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

(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 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Tammy Zehr RN 6-10-25

Reviewed and Acknowledged K.M. 06/12/25

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D 375	Continued From page 1 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	D 375		

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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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D 375	Continued From page 7 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	D 375		

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

Sunrise Senior Living
Plan of Correction

Name of Community: Brighton Gardens of Winston Salem
Address of Community: 2601 Reynolda Road Winston Salem, NC 27106
License number: HAL-034-026
Inspection date(s): 5-20-25 and 5-21-25
Name/Title of Legal Entity Representative Signing the Plan of Correction:

Signature of Sunrise Representative: **Tammy Felver, RN** Tammy Felver RN
Date of Submission: 6-12-25

Regulation	Target Date by Which Correction will be completed	Plan of Correction
D375 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)	*5/21/2025* *6/30/2025* *6/15/2025* *6/15/2025* *6/9/2025* *6/30/2025*	***A. With respect to the specific resident/situation cited:*** *Resident # 1 – Medication was removed from resident room.* ***B. With respect to how the facility will identify residents/situations for the identified concerns:*** *Resident Care Director and/or Wellness Nurse will conduct monthly assessments for residents with Self-Administer orders.* *Care Managers will be re-trained to report any medications, chemicals or other potential hazards found in a resident room to the neighborhood coordinator, Resident Care Director and/or ED* *Care Managers will be re-trained to put in a clinical alert in the PCC Dashboard when a medication, chemical or other hazards are found in a resident room* ***C. With respect to what systemic measures have been put into place to address the stated concern:*** *Assisted Living and Reminiscence Coordinator will conduct weekly suites audits to check medications, chemical or other hazards for 3 months.* *Self-Medicators assessed monthly by Resident Care Director and/or Wellness Nurse for compliance and safety.*

Responses on the enclosed plan of correction do not constitute an admission or agreement of the truth of the facts alleged or the conclusion set forth in the regulatory report. The responses are prepared solely as a matter of compliance with law.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
the self administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the residents chart; and (2) specific instructions for the administration of prescription medications are printed on the medication label	*6/30/2026*	***D. With respect to how the plan of correction will be monitored:*** Results of the weekly audits will be reviewed by the Executive Director and corrective action taken as necessary Results will also be reviewed by Quality Assurance Performance Improvement team monthly for 3 months. The Executive Director is responsible for confirming implementation and ongoing compliance with the components of the plan of correction and addressing and resolving variances that may occur.

Responses on the enclosed plan of correction do not constitute an admission or agreement of the truth of the facts alleged or the conclusion set forth in the regulatory report. The responses are prepared solely as a matter of compliance with law.