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THE MEADOWS OF ROCKWELL RETIREMENT	612 HIGHWAY 152 EAST ROCKWELL, NC 28138

(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, a follow-up survey and a complaint investigation from 05/12/26 through 05/14/26.	D 000	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts in the statement of deficiencies corrective action report; the plan of correction is prepared solely as a matter of compliance with state.	
D 253	10A NCAC 13F .0801 (a) (b) Resident Assessment 10A NCAC 13F .0801 Resident Assessment (a) The facility shall complete an assessment of each resident within 30 days following admission and annually thereafter. (b) The facility shall use the assessment instrument and instructional manual established by the Department or an instrument developed by the facility that contains at least the same information as required on the instrument established by the Department. The assessment shall be completed by an individual who has met the requirements of Rule .0508 of this Subchapter. If the facility develops its own assessment instrument, the facility shall ensure that the individual responsible for completing the resident assessment has completed training on how to conduct the assessment using the facility's assessment instrument. The assessment shall be a functional assessment to determine the resident's level of functioning to include psychosocial well-being, cognitive status, and physical functioning in activities of daily living. The assessment instrument established by the Department shall include the following: (1) resident identification and demographic information; (2) current diagnoses; (3) current medications; (4) the resident's ability to self-administer medications;	D 253	Resident Care Coordinator completed current care plan for Resident #1and sent to the PCP for signature. Resident Care Coordinator Audited resident records to ensure current annual care plans with physician signatures are in place. Resident Care Coordinator implemented electronic tracking for due dates. Executive Director Re-educated RCC and leadership on timely completion and follow-up for signatures. Executive Director/designee will audit care plans weekly x4 weeks, then monthly via QAPI.	

Reviewed and Acknowledged K.M. 06/23/26

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D 253	Continued From page 1 (5) the resident's ability to perform activities of daily living, including bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting, and eating; (6) mental health history; (7) social history, to include family structure, previous employment and education, lifestyle habits and activities, interests related to community involvement, hobbies, religious practices, and cultural background; (8) mood and behaviors; (9) nutritional status, including specialized diet or dietary needs; (10)skin integrity; (11)memory, orientation and cognition; (12)vision and hearing; (13)speech and communication; (14)assistive devices needed; and (15)a list of and contact information for health care providers or services used by the resident. The assessment instrument established by the Department is available on the Division of Health Service Regulation website at https://policies.ncdhhs.gov/divisional/health-benefits-nc-medicaid/forms/dma-3050r-adult-care-home-personal-care-physician/@@display-file/form_file/dma-3050R.pdf at no cost. This Rule is not met as evidenced by: Based on record reviews and interviews, the	D 253		

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D 253	Continued From page 2 facility failed to ensure 1 of 5 sampled residents (#1) had an annual care plan completed that was signed by a physician. The findings are: Review of Resident #1's FL2 dated 05/07/26 revealed diagnoses of type 2 diabetes mellitus, essential hypertension, cerebral infarction due to cerebral venous thrombosis, and gastro-esophageal reflux disease. Review of Resident #1's record revealed: -She was admitted to the facility on 12/12/09. -The most recent completed care plan was dated 03/14/25. Interview with Resident #1's Primary Care Provider (PCP) on 05/14/26 at 10:40am revealed: -She was not aware that Resident #1 did not have a current care plan. -She relied on facility staff to provide her with completed care plans to review and sign. Telephone interview with the Resident Care Coordinator (RCC) on 05/14/26 at 5:12pm revealed: -She was responsible for completing annual care plans and obtaining physician signatures for all assisted living residents. -She completed care plans upon admission, when changes of condition occurred and annually. -After care plans were completed, she put them in the PCP's folder for review and signature. -A resident tracker was used to remind her of care plan completion dates. -She was aware that Resident #1 had no care plan completed since 03/14/25. -She did not complete a new care plan for	D 253		

