a medication aide (MA) on 05/20/25 at 4:23pm. Refer to the interview with a PC) on 05/21/25 at 9:26am. Refer to the interview with a second MA on 05/21/25 at 9:28am. Refer to the interview with the facility's Registered Nurse (RN)/Interim Administrator on 05/21/25 at 10:07am. Refer to the telephone interview with a representative from Resident #1's PCP's office on 05/21/25 at 12:23pm. d. Review of Resident #1's signed physician's orders dated 03/18/25 revealed an order for guaifenesin 100mg/5ML give 10ml every 6 hours as needed (PRN) for cough. Observation of Resident #1's room on 05/20/25 at 9:28am revealed: -There was a bottle of severe cough and congestion liquid medication on the resident's bedside table. -There was 25% of the liquid remaining in the bottle. Interview with Resident #1 on 05/20/25 at 9:28am revealed: -She had the cough medicine because she needed an expectorant, and the MA told her they did not have any they could administer. -She did not recall when she last took the cough	D 375		

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D 375	Continued From page 6 medicine, but it was "when the pollen was bad". Attempted telephone interview with Resident #1's family member on 05/21/25 at 9:42am was unsuccessful. Refer to the interview a MA on 05/20/25 at 4:23pm. Refer to the interview with a PCA on 05/21/25 at 9:26am. Refer to the interview with a second MA on 05/21/25 at 9:28am. Refer to the interview with the facility's Registered Nurse (RN)/Interim Administrator on 05/21/25 at 10:07am. Refer to the telephone interview with a representative from Resident #1's PCP's office on 05/21/25 at 12:23pm. _____ Interview with a MA on 05/20/25 at 4:23pm revealed: -Resident #1 had "good days and bad days" as far as her memory. -She would administer her medication at 3:00pm and at 8:00pm the resident would not recall the 3:00pm medication being administered. -She did not think Resident #1 could administer her medications safely. Interview with a PCA on 05/21/25 at 9:26am revealed: -If staff saw medications in a resident's room, they were supposed to tell the MA. -The MA would make sure the resident had an order for the medication to be in their room, and if not, the MA would remove the medication and tell	D 375		

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the resident why.
-She had been in Resident #1's room today, 5/21/25, but she did not see the medications on the resident's bedside table.

Interview with a second MA on 05/21/25 at 9:28am revealed:
-Resident #1 did not have an order to self-administer her medications.
-She had seen eye drops in Resident #1's room before and told the resident she could not keep the eye drops in her room.
-She was concerned Resident #1 could take something she had already been administered by the MA.
-She did not see the medications on the resident's bedside table today, 05/21/25.

Interview with the facility's Registered Nurse (RN)/Interim Administrator on 05/21/25 at 10:07am revealed:
-The PCAs should tell the MA and/or the facility's nurse if medications were observed in a resident's room.
-The MA should let the nurse know and see if there was an order for the resident to have the medication at the bedside.
-Resident #1 could be difficult because she wanted medications at certain times.
-Resident #1 was non-compliant with medications in her room.
-She had not completed an assessment on Resident #1 for the resident to self-administer her medications because her family member did not want her to self-administer her medications.

Telephone interview with a representative from Resident #1's PCP's office on 05/21/25 at 12:23pm revealed Resident #1 could self-administer her medications as long as the

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D 375	Continued From page 8 facility staff was in agreement.	D 375		