STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SPRING ARBOR OF STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

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D 000	Initial Comments The Adult Licensure Section and Mecklenburg County Department of Social Services conducted an annual survey from May 27, 2026 to May 28, 2026.	D 000		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure therapeutic diets were served as ordered to 3 of 5 sampled residents (#1, #2, & #4) related to a mechanical soft diet (#1, & #4) and consistent or controlled carbohydrate (CCHO) diet (#1 & #2). The findings are: 1. Review of Resident #4's current FL2 dated 05/06/26 revealed: -Diagnoses included frontotemporal dementia, amnesia, overactive bladder, urinary incontinence, hypertension, and left knee osteoarthritis. -The recommended level of care was special care unit (SCU). -Resident #4 was ordered a regular diet that was bite sized and soft texture.	D 310		

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D 310	Continued From page 1 Review of Resident #4's Resident Register revealed: -There was no admission date on Resident #4's Register. -The Resident Register was signed by the responsible person, but was not signed by the Administrator. Review of Resident #4's record revealed a physician's order dated 05/06/26 for a mechanical soft diet. Review of the therapeutic diet list posted in the facilty's kitchen on 05/27/26 revealed Resident #4 was on a regular, mechanical soft diet. Review of the facility's lunch menu for 05/27/26 revealed cheese lasagna, tossed salad or baked fish, green peas, and a garlic stick. Review of the facility's therapeutic lunch menu for 05/27/26 revealed: -There were 10 columns of diets listed, which included a column labeled mechanical soft. -Residents on a mechanical soft diet were to served soft lasagna or baked fish ground, pureed peas, soft mashed brussel sprouts, garlic bread stick slurry. -The tossed salad was to be substituted with soft mashed brussel sprouts and the garlic stick was to be substituted with a garlic breadstick slurry. Review of the facility's recipes dated 04/14/26 revealed: -The soft mashable brussels sprouts were to be mashed, ground, or chopped to the appropriate consistency for textured diets. -The bread stick slurry was to be combined with 2% milk and food thickener to make a slurry consistency and soak the breadstick for plating.	D 310		

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D 310	Continued From page 2 Observation of Resident #4's lunch service on 05/27/28 at 11:59am revealed Resident #4 was served a tossed salad with whole grape sized tomatoes and a dry garlic breadstick. Review of the facility's dinner menu for 05/27/26 revealed cornflake chicken breast, poultry gravy, oven brown potatoes, mixed vegetables, and wheat roll or pork roast, gravy, and cheesy broccoli rice casserole. Review of the facility's therapeutic dinner menu for 05/27/26 revealed: -There were 10 columns of diets listed, which included a column labeled mechanical soft. -The mechanical soft column included instructions for substituting the potatoes with mashed potatoes, a wheat roll slurry, and ground pork roast. Review of the facility's recipe dated 04/14/26 revealed: -The pork roast was to be ground or chopped to the appropriate consistency for textured diets. -There was no recipe for the mashed potatoes. -The breadstick slurry was to be combined with 2% milk and food thickener to make a slurry consistency and soak the breadstick for plating. Observation of Resident #4's dinner service on 05/27/28 at 5:15pm revealed Resident #4 was served an approximately 5" round portion of a pork roast slice, potato wedges, and dry wheat roll. Interview with a Dietary Manager (DM) on 05/28/26 at 1:30pm revealed: -Resident #4 was ordered a mechanical soft diet which included chopped meats.	D 310		

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-She was did not know the therapeutic diet recipe for pork roast included instructions for ground meat.
-On 05/27/26 she was responsible for cooking and plating the dinner but did not know if she plated Resident #4's meal.
-She did not know the facility had therapeutic diet recipes for texture modified foods or menu item substitutions until yesterday (05/27/26) after Resident #4's lunchtime meal was served.
-She never received training for preparing the residents' therapeutic diets.

Telephone interview with the facility's contracted Registered Dietician (RD) on 05/28/26 at 11:39am revealed:
-She was responsible for reviewing the facility's menus and therapeutic diet spreadsheets.
-The facility was responsible for serving Resident #4's meals according to Resident #4's physician's order.
-The facility was responsible for following the preparation guidance for each therapeutic diet recipe.
-Resident #4's tossed salad was to be substituted according to the facility's therapeutic diet spreadsheet for mechanical soft diet with mashable brussels sprouts.
-Resident #4's bread was to be prepared into a slurry texture.
-Resident #4's potatoes were to be prepared to a soft, mashed texture.
-Resident #4's pork roast was to be prepared to a mechanically ground texture.
-If Resident #4 consumed food prepared and served with an incorrect texture, Resident #4 was at risk of choking or aspiration.

Interview with Resident #4's Primary Care Provider (PCP) on 05/28/26 at 1:05pm revealed:

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-Resident #4 was ordered a mechanical soft diet due to a history of dysphasia (impaired speech).
-She expected the facility to serve Resident #4's meals according to the facility's diet for mechanical soft texture foods.
-She did not know the facility had served Resident #4 a tossed salad instead of mashable brussel sprouts, potato wedges instead of mashed potatoes, bread that was not softened to a slurry consistency, and a slice of pork roast not ground.
-If Resident #4 was served foods that were not consistent with a mechanical soft texture, she could be at risk of choking or an aspiration event which could result in serious respiratory complications or death.

Attempted telephone interview with Resident #4's Power of Attorney (POA) on 05/28/26 at 8:34am was unsuccessful.

Refer to the interview with the DM on 05/27/26 at 10:30am.

Refer to the telephone interview with the facility's contracted RD on 05/28/26 at 11:39am.