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D 253	Continued From page 3 Resident #1 because the PCP had recommended skilled level of care for Resident #1 in March and she thought resident would be discharged to a skilled nursing facility before a new care plan was needed. Interview with the Administrator on 05/14/26 at 5:34pm revealed: -She was not aware that Resident #1 did not have a current care plan until 05/13/26. -The RCC was responsible for completing all care plans for assisted living residents. -It was her expectation that the RCC use a digital tracking system to ensure completion of care plans.	D 253		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions set forth in 15A NCAC 18A .1300 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions.	D 283	Dietary Manager immediately ice scoop cleaned and placed in a covered, sanitary holder. Area Maintenance Installed appropriate covered storage for ice scoop. Executive Director Re-educated all staff on infection control and food safety practices. Daily kitchen sanitation checks by Dietary Manager; weekly admin audits.	

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D 283	Continued From page 4 This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that the ice supply for all residents was protected from contamination related to an ice scoop lying uncovered. The findings are: Initial tour of the facility's kitchen on 05/12/26 at 3:05pm revealed: -There was one ice machine that supplied the entire facility. -The scoop for the ice machine was lying uncovered in a tray outside the machine. Second observation of the kitchen 05/13/26 at 8:55am revealed the ice scoop was lying uncovered in a tray outside the ice machine. Interview with a personal care assistant (PCA) on 05/13/26 at 10:33am revealed: -She was not aware that the ice scoop in the kitchen must remain covered when not in use nor the reason the scoop needed to remain covered. -She would place the ice scoop on the table beside the ice machine when she was finished using it. Interview with a medication aide (MA) on 05/13/26 at 10:50am revealed: -She was not aware that the ice scoop in the kitchen must remain covered when not in use nor the reason the scoop needed to remain covered. -The ice scoop was usually kept uncovered on the table beside the ice machine.	D 283		

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D 283	Continued From page 5 Interview with a dietary aide (DA) on 05/14/26 at 9:45am revealed she was not aware that the ice scoop in the kitchen should remain covered when not in use nor the reason the scoop needed to remain covered. Interview with a second DA on 05/14/26 at 9:42am revealed she was not aware that the ice scoop in the kitchen should remain covered when not in use nor the reason why the scoop needed to remain covered. Interview with the Dietary Manager (DM) on 05/14/26 at 9:50am revealed: -The facility received a new ice machine approximately 3 months ago and the previous machine had a covered ice scoop holder attached to the outside of the machine, but the new machine did not. -The ice machine in the kitchen supplied ice to all of the residents at the facility. -Dietary staff, clinical staff and activity staff used the ice machine in the kitchen. -She was not aware that the ice scoop needed to remain covered when not in use and thought that it could remain uncovered in a separate tray. -The ice scoop was run through the dish machine every 2-3 days for cleaning. Interview with the Administrator on 05/14/26 at 9:58am revealed: -She was not aware that the ice scoop in the kitchen was uncovered outside the ice machine on 05/12/26 and 05/13/26. -She was aware that the ice scoop must be stored in a cover when not in use for cleanliness and prevention of infection. -She was not aware that the new ice machine did not have a cover for the ice scoop. -She expected all staff to wash their hands before	D 283		

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D 283	Continued From page 6 using the ice scoop and to store it in a covered receptacle when not in use.	D 283	Resident Care Coordinator identified residents (#1, #2, #5, #6, #7) were assessed. Missing medications were obtained and administered per physician orders. PCPs and pharmacy were notified as needed. Resident Care Coordinator Conducted full medication cart, eMAR, and physician order audit for all residents. Verified all orders are accurately entered and medications available. Regional RN Re-education of all Medication Aides on: 6 Rights of medication administration Documentation accuracy (administer then chart) Parameters (e.g., insulin hold orders) Prohibition of task delegation (no PCA med application) Daily shift-to-shift narcotic/med availability checks 7-day reorder threshold compliance tracking Pharmacy order verification log (orders sent vs entered on eMAR) New admission/readmission medication reconciliation process	
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 ensure medications were administered as ordered by a licensed prescribing practitioner for 2 of 5 residents (#6, #7) observed during the 8:00am medication pass on 05/13/26 related to a medication to treat uncontrollable and involuntary movements (#7), and a medication used to treat fungal or yeast infections of the skin, a medication used to treat constipation, and a medication used to treat dry eyes (#6) and for 3 of 5 residents (#1, #2, #5) sampled for record review related to a resident who had an order for a medication used to reduce the risk of heart attack, stroke, and other cardiovascular complications (#2), a resident who had an order to hold insulin (#1) and a resident whose statin, antihistamine and beta blocker were not available for administration (#5). The findings are:	D 358		

