STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL050016	A. BUILDING: _____ B. WING _____	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSTAR ASSISTED LIVING	95 MORNINGSTAR LANE SYLVA, NC 28779

(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 an annual survey on 06/16/26 - 06/17/26.	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 serve therapeutic diets as ordered to 1 of 3 sampled residents (#5) related to an easy to chew diet. The findings are: Review of Resident #5's current FL2 dated 07/15/25 revealed diagnoses included Barrett's esophagus (a change in the mucosal cells of the lower esophagus), and dementia. Review of Resident #5's record revealed there was an order dated 03/31/26 for an easy to chew diet. Observation of the kitchen on 06/16/26 at 9:41am revealed: -There was a paper dated 05/15/26 on the bulletin board listing residents therapeutic diets -Resident #5 was documented on the list as receiving an easy to chew diet.	D 310		

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D 310	Continued From page 1 -There were three carts that contained trays for serving resident meals. -Resident meal trays were identified with a colored dot that indicated the diet consistency. -Resident #5's tray was labeled with a blue dot that indicated "chopped". Review of the facility's Therapeutic Diet Orders revealed an easy to chew diet was the regular diet with changes to make the food soft and easier to eat. Review of the facility's lunch menu for 06/16/26 revealed the meal consisted of a pork roast, rice, stewed tomatoes, a dinner roll and piece of cake. Review of the facility's easy to chew lunch menu for 06/16/26 revealed the meal consisted of an easy to chew pork roast, rice, stewed tomatoes, a dinner roll and a piece of cake. Observation of Resident #5's lunch meal service on 06/16/26 at 12:30pm revealed: -Resident #5 was served a whole piece of pork, rice, stewed tomatoes, a dinner roll and a piece of cake. -The cook replaced the whole piece of meat with chopped meat at the request of the surveyor. -Resident #5 ate all the meat and rice, a few bites of the tomatoes and none of the roll or the cake. Interview with Resident #5 on 06/16/26 at 12:45pm and 06/17/26 at 7:46am revealed his meat was normally served to him chopped. Interviews with a cook on 06/16/26 at 12:31pm and 06/17/26 at 7:53am revealed: -Resident #5 was ordered an easy to chew diet. -An easy to chew diet meant the resident was served the regular menu with chopped meat.	D 310		

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D 310	Continued From page 2 -The kitchen used a colored dot system so he knew what to put on the plate as he served the meals. -Resident #5's serving tray was marked with a blue dot which indicated the meat should be served chopped. -He did not chop Resident #5's meat because "it was hot in here and I was pushed for time and I just wanted to get the plates served". Telephone interview with Resident #5's primary care provider (PCP) on 06/16/26 at 1:08pm revealed: -Resident #5 was ordered an easy to chew diet because he had dysphagia (swallowing difficulties). -Resident #5 had a modified barium swallow study (MBSS) within the past year and the Speech Language Pathologist (SLP) who completed that study recommended the therapeutic diet. -She could not remember if Resident #5 actually choked prior to the MBSS. -Being served a whole piece of meat may cause Resident #5 to choke. Review of Resident #5's SLP plan of care dated 12/05/25 revealed: -Resident #5 had a diagnosis of dysphagia. -Diet texture recommendation was soft and bite sized. Attempted telephone interview with Resident #5's SLP on 06/17/26 at 9:45am was unsuccessful. _____ The facility failed to serve an easy to chew diet as ordered to Resident #5, who had dysphagia, when they served a whole piece of pork roast at lunch. This was detrimental to his health, safety and welfare and constitutes a Type B Violation.	D 310		

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D 310	Continued From page 3 _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on June 16, 2026. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 01, 2026.	D 310		
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 2 of 5 sampled residents (#1, and #5) related to medications used to treat elevated blood pressure, low blood pressure, blood clots, seizures and migraines (#1) and enlarged prostate and chronic obstructive pulmonary disease (#5). The findings are: Review of the facility's Medication Management Plan Policies and Procedures dated 2019 revealed: -Medications will be administered in accordance	D 358		

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D 358	Continued From page 4	D 358		

with the prescribing practitioner's orders.
-The facility will assure medications are provided for residents in accordance with the facility's medication management policy.
-New prescriptions can be sent to the pharmacy via fax or telephone; orders received by 4:00pm will be delivered the same day; after 5:00pm they will be delivered the following day.
-As needed prescriptions can be sent to the pharmacy via fax or telephone; orders received by 5:00pm, will be delivered the same day; after 5:00pm they will be delivered the following day.