Refer to the interview with the Regional Registered Nurse (RN) on 05/28/26 at 12:16pm.

Refer to the interview with the DM on 05/28/26 at 12:37pm.

Refer to the interview with the Director of Culinary on 05/28/26 at 12:54pm.

Refer to the interview with the Administrator on 05/28/26 at 2:12pm.

2. Review of Resident #1's current FL2 dated

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08/19/25 revealed diagnoses included diabetes type 2, protein calorie malnutrition, bipolar disorder, anemia, hypothyroidism, gout, hyperlipidemia, and allergic rhinitis.

Review of Resident #1's Resident Register revealed:
-There was no admission date on Resident #1's Register.
-The Resident Register was signed by the responsible party and the Administrator.

Observation of Resident #1 on 05/28/26 at 9:03am revealed:
-He did not have upper teeth.
-There were broken teeth located on the lower left and right mid section of the lower teeth.
-There were no back teeth located on the left and right side of the mouth.

Interview with Resident #1 on 05/28/26 at 9:03am revealed:
-It had been about a year to a year and a half since he had been to the dentist and because it was a terrible experience he refused to go back.
-He was admitted to the facilty because he lost a lot of weight and needed to be where someone could prepare all of his meals and made sure he ate.
-His diet was to be easy to chew because his teeth were missing and broken.
-Sometimes it hurts to chew meats so he did not eat his full meal because the staff did not serve him meats that he can chew.
-He did not send back the meat that he could not chew or tell anyone because he was afraid that someone would "spit" in it or worse.

a. Review of Resident #1's record revealed a physician's order dated 04/09/26 for a mechanical

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soft diet.

Review of the therapeutic diet posted in the facility's kitchen on 05/27/26 revealed Resident #1 was on a mechanical soft diet.

Review of the facility's lunch menu for 05/27/26 revealed cheese lasagna, tossed salad or baked fish, green peas, and a garlic stick.

Review of the facility's therapeutic lunch menu for the mechanical soft diet on 05/27/26 revealed:
-There were 10 columns of diets listed, which included a column labeled mechanical soft.
-Residents on a mechanical soft diet were to be served soft lasagna or baked fish ground, pureed peas, soft mashed brussel sprouts, and bread stick slurry.

Review of the facility's recipe dated 04/14/26 for garlic breadstick slurry included instructions for combining 2% milk and food thickener to make a slurry consistency and soak breadstick for plating.

Observation of Resident #1's lunch meal service on 05/27/26 at 12:15pm revealed he was served a whole piece of baked fish, green peas, and an approximately 11" garlic stick.

Interview with the DM on 05/27/26 at 12:15pm revealed:
-She did not know what Resident #1 was served for lunch because she was in the kitchen.
-She did not prepare Resident #1's meal mechanical soft because he did not like his fish cut up.
-Resident #1 liked to cut his fish up himself.
-She thought cutting up Resident #1's fish was what the therapeutic diet called for.
-She did not know Resident #1's fish should have

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been ground, the peas pureed, and the garlic stick slurry.
-She did not know about the therapeutic diet menu until today (05/27/26).
-She knew there was a binder with recipes for each diet ordered that provided instructions on how to prepare each diet.

Review of the facility's dinner menu for 05/27/26 revealed cornflake chicken breast, poultry gravy, oven brown potatoes, mixed vegetables, and wheat roll or pork roast, gravy, and cheesy broccoli rice casserole.

Review of the facility's therapeutic dinner menu on 05/27/26 revealed:
-There were 10 columns of diets listed, which included a column labeled mechanical soft.
-The mechanical soft column listed ground cornflake chicken, two ounces of poultry gravy, mashed potatoes, soft mashed squash, wheat roll slurry or ground pork roast, two ounces gravy, two scoops of chopped broccoli pureed.

Review of the facility's recipe dated 04/14/26 revealed:
-The cornflake chicken was to be ground.
-There was no recipe for the mashed potatoes.
-The breadstick slurry was to be combined with 2% milk and food thickener to make a slurry consistency and soak the breadstick for plating.

Observation of the dinner meal on 05/27/26 at 5:35pm revealed:
-Resident #1 received a whole piece of baked cornflake chicken, potatoes slices, and mixed vegetables.
-The meal service was stopped until the correct meal could be served to Resident #1.

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D 310	Continued From page 8 Interview with the DM on 05/28/26 at 5:35pm revealed: -She did not know what Resident #1 was served because she was working in the kitchen and did not see his plate. -She did not cook any of the food that evening. Interview with a dietary aide on 05/27/26 at 5:40pm revealed: -She had worked in the facility for about three months. -She delivered Resident #1's plate to him. -She was aware Resident #1 was on a mechanical soft diet, but she was not paying attention to his plate when she handed it to him. -She was in a hurry and forgot to refer to the board and make sure she had the correct food on the plate. -She knew she should have checked his plate for the correct consistency before she handed it to him. Telephone interview with Resident #1's hospice Registered Nurse (RN) on 05/28/26 at 8:57am revealed: -Resident #1 had unexplained weight loss around October 2025 or November of 2025. -Resident #1 got a diagnosis of failure to thrive and was placed on a mechanical soft diet to see if he would eat more. -Resident #1 had gained two pounds recently, but she was unsure of the date. -She observed a meal around January 2026 for Resident #1 and she did not notice it being incorrect. -She thought the meat should be chopped up and all the food should be soft. -She did not know their therapeutic diet menu called for ground meat for the mechanical soft diet.	D 310		

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-If Resident #1 was served the wrong diet, he may lose more weight, which could lead to worsening malnutrition and electrolytes being off, which could lead to heart malfunction.
-She thought the kitchen staff should follow the instructions on their therapeutic diet menu and serve the correct consistency.