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D 358	Continued From page 7 1. The medication error rate was 14% as evidenced by 4 errors out of 27 opportunities observed during the 8:00am medication pass on 05/13/26. a. Review of Resident #7's current FL2 dated 04/30/26 revealed: -Diagnoses included subacute dyskinesia, dementia, schizophrenia, and chronic kidney disease. -There was an order for tetrabenazine (a medication used to treat uncontrollable and involuntary movements) 25mg twice daily. Observation of the morning medication pass on 05/13/26 at 8:52am revealed: -The medication aide (MA) prepared 4 oral medications for administration to Resident #7 from pre-packaged multi-dose medication packages. -Tetrabenazine 25mg was not prepared to be administered. -The MA administered the 4 prepared oral medications to Resident #7. Observation of Resident #7's medications on hand on 05/13/26 at 2:07pm revealed there was a bubble pack medication card of tetrabenazine 25mg dispensed on 05/03/26 for 60 tablets with 59 tablets remaining available for administration. Review of Resident #7's May 2026 electronic medication administration record (eMAR) from 05/01/26 to 05/13/26 revealed: -There was an entry for tetrabenazine 25mg, one tablet twice daily, scheduled for administration at 8:00am and 8:00pm. -There was documentation that tetrabenazine 25mg was administered during the 8:00am	D 358	Clarified responsibility chain: RCC: order transmission and eMAR validation MAs: administration and availability along with documentation Executive Director: oversight and audit validation Resident Care coordinator will conduct bi- weekly medication pass observations x2 weeks Weekly cart/eMAR audits x4 weeks Monthly audits thereafter through QAPI Audit results reviewed by Executive Director and corrective action taken immediately for variances	Date Completed by: 6/28/26

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D 358	Continued From page 8 medication pass on 05/13/26. Telephone interview with a pharmacist from the facility's contracted pharmacy on 05/14/26 at 3:57pm revealed the last 3 dispense dates for Resident #7's tetrabenazine 25mg was 02/16/26 for a 30-day supply, 03/17/26 for a 30-day supply, and 05/03/26 for a 30-day supply. Interview with the MA on 05/14/26 at 2:33pm revealed: -She routinely worked the morning shift and administered Resident #7's morning medications. -She was aware of Resident #7's tetrabenazine 25mg order. -She was not sure why she did not administer Resident #7's tetrabenazine 25mg that morning. -She may have been nervous due to the surveyor watching her administer medications. -Her expectations were to look at each medication scheduled to be administered on the eMAR and assure each of those medications were prepared to be administered. Interview with Resident #7's psychiatric provider on 05/14/26 at 11:03am revealed: -She was not aware Resident #7 had not received her tetrabenazine 25mg as ordered during the 8:00am medication pass on 05/13/26. -If Resident #7 was not receiving her tetrabenazine 25mg as ordered, she was at risk for experiencing gait instability and falls. -About a month ago, MAs reported to her that Resident #7 was experiencing gait instability, but she had not received any reports about Resident #7's gait since then. -She expected the facility to ensure medications were administered as ordered. Interview with the Special Care Unit Coordinator	D 358		