1. Review of Resident #1's current FL2 dated 03/30/26 revealed diagnoses included anxiety disorder, chronic obstructive pulmonary disease (COPD) (lung disease that blocks airflow), hypertension (elevated blood pressure), epilepsy (neurological disorder characterized by seizures) and insomnia.

Review of Resident #1's Resident Register revealed an admission date of 03/27/26.

a. Review of Resident #1's physician orders dated 03/30/26 revealed there was an order for Xarelto 20mg daily (used to treat blood clots).

Interview with Resident #1 on 06/16/26 at 9:07am and 06/17/26 at 7:57am revealed:
-She was recently admitted to the facility from a local skilled nursing facility.
-She sometimes was not administered all her medications.
-The medication aides (MA) told her she was out of medications due to the pharmacy not delivering them.
-She brought some medications with her from the other facility but she could not remember which medications she brought.

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D 358	Continued From page 5 Review of Resident #1's April 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Xarelto 20mg daily. -There was documentation Xarelto 20mg was not administered from 04/01/26 to 04/07/26 due to awaiting pharmacy delivery. Review of Resident #1's May 2026 eMAR revealed: -There was an entry for Xarelto 20mg daily. -There was documentation Xarelto 20mg was not administered from 05/15/26 to 05/17/26 due to awaiting pharmacy delivery. Review of Resident #1's June 2026 eMAR revealed: -There was an entry for Xarelto 20mg daily. -There was documentation Xarelto 20mg was not administered from 06/12/26 to 06/15/26 due to awaiting pharmacy delivery. Observation of Resident #1's medications on hand on 06/17/26 at 10:05am revealed Xarelto 20mg was not available to administer. Interview with a MA on 06/17/26 at 10:05am revealed: -According to the notations on the eMAR, another MA requested a refill on 06/05/26. -When she received and checked in the pharmacy delivery on 06/11/26 there was a note that Xarelto 20mg was on order and not delivered. Review of the pharmacy delivery sheet dated 06/03/26 revealed: -Xarelto 20mg was documented as on order and was not delivered.	D 358		

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D 358	Continued From page 6 -A MA signed for the delivery on 06/11/26. Telephone interview with a pharmacist at the facility's contracted pharmacy on 06/16/26 at 3:12pm revealed: -The pharmacy dispensed 30 tablets on 04/01/26 and 28 tablets on 05/07/26. -The pharmacy had documentation they sent the Xarelto 20mg prescription to the local back-up pharmacy to be filled on 04/03/26. -The pharmacy had documentation the back-up pharmacy dispensed 30 tablets on 04/08/26. -The pharmacy dispensed 28 tablets on 05/07/26 with the routine cycle fill. Telephone interview with the facility's PA on 06/17/26 at 11:03am revealed: -Resident #1 was prescribed Xarelto because she had a history of deep vein thrombosis (DVT) (a blood clot in the leg). -If she did not receive the Xarelto as prescribed she could develop another DVT. -An untreated DVT could lead to a pulmonary embolism (blood clot in the lung) and could result in Resident #1 having shortness of breath and a rapid heart rate resulting in the need to be hospitalized. -She was concerned about Resident #1 missing doses of Xarelto. Refer to the interview with a medication aide (MA) on 06/17/26 at 9:55am. Refer to the interview with a second MA on 06/17/26 at 10:00am. Refer to the interview with a third MA on 06/17/26 at 2:30pm. Refer to the interview with the Administrator on	D 358		

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D 358	Continued From page 7 06/17/26 at 2:42pm. b. Review of Resident #1's physician orders dated 03/30/26 revealed there was an order for Levetiracetam 500mg twice daily (used to treat seizures). Interview with Resident #1 on 06/16/26 at 9:07am and 06/17/26 at 7:57am revealed: -She was recently admitted to the facility from a local skilled nursing facility. -She sometimes was not administered all her medications. -The medication aides (MA) told her she was out of medications due to the pharmacy not delivering them. -She brought some medications with her from the other facility but she could not remember which medications she brought. Review of Resident #1's May 2026 eMAR revealed: -There was an entry for Levetiracetam 500mg twice daily at 6:00am and 6:00pm. -There was documentation Levetiracetam 500mg was not administered at 6:00pm on 05/29/26/26 and not administered at 6:00am or 6:00pm on 05/30/26 and 05/31/26 due to awaiting pharmacy delivery. Review of Resident #1's June 2026 eMAR revealed: -There was an entry for Levetiracetam 500mg twice daily at 6:00am and 6:00pm. -There was documentation Levetiracetam 500mg was not administered at 6:00am on 06/01/26, 06/02/26, 06/06/26, 06/08/26 and 06/09/26 and not administered on 06/06/26 and 06/07/26 at 6:00pm due to awaiting pharmacy delivery.	D 358		