Telephone interview with Resident #1's Primary Care Provider (PCP) on 05/28/26 revealed:
-She did not know why Resident #1 was on a mechanical soft diet.
-She signed the order, but it came from hospice and hospice was his primary provider.
-A resident could choke or aspirate if given the wrong diet depending on the reason why the person is on the diet.

Refer to the interview with the DM on 05/27/26 at 10:30am.

Refer to the telephone interview with the facility's contracted RD on 05/28/26 at 11:39am.

Refer to the interview with the Regional Registered Nurse (RN) on 05/28/26 at 12:16pm.

Refer to the interview with the DM on 05/28/26 at 12:37pm.

Refer to the interview with the Director of Culinary on 05/28/26 at 12:54pm.

Refer to the interview with the Administrator on 05/28/26 at 2:12pm.

b. Review of Resident #1's record revealed a physician's order dated 04/09/26 for CCHO diet.

Review of the therapeutic diet menu posted in the

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facility's kitchen on 05/27/26 revealed Resident #1 was on a CCHO diet.

Review of the lunch menu for 05/27/26 revealed cheese lasagna, tossed salad or baked fish, green peas, and a garlic stick.

Review of the facility's therapeutic lunch menu for CCHO on 05/27/26 revealed:
-There were 10 columns of diets listed, which included a column labeled CCHO.
-The CCHO column listed 2" x 3" square of lasagna and one-half garlic stick or baked fish.

Observation of Resident #1's lunch meal service on 05/27/26 at 12:15pm revealed he was served a whole piece of baked fish, green peas, and a whole 11" garlic stick.

Interview with the DM on 05/27/26 at 12:15pm revealed she did not realize Resident #1 should have gotten only half a breadstick since he was on the CCHO diet.

Interview with a dietary aide on 05/27/26 at 5:40pm revealed she did not realize Resident #1 should have gotten only half a breadstick.

Refer to the interview with the DM on 05/27/26 at 10:30am.

Refer to the telephone interview with the facility's contracted RD on 05/28/26 at 11:39am.

Refer to the interview with the Regional RN on 05/28/26 at 12:16pm.

Refer to the interview with the DM on 05/28/26 at 12:37pm.

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Refer to the interview with the Director of Culinary on 05/28/26 at 12:54pm.

Refer to the interview with the Administrator on 05/28/26 at 2:12pm.

3. Review of Resident #2's current FL2 dated 03/26/26 revealed:
-Diagnoses included vascular dementia, diabetes mellitus, psychosis, anemia, cardio-vascular accident, adjustment disorder, anxiety, and brain tumor.
-The recommended level of care was special care unit (SCU).

Review of Resident #2's Resident Register revealed no admission date.

Review of Resident #2's record revealed a physician's order dated 04/13/26 for consistent or controlled carbohydrate (CCHO).

Review of the therapeutic diet menu posted in the kitchen on 05/27/26 revealed Resident #2 was on a CCHO diet.

Review of the lunch menu for 05/27/26 revealed cheese lasagna, tossed salad or baked fish, green peas, and a garlic stick.

Review of the facility's therapeutic diet lunch menu for 05/27/26 revealed:
-There were ten columns of diets listed, which included a column labeled CCHO.
-The CCHO column included instructions for serving a 2" x 3" square of lasagna, and one-half of a garlic breadstick.

Observation of Resident #2's lunch meal service on 05/27/26 at 11:59am revealed she was served

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D 310	Continued From page 12 a full-length bread stick, approximately 11" in length and a large portion of lasagna, approximately 2" x 6" in size. Telephone interview with the facility's contracted RD on 05/28/26 at 11:39am revealed: -She was responsible for reviewing the facility's menus and therapeutic diet spreadsheet. -She did not know Resident #2. -The facility was responsible for serving Resident #2's meals according to Resident #2's physician's order. -The facility was responsible for following the preparation guidance for each therapeutic diet recipe, which included portion sizes for CCHO menu foods. Interview with Resident #2's PCP on 05/28/26 at 1:05pm revealed: -Resident #2's diagnoses included Diabetes Mellitus. -She had ordered Resident #2 a CCHO therapeutic diet. -She expected the facility to serve Resident #2 the therapeutic diet as ordered. -She did not know what guidance the facility used to prepare CCHO meals. -She did not know Resident #2 had been served a lunch meal on 05/27/26 which included a large portion of lasagna and a full-length breadstick. -If Resident #2 received meals with portions greater than listed on the CCHO therapeutic diet, it could result in inconsistent blood glucose results which could lead to cardiovascular issues. Interview with a dietary aide on 02/28/26 at 10:14am revealed: -She was responsible for preparing and plating food according to the facility's menu, not the facility's therapeutic diet spreadsheet.	D 310		

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D 310	Continued From page 13 -On 05/27/26 she plated Resident #2's lunch meal, which included a large scoop of lasagna and a full-length breadstick. -She was unaware the facility's therapeutic diet spreadsheet for CCHO diets included instructions to serve a 2" x 3" square portion of lasagna and 1/2 length of a breadstick. Attempted telephone interview with Resident #2's POA on 05/28/26 at 9:41am was unsuccessful. Refer to the interview with the DM on 05/27/26 at 10:30am. Refer to the telephone interview with the facility's contracted RD on 05/28/26 at 11:39am. Refer to the interview with the Regional RN on 05/28/26 at 12:16pm. Refer to the interview with the DM on 05/28/26 at 12:37pm. Refer to the interview with the Director of Culinary on 05/28/26 at 12:54pm. Refer to the interview with the Administrator on 05/28/26 at 2:12pm. _____ Interview with the DM on 05/27/26 at 10:30am revealed: -She located the therapeutic diet menu and brought the menu to the surveyors today (05/27/26). -She did not know what the acronyms stood for on the therapeutic diet menu. -She did not know that the facility had a therapeutic diet menu until today (05/27/26). Interview with the facility's contracted RD on	D 310		