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D 358	Continued From page 9 (SCUC) on 05/14/26 at 12:09pm revealed: -She was aware of Resident #7's tetrabenazine 25mg order. -She was not aware Resident #7 was not administered her tetrabenazine 25mg during the 8:00am medication pass on 05/13/26. -No staff had reported gait instability in Resident #7 to her. Interview with the Administrator on 05/14/26 at 5:40pm revealed: -She was not aware Resident #7 did not receive her tetrabenazine 25mg during the 8:00am medication pass on 05/13/26. -She expected MAs to administer all scheduled medications. Refer to the interview with a second MA on 05/14/26 at 4:55pm. Refer to the interview with the SCUC on 05/14/26 at 12:10pm. Refer to the telephone interview with the RCC on 05/14/26 at 5:13pm. Refer to the interview with the Administrator on 05/14/26 at 5:34pm. b. Review of Resident #6's current FL2 dated 04/16/26 revealed diagnoses included type 2 diabetes and hypoglycemia. 1. Review of Resident #6's signed physician orders dated 04/16/26 revealed there was an order for nystatin powder (an antifungal medication used to treat fungal or yeast infections of the skin) apply to bilateral skin folds twice daily. Observation of the morning medication pass on	D 358		

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D 358	Continued From page 10 05/13/26 at 8:15am revealed: -The medication aide (MA) prepared 9 oral medications from pre-packaged multi-dose medication packages, and 2 insulin medications for administration to Resident #6. -Nystatin powder was not prepared to be administered. -The MA administered the 9 prepared oral medications and 2 insulin medications to Resident #6. Observation of Resident #6's medications on hand on 05/13/26 at 1:44pm revealed there was an almost empty bottle of nystatin powder dispensed on 03/24/26 available for administration. Review of Resident #6's May 2026 electronic medication administration record (eMAR) from 05/01/26 to 05/13/26 revealed: -There was an entry for nystatin powder, apply to bilateral skin folds twice daily, scheduled for administration at 8:00am and 8:00pm. -There was documentation that nystatin powder was administered during the 8:00am medication pass on 05/13/26. Interview with Resident #6 on 05/13/26 at 11:55am revealed her nystatin powder had not been administered to her that morning. Interview with the MA on 05/14/26 at 2:33pm revealed: -She routinely worked the morning shift and administered Resident #6's morning medications. -She was aware of Resident #6's nystatin powder order. -She gave Resident #6's nystatin powder to a personal care aide (PCA) to apply during the 8:00am medication pass on 05/13/26.	D 358		

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D 358	Continued From page 11 -She was not aware PCAs could not apply nystatin powder. -Resident #6 received her nystatin powder despite Resident #6 saying she did not receive it. -The facility expected all medications to be documented as administered after she administered the medication herself. Interview with Resident #6's Primary Care Provider (PCP) on 05/14/26 at 10:39am revealed: -If Resident #6 had not received her nystatin powder as ordered, she would be at risk for yeast infection exacerbation. -She had not received any reports of yeast infection exacerbations for Resident #6. Interview with the Administrator on 05/14/26 at 4:43pm revealed: -She was not aware the MA gave Resident #6's nystatin powder to a PCA to administer. -She expected all medications to be documented as administered after MAs administered the medication themselves. Refer to the interview with a second MA on 05/14/26 at 4:55pm. Refer to the interview with the SCUC on 05/14/26 at 12:10pm. Refer to the telephone interview with the RCC on 05/14/26 at 5:13pm. Refer to the interview with the Administrator on 05/14/26 at 5:34pm. 2. Review of Resident #6's signed physician orders dated 04/16/26 revealed there was an order for polyethylene glycol (a medication used to treat constipation) 17gm daily.	D 358		