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D 358	Continued From page 8 Observation of Resident #1's medications on hand on 06/17/26 at 10:05am revealed: -There was a bottle of Levetiracetam 500mg tablets that had been dispensed by the back-up pharmacy. -The bottle documented 14 Levetiracetam 500mg tablets were dispensed on 06/08/26. Telephone interview with a pharmacist at the facility's contracted pharmacy on 06/16/26 at 3:12pm revealed: -The pharmacy dispensed 12 Levetiracetam 500mg tablets on 04/10/26, enough to get the medication in sync with the cycle fill. -The pharmacy also dispensed 28 tablets on 04/20/26, 28 tablets on 05/07/26 and 56 tablets on 06/14/26. Interview with a MA on 06/17/26 at 10:05am revealed: -The contract pharmacy sent 28 Levetiracetam 500mg tablets in May 2026 because that was all they had. -Since they did not have enough the pharmacy had the back-up pharmacy supply the remainder so they had enough to make it to cycle fill. Telephone interview with the facility's PCP on 06/17/26 at 11:03am revealed: -Resident #1 was prescribed Levetiracetam due to her history of seizures. -Not receiving the medication as prescribed put her at risk of having more seizures. Refer to the interview with a medication aide (MA) on 06/17/26 at 9:55am. Refer to the interview with a second MA on 06/17/26 at 10:00am.	D 358		

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D 358	Continued From page 9 Refer to the interview with a third MA on 06/17/26 at 2:30pm. Refer to the interview with the Administrator on 06/17/26 at 2:42pm. c. Review of Resident #1's physician orders dated 03/30/26 revealed there was an order for Midodrine HCL 5mg- take 1/2 tablet every 6 hours as needed for SBP less than 110 on routine vitals monitoring (used to treat low blood pressure). Review of Resident #1's April 2026 eMAR revealed: -There was an entry for Midodrine HCL 5mg- take 1/2 tablet every 6 hours as needed for SBP less than 110 on routine vitals monitoring. -There was documentation the Midodrine HCL was administered on 04/01/26 when there was no documentation a blood pressure was obtained. -There was documentation the Midodrine HCL was administered on 04/04/26 when SBP was documented as 130. -There was documentation the Midodrine HCL was administered on 04/05/26 when SBP was documented as 118. -There was documentation the Midodrine HCL was administered on 04/06/26 when SBP was documented as 118. -There was documentation the Midodrine HCL was administered on 04/07/26 when SBP was documented as 123. -There was documentation the Midodrine HCL was administered on 04/09/26 when SBP was documented as 118. -There was documentation the Midodrine HCL was administered on 04/10/26 when SBP was documented as 122. -There was documentation the Midodrine HCL was administered on 04/12/26 when SBP was	D 358		

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D 358	Continued From page 10 documented as 124. -There was documentation the Midodrine HCL was administered on 04/13/26 when SBP was documented as 120. -There was documentation the Midodrine HCL was administered on 04/14/26 when SBP was documented as 137. -There was documentation the Midodrine HCL was administered on 04/15/26 when SBP was documented as 122. -There was documentation the Midodrine HCL was administered on 04/16/26 when SBP was documented as 126. -There was documentation the Midodrine HCL was administered on 04/17/26 when there was no documentation a blood pressure was obtained. -There was documentation the Midodrine HCL was administered on 04/18/26 when there was no documentation a blood pressure was obtained. -There was documentation the Midodrine HCL was administered on 04/19/26 when there was no documentation a blood pressure was obtained. -There was documentation the Midodrine HCL was administered on 04/20/26 when there was no documentation a blood pressure was obtained. -There was documentation the Midodrine HCL was administered on 04/21/26 when there was no documentation a blood pressure was obtained. -There was documentation the Midodrine HCL was administered on 04/22/26 when there was no documentation a blood pressure was obtained. -There was documentation the Midodrine HCL was administered on 04/23/26 when SBP was documented as 158. -There was documentation the Midodrine HCL was administered on 04/24/26 when SBP was documented as 120. -There was documentation the Midodrine HCL was administered on 04/25/26 when SBP was documented as 129.	D 358		