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D 310	Continued From page 14 05/28/26 at 11:39am revealed: -She signed the menus for the facility, but she had never seen any of the residents at the facility. -For mechanical soft diets, the meats could be chopped or ground depending on the diet orders. -If the therapeutic menus stated for it to be ground, they should follow the menu and do what the menu instructed the staff to do. -If residents did not have teeth, it would be hard to chew and eat the meal if it were not cooked as ordered. -A resident could choke if served regular foods instead of a mechanical soft diet. Interview with the Regional RN on 05/28/26 at 12:16pm revealed: -She did not know what training the staff in the kitchen were provided. -She expected all dietary staff to be aware of the diet orders and follow them. -The DM should have trained all the cooks and dietary aides. -She did not know diet orders were not being followed correctly. -She expected diet orders to be followed correctly. Interview with the DM on 05/28/26 at 12:37pm revealed: -She had been in her position since April 2025. -She was responsible for scheduling dietary aides. -She was responsible for training dietary aides related to food preparation. -She had never received training on the facility's therapeutic diet spreadsheets. -She had never received training on the use of the facility's therapeutic diet recipes. -She and the dietary aides were responsible for cooking and plating meals.	D 310		

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-She and the dietary aides prepared meals using the facility's regular menu.
-She expected dietary aides to refer to the recipe manual, which included therapeutic diet recipes to prepare food that was kept in a binder.
-She had a mentor she talked to when she had questions about how to prepare something.
-The binder was purchased and placed on the shelf within the last couple of months.
-She trained all the dietary aides on the menus in May 2026.

Interview with the Director of Culinary on 05/28/26 at 12:54pm revealed:
-He started his position with the facility in February 2026.
-His primary role was to provide training to facilities, but he never provided training to this facility.
-He received a call yesterday (05/27/26) to assist the facility with training.
-He did not know the staff were not following orders or referring to the recipes or therapeutic menus.

Interview with the Administrator on 05/28/26 at 2:12pm revealed:
-She had been employed as the Administrator since July 2025.
-She did not know what training the kitchen staff were provided.
-She knew the DM had a mentor she could ask questions if needed.
-She was not aware therapeutic diets were not being served correctly.
-She thought the staff were going by the board displayed in the kitchen with therapeutic diets.
-She discussed the rules and regulations for dietary with all the staff earlier in 2026, but she did not which month.

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D 310	Continued From page 16 -She let all the kitchen staff know about the recipe book that was kept in a binder in the kitchen. -She thought the plates looked right to her when she observed meals about once weekly, but she had never read the therapeutic diet menus and recipes and did not know the meat should be ground. -It was the DM's responsibility to train the dietary aides. -It was her responsibility to check behind the DM and make sure diets were served as ordered. _____ The facility failed to ensure therapeutic diets were served as ordered for residents on a mechanical soft diet which could have resulted in choking, aspiration, serious respiratory issues and/or death (#4), malnutrition, and electrolytes being off which could lead to heart malfunction (#1) and serving consistent or controlled carbohydrate (CCHO) diets as ordered (#1, and #2) which could result in higher blood sugars and difficulty with medication management and long standing could result in cardiovascular issues (#2). 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 05/28/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 12, 2026.	D 310		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 358		

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D 358	Continued From page 17 (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 record reviews and interviews, the facility failed to ensure medications were administered as ordered for 2 of 5 sampled residents (#3 & #5) related to a medications to treat high blood pressure (#5) and high blood sugar (#3 & #5). The findings are: 1. Review of Resident #5's current FL2 dated 08/16/25 revealed diagnoses included Type 2 diabetes and hypertension. a. Review of Resident #5's signed physician's orders dated 01/28/26 revealed: -An order for finger stick blood sugar (FSBS) every morning at 7:30am before Lantus administration and to notify the physician if the FSBS was less than 60 or greater than 450. -An order for Lantus 100 units/ml (a long acting insulin to treat insulin) 28 units every day, hold for a FSBS less than 90. Review of Resident #5's March 2026 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Lantus 100units/ml administer 28 units every day at 8:00am and to hold for a FSBS less than 150 with a start date of 01/28/26.	D 358		

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D 358	Continued From page 18 -There was no entry to hold the Lantus for a FSBS less than 90. -The Lantus was documented as administered on 03/01/26 to 03/31/26 at 8:00am. -There was no documentation a FSBS was obtained. -There was no documentation the Lantus was held for a FSBS less than 90. Review of Resident #5's April 2026 eMAR revealed: -There was an entry for Lantus 100units/ml administer 28 units every day at 8:00am and to hold for a FSBS less than 150 with a start date of 01/28/26. -There was no entry to hold the Lantus for a FSBS less than 90. -There was an entry for a FSBS at 7:30am and there was no start date documented. -On 04/01/26 to 04/03/26, there was no documentation a FSBS was obtained and the Lantus was documented as administered at 8:00am. -On 04/05/26, there was documentation the FSBS was 81 and the Lantus was documented as administered and should not have been. -On 04/06/26 to 04/08/26, there was no documentation a FSBS was obtained and the Lantus was documented as administered at 8:00am. -On 04/09/26, there was documentation the FSBS was 81 and the Lantus was documented as "other". -On 04/11/26, to 04/15/26, there was no documentation a FSBS was obtained and the Lantus was documented as administered at 8:00am. -On 04/16/26, there was no documentation a FSBS was obtained and the Lantus was documented as "other".	D 358		

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D 358	Continued From page 19 -On 04/17/26, there was no documentation a FSBS was obtained and the Lantus was documented as administered at 8:00am. -On 04/19/26 to 04/24/26, there was no documentation a FSBS was obtained and the Lantus was documented as administered at 8:00am. -On 04/26/26, there was no documentation a FSBS was obtained and the Lantus was documented as administered at 8:00am. -On 04/28/26 to 04/30/26, there was no documentation a FSBS was obtained and the Lantus was documented as administered at 8:00am. -There was no documentation a FSBS was obtained for 23 out of 30 opportunities. -There was documentation the Lantus was administered when it should not have been for 1 out of 7 opportunities. -There was no other documentation for what "other" meant for 2 out of 7 opportunities. Review of Resident #5's May 2026 eMAR revealed: -There was an entry for Lantus 100units/ml administer 28 units every day at 8:00am and to hold for a FSBS less than 150 with a start date of 01/28/26. -There was no entry to hold the Lantus for a FSBS less than 90. -There was an entry for a FSBS at 7:30am and there was no start date documented. -On 05/01/26 to 05/08/26, there was no documentation a FSBS was obtained and the Lantus was documented as administered at 8:00am. -On 05/10/26 to 05/12/26, there was no documentation a FSBS was obtained and the Lantus was documented as administered at 8:00am.	D 358		

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D 358	Continued From page 20 -On 05/13/26, there was documentation the FSBS was 87 and the Lantus was documented as administered and should not have been. -On 05/14/26 to 05/18/26, there was no documentation a FSBS was obtained and the Lantus was documented as administered at 8:00am. -On 05/22/26 to 05/23/26, there was no documentation a FSBS was obtained and the Lantus was documented as administered at 8:00am. -On 05/24/26, there was documentation the FSBS was 112 and the Lantus was documented as administered and should not have been. -On 05/25/26, there was documentation the FSBS was 125 and the Lantus was documented as "did not give". -On 05/26/26, there was no documentation a FSBS was obtained and the Lantus was documented as administered at 8:00am. -There was no documentation a FSBS was obtained for 19 out of 27 opportunities. -There was documentation the Lantus was administered when it should not have been for 2 out of 8 opportunities. Telephone interview with a Pharmacist from the facility's contracted pharmacy on 05/27/26 at 5:21pm revealed: -There was a six-month signed physician's order dated 01/28/26 for Lantus 100 units/ml 28 units every morning with a handwritten order to the side of the order to "hold if FSBS less than 90". -There was a six-month signed physician's order dated 01/28/26 to obtain a FSBS daily at 7:30am and notify the physician if the FSBS was less than 60 or greater than 450. -There was a separate order dated 01/28/26 for obtaining a FSBS before the Lantus was administered or to hold the Lantus for a FSBS	D 358		

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less than 90.
-There was an active order dated 02/28/25 to hold the Lantus for a FSBS less than 150.
-The facility staff were responsible to verify the orders once entered into the eMAR system before the MAs were to administer the medication to make sure the entries were correct according to the physician's order.
-Receiving Lantus for a FSBS less than 90 could cause hypoglycemia with symptoms of paleness, shakiness, headache, sweating, dizziness and confusion.

Telephone interview with Resident #5's Primary Care Provider (PCP) on 05/28/26 at 10:57am revealed:
-On 01/28/26, she wrote an order to check Resident #5's FSBS before the Lantus administration and to hold the Lantus if the FSBS was less than 90 to prevent his blood sugar from dropping too low.
-She expected the medication aides (MA) to follow her orders as they were written to prevent Resident #5 from having complications of dizziness and confusion.

Interview with a MA on 05/28/26 at 10:50am revealed:
-Before January 2026, when she obtain Resident #5's FSBS every morning before his Lantus administration she was to hold the Lantus for a FSBS less than 150.
-In January 2026 she asked the former Health and Wellness Director (HWD) about holding Lantus for a FSBS less than 150 because on the eMAR there were no directions to hold the insulin or a place to document the FSBS.
-In January 2026, the former HWD instructed her to administer the Lantus no matter if the FSBS was less than 150 because it was a direct order.

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D 358	Continued From page 22 -Today (05/28/26), when she reviewed Resident #5's March 2026 paper MAR, there was an entry to hold Resident #5's Lantus for a FSBS less than 150 with an original date of 02/28/25 that did not show up on the eMAR. -Today (05/28/26), when she reviewed Resident #5's April 2026 and May 2026 eMAR, she did not document a FSBS every time she administered Lantus to Resident #5. -There was prompting to document Resident #5's FSBS on the April 2026 and May 2026 eMAR. -When she documented "administered" then she administered the Lantus and did not know what the FSBS was or if it was obtained. -She was trained by the former HWD to obtain the FSBS, document it on the eMAR, and if the FSBS was less than 150, hold the insulin and document holding the insulin by using the drop down menu with the insulin by selecting either hold or other and give the reason as the FSBS less than 150. Interview with the current HWD on 05/27/26 at 5:00pm revealed: -She started working at the facility on May 17, 2026. -She had not been trained to verify orders after the pharmacy enetered them into the eMAR system. -She did not know Resident #5's orders dated 01/28/26 to hold Lantus for a FSBS less than 150. -She was not trained on completing medication cart audits which included matching the eMAR, medications on hand and the recent orders for Resident #5. Refer to interview with a MA on on 05/28/26 at 10:50am.	D 358		