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D 358	Continued From page 11 -There was documentation the Midodrine HCL was administered on 04/26/26 when SBP was documented as 115. -There was documentation the Midodrine HCL was administered on 04/27/26 when SBP was documented as 131. -There was documentation the Midodrine HCL was administered on 04/28/26 when SBP was documented as 129. -There was documentation the Midodrine HCL was administered on 04/29/26 when SBP was documented as 158. -There was documentation the Midodrine HCL was administered on 04/30/26 when SBP was documented as 128. Review of Resident #1's May 2026 eMAR revealed: -There was an entry for Midodrine HCL 5mg- take 1/2 tablet every 6 hours as needed for SBP less than 110 on routine vitals monitoring. -There was documentation the Midodrine HCL was administered on 05/01/26 when SBP was documented as 165. -There was documentation the Midodrine HCL was administered on 05/02/26 when SBP was documented as 121. -There was documentation the Midodrine HCL was administered on 05/03/26 when SBP was documented as 119. -There was documentation the Midodrine HCL was administered on 05/04/26 when SBP was documented as 116. -There was documentation the Midodrine HCL was administered on 05/05/26 when SBP was documented as 135. -There was documentation the Midodrine HCL was administered on 05/06/26 when SBP was documented as 138. -There was documentation the Midodrine HCL	D 358		

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was administered on 05/07/26 when SBP was documented as 153.
-There was documentation the Midodrine HCL was administered on 05/08/26 when SBP was documented as 127.
-There was documentation the Midodrine HCL was administered on 05/09/26 when SBP was documented as 115.
-There was documentation the Midodrine HCL was administered on 05/10/26 when SBP was documented as 119.
-There was documentation the Midodrine HCL was administered on 05/11/26 when SBP was documented as 130.
-There was documentation the Midodrine HCL was administered on 05/12/26 when SBP was documented as 138.
-There was documentation the Midodrine HCL was administered on 05/13/26 when SBP was documented as 135.
-There was documentation the Midodrine HCL was administered on 05/14/26 when SBP was documented as 116.
-There was documentation the Midodrine HCL was administered on 05/16/26 when SBP was documented as 120.
-There was documentation the Midodrine HCL was administered on 05/17/26 when SBP was documented as 130.
-There was documentation the Midodrine HCL was administered on 05/18/26 when SBP was documented as 114.
-There was documentation the Midodrine HCL was administered on 05/19/26 when SBP was documented as 140.
-There was documentation the Midodrine HCL was administered on 05/20/26 when SBP was documented as 160.
-There was documentation the Midodrine HCL was administered on 05/21/26 when SBP was

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D 358	Continued From page 13 documented as 119. -There was documentation the Midodrine HCL was administered on 05/22/26 when SBP was documented as 118. -There was documentation the Midodrine HCL was administered on 05/23/26 when SBP was documented as 124. -There was documentation the Midodrine HCL was administered on 05/24/26 when SBP was documented as 173. -There was documentation the Midodrine HCL was administered on 05/25/26 when SBP was documented as 131. -There was documentation the Midodrine HCL was administered on 05/26/26 when SBP was documented as 130. -There was documentation the Midodrine HCL was administered on 05/27/26 when SBP was documented as 135. -There was documentation the Midodrine HCL was administered on 05/28/26 when SBP was documented as 129. -There was documentation the Midodrine HCL was administered on 05/29/26 when SBP was documented as 138. -There was documentation the Midodrine HCL was administered on 05/30/26 when SBP was documented as 123. -There was documentation the Midodrine HCL was administered on 05/31/26 when SBP was documented as 157. Review of Resident #1's June 2026 eMAR revealed: -There was an entry for Midodrine HCL 5mg- take 1/2 tablet every 6 hours as needed for SBP less than 110 on routine vitals monitoring. -There was documentation the Midodrine HCL was administered on 06/01/26 when SBP was documented as 145.	D 358		

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D 358	Continued From page 14 -There was documentation the Midodrine HCL was administered on 06/02/26 when SBP was documented as 139. -There was documentation the Midodrine HCL was administered on 06/03/26 when SBP was documented as 129. -There was documentation the Midodrine HCL was administered on 06/04/26 when SBP was documented as 111. -There was documentation the Midodrine HCL was administered on 06/05/26 when SBP was documented as 133 -There was documentation the Midodrine HCL was administered on 06/06/26 when SBP was documented as 135. -There was documentation the Midodrine HCL was administered on 06/07/26 when SBP was documented as 121. -There was documentation the Midodrine HCL was administered on 06/08/26 when SBP was documented as 121. -There was documentation the Midodrine HCL was administered on 06/09/26 when SBP was documented as 118. -There was documentation the Midodrine HCL was administered on 06/10/26 when SBP was documented as 120. -There was documentation the Midodrine HCL was administered on 06/11/26 when SBP was documented as 126. -There was documentation Midodrine HCL was not administered on 06/12/26 when SBP was 104 with a reason of withheld per doctors orders. -There was documentation Midodrine HCL was not administered on 06/13/26 when SBP was 109 with a reason of awaiting pharmacy delivery. Observation of Resident #1's medications on hand on 06/17/26 at 10:05am revealed Midodrine HCL was not available to administer.	D 358		