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D 358	Continued From page 23 Refer to interview with the Regional Nurse on 05/28/26 at 11:40am. Refer to interview with the Administrator on 05/27/26 at 4:45pm. b. Review of Resident #5's six-month signed physician's orders dated 01/28/26 revealed an order for carvedilol (a medication used to treat high blood pressure) 25mg two times a day. and to obtain pule rate and hold for a pulse less than 60. Review of Resident #5's signed physician orders dated 01/28/26 revealed in addition to the carvedilol order: obtain a pulse and hold if less than 60. Review of Resident #5's March 2026 eMAR revealed: -There was an entry for carvedilol 25mg two times a day at 8:00am and 5:00pm with a start date of 02/28/25. -The carvedilol was documented as administered 03/01/26 to 03/31/26 at 8:00am and 5:00pm. -There was no documentation a pulse was obtained, or the carvedilol was held for a pulse rate less than 60. Review of Resident #5's April 2026 eMAR revealed: -There was an entry for carvedilol 25mg two times a day at 8:00am and 5:00pm with a start date of 02/28/25. -The carvedilol was documented as administered 04/01/26 to 04/30/26 at 8:00am and 5:00pm. -There was no documentation a pulse was obtained, or the carvedilol was held for a pulse rate less than 60.	D 358		

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D 358	Continued From page 24 Review of Resident #5's May 2026 eMAR revealed: -There was an entry for carvedilol 25mg two times a day at 8:00am and 5:00pm with a start date of 02/28/25. -The carvedilol was documented as administered 05/01/26 to 05/26/26 at 8:00am and 5:00pm, and on 05/27/26 at 8:00am. -There was no documentation a pulse was obtained, or the carvedilol was held for a pulse rate less than 60. Telephone interview with a Pharmacist from the facility's contracted pharmacy on 05/27/26 at 5:21pm revealed: -There was a six-month signed physician's order dated 01/28/26 for carvedilol 25mg two times a day. -There were no orders received to obtain a pulse and hold the carvedilol if the pulse was less than 60. -Receiving carvedilol with a pulse rate less than 60 could cause dizziness. Telephone interview with Resident #5's Primary Care Provider (PCP) on 05/28/26 at 10:57am revealed: -On 01/28/26, he wrote an order to obtain a pulse and hold carvedilol if the pulse is less than 60. -Taking carvedilol with a heart rate less than 60 could cause dizziness. Interview with a MA on on 05/28/26 at 10:50am revealed there was no entry to obtain a pulse before administering carvedilol to Resident #5. Interview with the current HWD on 05/27/26 at 5:00pm revealed: -She started working at the facility on May 17, 2026.	D 358		

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D 358	Continued From page 25 -She had not been trained to verify orders after the pharmacy enetered them into the eMAR system. -She did not know Resident #5's orders dated 01/28/26 were to hold the carvedilol for a pulse less than 60. -She was not trained on completing medication cart audits which included matching the eMAR, medications on hand and the recent orders for Resident #5. Refer to interview with a MA on on 05/28/26 at 10:50am. Refer to interview with the Regional Nurse on 05/28/26 at 11:40am. Refer to interview with the Administrator on 05/27/26 at 4:45pm. 2. Review of Resident #3's current FL2 dated 08/06/25 revealed: -Diagnoses included diabetes, lymphedema, hypertension, hyperlipidemia, vitamin D deficiency, peripheral vascular disease and chronic kidney disease. -Resident #3 was semi-ambulatory. -Resident #3's level of care was assisted living. Review of Resident #3's physician order summary dated 01/22/26 revealed: -There was an order for FSBS twice daily at 8:00am and 8:00pm via FSBS checks. -There was a written sticky note dated 01/28/26, attached to the physician order summary that stated recommendations: blood sugar checks need parameters, notify physician if blood sugars are greater than 450 or less than 60. -There was an order for Lantus 100 units/ml, administer 16 units subcutaneously every day for diabetes.	D 358		

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D 358	Continued From page 26 Review of Resident #3's March 2026 eMAR revealed: -There was an entry for FSBS checks at 8:00am and 8:00pm. -There was documentation Resident #3 received FSBS checks at 8:00am and 8:00pm. -There was an entry for Lantus 100 units/ml, administer 16 units every day at 8:00am, hold for FSBS less than 150, call physician for FSBS greater than 400. -There was documentation Resident #3 had a FSBS of 120 at 8:00am on 03/01/26 and was administered Lantus 100 units/ml 16 units. -There was documentation Resident #3 had a FSBS of 146 at 8:00am on 03/07/26 and was administered Lantus 100 units/ml 16 units. -There was documentation Resident #3 had a FSBS of 132 at 8:00am on 03/09/26 and was administered Lantus 100 units/ml 16 units. -There was documentation Resident #3 had a FSBS of 110 at 8:00am on 03/10/26 and was administered Lantus 100 units/ml 16 units. -There was documentation Resident #3 had a FSBS of 141 at 8:00am on 03/11/26 and was administered Lantus 100 units/ml 16 units. -There was documentation Resident #3 had a FSBS of 124 at 8:00am on 03/13/26 and was administered Lantus 100 units/ml 16 units. -There was documentation Resident #3 had a FSBS of 130 at 8:00am on 03/14/26 and was administered Lantus 100 units/ml 16 units. -There was documentation Resident #3 had a FSBS of 149 at 8:00am on 03/15/26 and was administered Lantus 100 units/ml 16 units. -There was documentation Resident #3 had a FSBS of 132 at 8:00am on 03/21/26 and was administered Lantus 100 units/ml 16 units. -There was documentation Resident #3 had a FSBS of 149 at 8:00am on 03/22/26 and was	D 358		

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	HAL060175	A. BUILDING: _____ B. WING _____	05/28/2026

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administered Lantus 100 units/ml 16 units.
-There was documentation Resident #3 had a FSBS of 130 at 8:00am on 03/23/26 and was administered Lantus 100 units/ml 16 units.
-There was documentation Resident #3 had a FSBS of 140 at 8:00am on 03/24/26 and was administered Lantus 100 units/ml 16 units.
-There was documentation Resident #3 had a FSBS of 123 at 8:00am on 03/25/26 and was administered Lantus 100 units/ml 16 units.