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D 358	Continued From page 15 Telephone interview with a medication aide (MA) on 06/17/26 at 1:33pm revealed: -He always obtained Resident #1's BP when he administered the blood pressure medications unless she refused to have it taken. -He did not know of any medication Resident #1 had that needed to be administered if her SBP was lower than 110. -If there was documentation he administered Midodrine HCL he must have administered the medication. -He could only remember Resident #1 had a blood pressure medication that needed to be held if the SBP was low. -He "always" read the complete order on the eMAR when he administered medications and did not remove the as needed medications out of the bubble packs until he knew it needed to be administered. Telephone interview with a pharmacist at the facility's contracted pharmacy on 06/16/26 at 3:12pm revealed as needed medications were only refilled upon request and not with the routine cycle fill. Telephone interview with the facility's PCP on 06/17/26 at 11:03am revealed: -Resident #1 was prescribed Midodrine HCL for low blood pressure and if she received it when her blood pressure was elevated it could cause her blood pressure to elevate further. -Resident #1 was at risk of a stroke if her blood pressure was elevated for too long. -She was concerned about the inappropriate administration of the medication. Interview with the Administrator on 06/16/26 at 2:45pm revealed:	D 358		

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-All MAs were trained to read the medication orders carefully and she expected them to follow parameters as written.
-She did not understand why Midodrine was being administered daily if the order was written to only administer if the SBP was less than 110.

Refer to the interview with a MA on 06/17/26 at 9:55am.

Refer to the interview with a second MA on 06/17/26 at 10:00am.

Refer to the interview with a third MA on 06/17/26 at 2:30pm.

Refer to the interview with the Administrator on 06/17/26 at 2:42pm.

d. Review of Resident #1's physician orders dated 03/30/26 revealed there was an order for Amlodipine Besylate 2.5mg once daily- hold for systolic blood pressure (SBP) less than 100 or heart rate (HR) less than 50 (used to treat high blood pressure).

Interview with Resident #1 on 06/16/26 at 9:07am and 06/17/26 at 7:57am revealed:
-She was recently admitted to the facility from a local skilled nursing facility.
-She sometimes was not administered all her medications.
-The medication aides (MA) told her she was out of medications due to the pharmacy not delivering them.
-She brought some medications with her from the other facility but she could not remember which medications she brought.

Review of Resident #1's April 2026 eMAR

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revealed:
-There was an entry for Amlodipine Besylate 2.5mg once daily- hold for SBP less than 100 or HR less than 60.
-There was documentation Amlodipine Besylate was not administered from 04/17/26 to 04/22/26 due to medication awaiting pharmacy delivery.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 06/17/26 at 9:30am revealed:
-The pharmacy received a faxed order for Amlodipine Besylate 2.5mg once daily for Resident #1 on 03/26/26.
-The pharmacy dispensed 28 tablets on 04/10/26, and the resident should not have run out of the medication in April 2026.

Telephone interview with the facility's contracted primary care provider (PCP) on 06/17/26 at 11:03am revealed:
-Resident #1 was prescribed Amlodipine Besylate for hypertension.
-Resident #1 was at risk of increased blood pressure and possible stroke if the medication was not administered daily.

Refer to the interview with a medication aide (MA) on 06/17/26 at 9:55am.

Refer to the interview with a second MA on 06/17/26 at 10:00am.

Refer to the interview with a third MA on 06/17/26 at 2:30pm.