Review of Resident #3's April 2026 eMAR revealed:
-There was an entry for FSBS checks at 8:00am and 8:00pm.
-There was documentation Resident #3 received FSBS blood sugar checks at 8:00am and 8:00pm.
-There was an entry for Lantus 100 units/ml, administer 16 units subcutaneously every day at 8:00am, hold for FSBS less than 150, call physician for FSBS greater than 400.
-There was documentation Resident #3 had a FSBS of 147 at 8:00am on 04/03/26 and was administered Lantus 100 units/ml 16 units.
-There was documentation Resident #3 had a FSBS of 122 at 8:00am on 04/08/26 and was administered Lantus 100 units/ml 16 units.
-There was documentation Resident #3 had a FSBS of 142 at 8:00am on 04/17/26 and was administered Lantus 100 units/ml 16 units.
-There was documentation Resident #3 had a FSBS of 149 at 8:00am on 04/20/26 and was administered Lantus 100 units/ml 16 units.
-There was documentation Resident #3 had a FSBS of 122 at 8:00am on 04/24/26 and was administered Lantus 100 units/ml 16 units.

Review of Resident #3's May 2026 eMAR revealed:

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-There was an entry for FSBS checks at 8:00am and 8:00pm.
-There was documentation Resident #3 received FSBS checks at 8:00am and 8:00pm.
-There was an entry for Lantus 100units/ml, administer 16 units every day, hold for FSBS less than 150, call physician for FSBS greater than 400.
-There was documentation Resident #3 had a FSBS of 148 at 8:00am on 05/04/26 and was administered Lantus 100 units/ml 16 units.
-There was documentation Resident #3 had a FSBS of 133 at 8:00am on 05/26/26 and was administered Lantus 100 units/ml 16 units.

Interview with a MA on 05/28/26 at 1:00pm revealed:
-She usually held Resident #3's Lantus if his FSBS was less than 150 according to the physician's order.
-On 03/07/26, 03/11/26, 05/04/26 and 05/26/26, she mistakenly documented that she administered Lantus to Resident #3 although his FSBS was less than 150.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 05/27/26 at 5:11pm revealed:
-Resident #3 had an active order for lantus 100 units/ml, administer 16 units each day at 8:00am, hold insulin for FSBS less than 150, and contact the physician for FSBS is greater than 400.
-A 90-day supply (1500 units) of Lantus was last dispensed on 05/08/26 for Resident #3.

Interview with another MA on 05/28/26 at 10:50am revealed:
-Before January 2026, she obtained Resident #3's FSBS every morning before his insulin administration and she was to hold the insulin for

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D 358	Continued From page 29 a FSBS less than 150. -In January 2026 she asked the former Health and Wellness Director (HWD) about holding Resident #3's insulin for a FSBS less than 150 because on the eMAR there were no directions to hold insulin. -In January 2026, the former HWD instructed her to administer Resident #3's insulin no matter if the FSBS was less than 150 because it was a direct order. -Today (05/28/26), when she reviewed Resident #3's March 2026 paper eMAR, there was an entry to hold Resident #3's insulin for a FSBS less than 150 that did not show up on the eMAR before. -She was trained by the former HWD to obtain the FSBS, document it on the eMAR, and if the FSBS was less than 150, hold the insulin and document holding the insulin by using the drop down menu with the insulin by selecting either hold or other and give the reason as the FSBS less than 150. Interview with Resident #3's Primary Care Provider (PCP) on 05/28/26 at 11:15pm revealed: -She did not usually order (insulin) parameters for residents who were receiving long acting insulin with no outcome. -She recently ordered parameters for residents who required insulin per the facility's request. -Resident #3 had not experienced any issues related to hyperglycemia (high blood sugar). -She expected MAs to follow the parameters associated with insulin orders. Refer to interview with a MA on on 05/28/26 at 10:50am. Refer to interview with the facility's Regional Nurse on 05/28/26 at 11:40am.	D 358		

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D 358	Continued From page 30 Refer to interview with the Administrator on 05/27/26 at 4:45pm. _____ Interview with a MA on 05/28/26 at 10:50am revealed: -After pharmacy entered the orders into the eMAR system, the former HWD, Resident Care Coordinator (RCC) or the Special Care Coordinator (SCC) were to verify the orders in the eMAR with the physician's orders before the MA could administer the medications. -MAs were responsible for verifying the medication orders on the eMAR with the medications on hand prior to administering them. -The MAs were responsible for administering medications according to the physician's orders. -The MAs were responsible for completing weekly medication cart audits where the MAs checked the eMAR orders against the medications on hand, but did not look at the original orders. -She did not know if the former HWD, RCC or SCC completed medication cart audits. Interview with the facility's Regional Nurse on 05/28/26 at 11:40am revealed: -She trained the current HWD on processing new orders and verification of those orders once the pharmacy entered the orders into the eMAR system so that the MAs could administer the medications, FSBS and pulse rates according to the current orders. -She also trained the current HWD on how to complete medication cart audits which consisted of comparing the orders in the eMAR system with the medications on hand and current physician's orders. -The current HWD was to complete the medication cart audits weekly. and correct any orders that were not documented or being followed.	D 358		