Refer to the interview with the Administrator on 06/17/26 at 2:42pm.

e. Review of Resident #1's physician orders

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D 358	Continued From page 18 dated 03/30/26 revealed there was an order for Sumatriptan 100mg every 4 hours as needed; maximum dose 200mg/24 hours (used to treat migraines). Interview with Resident #1 on 06/17/26 at 7:57am revealed: -She had migraines and took medication regularly throughout the month for them. -Sometimes the migraine would not go away and she needed more than one tablet in a day. -She took 3 in a day a few times because the migraine just would not go away. -She learned recently that she was only allowed 2 a day so she did not take 3 a day anymore. Review of Resident #1's April 2026 eMAR revealed: -There was an entry for Sumatriptan 100mg every 4 hours as needed; maximum dose 200mg/24 hours. -There was documentation Sumatriptan 100mg was administered three times on 04/11/26, 04/25/26 and 04/26/26. Review of Resident #1's May 2026 eMAR revealed: -There was an entry for Sumatriptan 100mg every 4 hours as needed; maximum dose 200mg/24 hours. -There was documentation Sumatriptan 100mg was administered three times on 05/15/26, 05/17/26, 05/18/26 and 05/27/26. Observation of Resident #1's medications available for administration on 06/17/26 at 10:05am revealed: -Twenty Sumatriptan 100mg were dispensed by the contracted pharmacy on 06/08/26. -There were 8 tablets available for administration.	D 358		

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D 358	Continued From page 19 -There was a note on the label documenting max dose 200mg /24 hours. Telephone interview with the facility's PCP on 06/17/26 at 11:03am revealed: -Resident #1 was prescribed Sumatriptan for migraines. -The maximum dose of Sumatriptan was 200mg /24 hours and if she took more than that she may have minor side effects such as hand tremors. Interview with a MA on 06/17/26 at 10:05am revealed: -Resident #1 requested her migraine medicine frequently and sometimes she wanted 3 in a day if it was a bad migraine. -She and the other MAs read the Sumatriptan label carefully one day and discovered Resident #1 could have a maximum dose of 2 tablets per day. -After reading the label carefully they explained the limit to Resident #1 and since then had not administered 3 tablets in a day. Telephone interview with a medication aide (MA) on 06/17/26 at 1:33pm revealed: -Resident #1 was limited to 2 Sumatriptan tablets in 24-hours. -He and the other MAs discovered the limit a few weeks ago. -He did not remember ever administering a third tablet in a 24-hour period and it must have been an error if his initials were on the eMAR documenting he did. Refer to the interview with the Administrator on 06/17/26 at 2:42pm. 2. Review of Resident #5's current FL2 dated 07/15/25 revealed diagnoses included dementia	D 358		

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(memory loss and impaired cognition), anxiety, chronic obstructive pulmonary disease (COPD) (lung disease that blocks airflow), anemia (low levels of red blood cells), vitamin B12 deficiency, and Barrett's esophagus (damaged lining of the esophagus) with dysphagia (swallowing difficulty).

Review of Resident #5's Resident Register revealed an admission date of 08/29/22.

a. Review of Resident #5's physician orders dated 01/14/26 revealed Myrbetriq ER (medication used to treat overactive bladder that occurs with enlarged prostate) 25mg daily.

Review of Resident #5's electronic medication administration record (eMAR) for April 2026 revealed:
-There was an entry for Myrbetriq ER 25mg daily at 8:00am.
-There was documentation the Myrbetriq ER was not administered from 04/17/26 to 04/22/26 at 8:00am due to medication awaiting pharmacy delivery.

Observation of Resident #5's medications on hand on 06/17/26 at 2:27pm revealed there was one bubble pack of medications labeled Myrbetriq 25mg one tablet daily and 28 tablets were dispensed on 06/12/26 and 22 tablets remained.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 06/17/26 at 2:00pm revealed:
-The pharmacy received a faxed order for Myrbetriq 25mg daily for Resident #5 on 08/12/25.
-The pharmacy dispensed 28 tablets on 03/10/26 and 28 tablets on 04/21/26 and the resident should not have run out of the medication.

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D 358	Continued From page 21 -The pharmacy did not have any documentation that the facility requested a refill for the Myrbetriq. Telephone interview with the facility's contracted primary care provider (PCP) on 06/17/26 at 2:20pm revealed: -Resident #5 was prescribed Myrbetriq for benign prostatic hyperplasia (BPH) (enlarged prostate). -Resident #5 was at risk of decreased urinary output when doses of the medication were not administered. -She was concerned the resident missed doses of the medication. Refer to the interview with a medication aide (MA) on 06/17/26 at 9:55am. Refer to the interview with a second MA on 06/17/26 at 10:00am. Refer to the interview with a third MA on 06/17/26 at 2:30pm. Refer to the interview with the Administrator on 06/17/26 at 2:42pm. b. Review of Resident #5's physician orders dated 01/14/26 revealed Symbicort 160-4.5mcg (medication used to treat COPD) inhale 2 puffs twice daily. Review of Resident #5's eMAR for April 2026 revealed: -There was an entry for Symbicort 160-4.5mcg inhale 2 puffs twice daily at 8:00am and 8:00pm. -There was documentation the Symbicort was not administered on 04/19/26 at 8:00pm, from 04/20/26 to 04/21/26 at 8:00am and 8:00pm, 04/22/26 at 8:00am, 04/23/26 at 8:00am and 8:00pm, and 04/24/26 at 8:00am due to	D 358		

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medication awaiting pharmacy delivery.

Review of Resident #5's eMAR for May 2026 revealed:
-There was an entry for Symbicort 160-4.5mcg inhale 2 puffs twice daily at 8:00am and 8:00pm.
-There was documentation the Symbicort was not administered on 05/23/26 at 8:00pm, from 05/24/26 to 05/27//26 at 8:00am and 8:00pm, and 05/28/26 at 8:00 due to medication awaiting pharmacy delivery.

Observation of Resident #5's medications on hand on 06/17/26 at 2:27pm revealed there was one inhaler in a box labeled Symbicort 160/4.5mcg, 2 puffs twice daily with a dispense date of 05/27/26.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 06/17/26 at 2:00pm revealed:
-The pharmacy received a faxed order for Symbicort 160/4.5mcg 2 puffs twice daily for Resident #5 on 03/02/26.
-The pharmacy received a refill request for the Symbicort on 04/19/26 but the pharmacy was having difficulty getting the medication from their supplier, so they sent the prescription to the facility's back up pharmacy on 04/23/26 and it was delivered to the facility.
-The pharmacy had a lot of medications not available from their supplier.
-The facility should notify the pharmacy that a refill was needed before the medication was totally out.

Telephone interview with the facility's contracted primary care provider (PCP) on 06/17/26 at 2:20pm revealed:
-Resident #5 was prescribed Symbicort for

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treatment of COPD.
-Resident #5 was at risk of chronic obstructive pulmonary disease (COPD) exacerbation and shortness of breath when doses of the medication were not administered.
-She was concerned the resident missed doses of the medication.

Interview with Resident #5 on 06/16/26 at 9:09am revealed all his medications were administered to him and he was not having any concerns.

Refer to the interview with a medication aide (MA) on 06/17/26 at 9:55am.

Refer to the interview with a second MA on 06/17/26 at 10:00am.

Refer to the interview with a third MA on 06/17/26 at 2:30pm.

Refer to the interview with the Administrator on 06/17/26 at 2:42pm.

_____

Interview with a medication aide (MA) on 06/17/26 at 9:55am revealed:
-She made a note when medications were not available and then she checked in the computer to find out if there was already a refill request sent to the facility's contracted pharmacy.
-She called the pharmacy if the medications were not in the facility after three days and notified the former Resident Care Coordinator (RCC).
-She never called the facility's back up pharmacy for medications because that was the former RCC's responsibility.

Interview with a second MA on 06/17/26 at 10:00am revealed:
-She called the pharmacy daily to have them

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deliver medication when the medication was out.
-She requested the pharmacy ask the facility's back-up pharmacy to deliver the medication.
-The pharmacy would always inform her they would deliver it.
-The former RCC was made aware when medications were not available.

Interview with a third MA on 06/17/26 at 2:30pm revealed:
-When bubble packs of medications were at the last row it would be time to request a refill by clicking a button on the computer system which went straight to the pharmacy.
-The medications should have been delivered within 2 days after a refill request.
-She reported to the former RCC when medications were not delivered within 2 days and the former RCC should have followed up with the pharmacy.
-She knew the pharmacy was responsible for calling the facility's back up pharmacy for medications they did not have.
-The facility staff would pick up the medications from the back up pharmacy because they would not deliver them.
-The former RCC was responsible for conducting medication cart audits for expired medications and medications not available.

Interview with the Administrator on 06/17/26 at 2:42pm revealed:
-The facility's contracted pharmacy dispensed and delivered a few of newly ordered medications and then the medications would go into a cycle fill and delivered monthly.
-The MAs would reorder medications via the computer when the medication was at the last row on the bubble pack.
-The medications were delivered in 2 or 3 days by