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D 358	Continued From page 31 -The MAs were to complete weekly medication cart audits which included comparing the eMAR to the medications on hand and report issues to the current HWD. -She met with the facility's contracted physician on 01/28/26 to add parameters to all vital sign orders which included FSBS and hold orders for all insulin to be administered for a FSBS less than 150 as well as hold orders for blood pressure medications. -She did not know the eMAR system did not show the full order like on the paper eMAR. Interview with the Administrator on 05/27/26 at 4:45pm revealed: -The MAs were responsible to fax all orders to the pharmacy. -The MAs were responsible to follow the physician's orders. -The pharmacy was responsible to enter orders into the eMAR system. -The former and current HWDs were responsible to to verify all new orders by comparing the new orders to the eMAR to make sure the orders were correct. -The former and current HWDs were responsible to have the MAs complete weekly medication cart audits to compare the eMAR to the medications on hand. -The former and current HWDs were responsible to complete weekly medication cart audits to compare the eMAR to the medications on hand with the current physician's orders. -The former and current HWD did not print off the current eMAR which would have caught the hold orders for the insulin and carvedilol not showing up on the eMAR but on the paper MAR.	D 358		

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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; (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, record review and interviews, the facility failed to ensure medication administration records were accurate for 1 of 5 sampled residents (#3) related to medications to treat vitamin B12 and vitamin D deficiency. The findings are: Review of Resident #3's current FL2 dated 08/06/25 revealed:	D 367		

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D 367	Continued From page 33 -Diagnoses included diabetes, lymphedema, hypertension, hyperlipidemia, vitamin D deficiency, peripheral vascular disease, and chronic kidney disease. -Resident #3 was semi-ambulatory. -Resident #3's level of care was assisted living. a.Review of Resident #3's physician order summary dated 01/22/26 revealed there was an order for vitamin B-12 ER (extended release) 1,000mcg (to treat vitamin B12 deficiency), take one tablet by mouth once daily. Review of Resident #3's March 2026, April 2026 and May 2026 eMARs on 05/27/26 revealed: -There were two separate entries for B-12 ER 1,000mcg tablets, one tablet by mouth once daily. -There was documentation B-12 extended release 1,000mcg tablets, one tablet by mouth once daily, was administered twice daily. Refer to telephone interview with medication aide (MA) on 05/28/26 at 12:20pm. Refer to telephone interview with a pharmacist from the facility's contracted pharmacy on 05/27/26 at 5:11pm. Refer to telephone interview with Resident #3's Primary Care Provider (PCP) on 05/27/26 at 5:11pm. Refer to interview with the Administrator on 05/28/26 at 2:10pm. b.Review of Resident #3's physician order summary dated 01/22/26 revealed there was an order for D3 2,000 units, one tablet by mouth once daily.	D 367		

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D 367	Continued From page 34 Review of Resident #2's March 2026, April 2026, and May 2026 eMARs revealed: -There were two entries for vitamin D-3 2,000 units, one tablet by mouth once daily. -There was documentation vitamin D-3 2,000 units, take one tablet by mouth once daily, was administered twice daily. Refer to telephone interview with a MA on 05/28/26 at 12:20pm. Refer to telephone interview with a pharmacist from the facility's contracted pharmacy on 05/27/26 at 5:11pm. Refer to telephone interview with Resident #3's PCP on 05/27/26 at 5:11pm. Refer to interview with the Administrator on 05/28/26 at 2:10pm. _____ Telephone interview with a MA on 05/28/26 at 12:20pm revealed: -She administered Resident #3's vitamin B-12 and D-3 once daily as ordered and documented on the eMAR. -She did not know why Resident #3's eMARs were showing duplicate entries and documentation of duplicate administrations of vitamin B-12 and D-3. Telephone interview with a pharmacist from the facility's contracted pharmacy on 05/27/26 at 5:11pm revealed: -There was one order for vitamin B-12 ER 1,000mcg, take one tablet by mouth once daily and a 30-day supply was last dispensed on 05/07/26. -There was one order for vitamin D-3 2000 units,	D 367		

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D 367	Continued From page 35 take one tablet by mouth once daily and a 30-day supply was last dispensed on 05/07/26. -She did not know why the facility's eMARs were showing double entries vitamin B-12 and vitamin D-3 were administered twice a day. -The 30-day supply of B-12 and D-3 was enough to be administered once daily and not enough to be administered twice a day. Interview with Resident #3's PCP on 05/27/26 at 5:11pm revealed: -Vitamin B-12 and vitamin D-3, one tablet once daily, were in ordered since 2025. -The eMARs for March, April and May 2026 should not show double orders and the facility was responsible for communicating the discontinued orders and refilled or expired orders to the pharmacy. Interview with the Administrator on 05/28/26 at 2:10pm revealed: -The former Health and Wellness Director HWD was responsible for verifying and auditing orders for accuracy and Resident #3's double order entries of vitamin B-12 and D-3 on the March 2026, April 2026 and May 2026 eMARs should have been caught. -The old/ expired orders for Resident #3's B-12 and D-3 were not removed from March 2026, April 2026, and May 2026 eMARs, causing duplicate orders on the eMARS. -MAs did not administer double doses as it appeared on the eMARs. -Her expectation was for all eMARs to be accurate according to the order and medications on the cart.	D 367		