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D 358	Continued From page 25 a national delivery company. -The MAs informed the former RCC if the medications were not delivered and the former RCC should have followed up on it. -Sometimes the pharmacy could not get the medications from their supplier and failed to inform the facility they requested the facility's back up pharmacy to fill the medications. -The back up pharmacy did not always inform the facility they filled the medications. -The pharmacy would send the facility a fax that the medications were requested from the back up pharmacy but they did not always send a fax. -There was a breakdown in communication. -The former RCC failed to follow up with the pharmacy. -The MAs would scan delivered medications into the computer system and then put the medications in the medication cart. -The monthly cycle fill medications were placed in the former RCC office and staff would scan them in the computer at a later time and the medications may have been left in the office for a few days and not available to administer. -The former RCC was responsible for medication cart audits and she failed to do the audits. _____ The facility failed to ensure medications to treat blood pressure, deep vein thrombosis (blood clot in the leg), seizures and migraines for Resident #1 and medications to treat chronic obstructive pulmonary disease (COPD) and an overactive bladder to Resident #5 were administered as ordered. This failure put Resident #1 at risk for a stroke, a pulmonary embolism or increased seizures and Resident #5 at risk of COPD exacerbation, shortness of breath, and decreased urinary output. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.	D 358		

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D 358	Continued From page 26 The facility provided a plan of protection in accordance with G.S. 131D-34 on June 17, 2026. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 01, 2026.	D 358		
D 378	10A NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record review, the facility failed to ensure all medications were maintained under locked security except when under the direct physical supervision of staff related to 5 large boxes of medications in an unlocked office. The findings are: Review of the facility's Storage of Medications policy and procedure dated 2019 revealed all medications, prescription, and non-prescription,	D 378		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL050016	A. BUILDING: _____ B. WING _____	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSTAR ASSISTED LIVING	95 MORNINGSTAR LANE SYLVA, NC 28779

(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 378	Continued From page 27	D 378		

administered by facility staff, would be kept locked except when staff responsible for medication administration were in close proximity and could see the medications.

Observation of the former Resident Care Coordinator's (RCC) office in the facility on 06/16/26 at 2:37pm revealed:
-It was located on the 300 hallway.
-The door to the office was unlocked and open and there was no one in the room.
-There were 5 open cardboard boxes with bubble packs of medications, bottles of medications, and small boxes of medications in them.

Observation of the medications in the cardboard boxes on 06/16/26 from 3:06pm - 3:50pm revealed:
-There were 597 bubble packs of medications with various numbers of capsules and tablets in each bubble pack.
-There were 3 small boxes of medications, 1 small bag of medications, and 23 bottles of medications.

Review of the facility census for 06/16/26 revealed there were 5 occupied resident rooms on the 300 hall.

Interview with a medication aide (MA) on 06/16/26 at 3:53pm revealed:
-She did not know why the door to the office was not locked.
-All medications should be kept in a locked area.

Interview with a second MA on 06/17/26 at 8:00am revealed:
-She never saw the door to the office with the medications left unlocked.
-She knew medications should always be in a

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D 378	Continued From page 28	D 378		

locked area.
-She knew the resident (Resident #4) that resided in room 302 had a diagnosis of cognitive impairment.

Review of Resident #4's current FL2 dated 05/13/26 revealed:
-Diagnoses included dementia (a decline in mental ability affecting memory and thinking causing poor judgement and reasoning).
-The resident was intermittently disoriented.

Telephone interview with the facility's contracted Physician's Assistant (PA) on 06/17/26 at 11:17pm revealed:
-Medications should always be in a locked area.
-There were residents in the facility with a diagnosis of dementia.
-"Anyone" could get the medications and take a medication that was not prescribed to them.

Interview with a visitor on 06/16/26 at 2:56pm revealed:
-She was a camp leader and brought a group of campers to the facility to do yard work and conduct activities with the residents.
-There were 27 campers, 14-18 years old, inside the facility and outside of the facility on 06/16/26.

Interview with the Administrator on 06/16/26 at 2:50pm revealed:
-The office with the medications was the former Resident Care Coordinator's (RCC) office who had been gone for 2 weeks.
-The cycle fill medications for all the residents were delivered monthly from the facility's contracted pharmacy.
-A supervisor would remove all the medications in the medication carts and staff on 3rd shift placed the newly delivered medications in the medication

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D 378	Continued From page 29 carts for the new cycle. -There were two months of medications in the boxes that should have been returned to the pharmacy. -The former RCC was responsible for ensuring the medications were returned but she had not. -The office door was normally locked but the PCP was working in that room on 06/16/26. -She was not paying attention and did not know the door was open and the room unoccupied. _____ The facility failed to ensure all medications were maintained under locked security by leaving 597 bubble packs of medications and 23 bottles of medications in cardboard boxes in an unlocked office near the room of a resident with a diagnosis of impaired cognition and other residents in the facility with dementia, who have decreased judgement and reasoning, risking the residents taking medications not prescribed to them. This failure was detrimental to the residents' health, safety, and welfare and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on June 16, 2026. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 01, 2026.	D 378		