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D 358	Continued From page 12 Observation of the morning medication pass on 05/13/26 at 8:15am revealed: -The MA prepared 9 oral medications from pre-packaged multi-dose medication packages, and 2 insulin medications for administration to Resident #6. -Polyethylene glycol 17gm was not prepared to be administered. -The MA administered the 9 prepared oral medications and 2 insulin medications to Resident #6. Observation of Resident #6's medications on hand on 05/13/26 at 1:44pm revealed there was no polyethylene glycol 17gm available for administration. Review of Resident #6's May 2026 eMAR from 05/01/26 to 05/13/26 revealed: -There was an entry for polyethylene glycol 17gm daily, scheduled for administration at 8:00am. -There was documentation that polyethylene glycol 17gm was administered during the 8:00am medication pass on 05/13/26. Interview with Resident #6 on 05/13/26 at 11:55am revealed she did not take polyethylene glycol anymore due to receiving another medication that better assisted with her constipation. Telephone interview with a pharmacist from the facility's contracted pharmacy on 05/14/26 at 3:57pm revealed: -The last dispense date for Resident #6's polyethylene glycol 17gm was 03/19/26 for a 30-day supply. -Resident #6's polyethylene glycol 17gm had not been dispensed since 03/19/26.	D 358		

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(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 358	Continued From page 13 Interview with the MA on 05/14/26 at 2:33pm revealed: -She routinely worked the morning shift and administered Resident #6's morning medications. -She was aware of Resident #6's polyethylene glycol 17gm order. -She gave Resident #6 her polyethylene glycol 17gm from another resident's medication bottle "later on" after the 8:00am medication pass on 05/13/26. -She did administer Resident #6's polyethylene glycol despite Resident #6 saying she did not receive the polyethylene glycol. -All medications should be documented as administered after she administered the medication. Interview with Resident #6's PCP on 05/14/26 at 10:39am revealed: -She expected Resident #6's polyethylene glycol to be administered as ordered. -If Resident #6 did not receive her polyethylene glycol as ordered she was at risk for experiencing constipation. Interview with the SCUC on 05/14/26 at 12:07pm revealed: -She was aware of Resident #6's polyethylene glycol 17gm order. -She was not aware the MA administered Resident #6's polyethylene glycol 17gm "later on" after the 8:00am medication pass on 5/13/26. -She expected that all medications be documented as administered after MAs administered the medication. Interview with the Administrator on 05/14/26 at 4:43pm revealed: -She was not aware the MA administered	D 358		

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D 358	Continued From page 14 Resident #6's polyethylene glycol 17gm "later on" after the 8:00am medication pass on 5/13/26. -She expected that all medications be documented as administered after MAs administered the medication. Refer to the interview with a second MA on 05/14/26 at 4:55pm. Refer to the interview with the SCUC on 05/14/26 at 12:10pm. Refer to the telephone interview with the RCC on 05/14/26 at 5:13pm. Refer to the interview with the Administrator on 05/14/26 at 5:34pm. 3. Review of Resident #6's signed physician orders dated 04/16/26 revealed there was an order for refresh solution (a medication used to treat dry eyes) 1 drop in both eyes three times daily. Observation of the morning medication pass on 05/13/26 at 8:15am revealed: -The MA prepared 9 oral medications from pre-packaged multi-dose medication packages, and 2 insulin medications for administration to Resident #6. -Refresh solution was not prepared to be administered. -The MA administered the 9 prepared oral medications and 2 insulin medications to Resident #6. Observation of Resident #6's medications on hand on 05/13/26 at 1:44pm revealed there was a box of refresh solution vials dispensed on 04/20/26 for 30 vials with 12 vials remaining	D 358		

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D 358	Continued From page 15 available for administration. Review of Resident #6's May 2026 eMAR from 05/01/26 to 05/13/26 revealed: -There was an entry for refresh solution eye drops, instill 1 drop in both eyes three times daily, scheduled for administration at 8:00am, 2:00pm and 8:00pm. -There was documentation that refresh solution was administered during the 8:00am medication pass on 05/13/26. Interview with Resident #6 on 05/13/26 at 11:55am revealed she had not received her refresh solution eye drops that morning. Interview with the MA on 05/14/26 at 2:33pm revealed: -She routinely worked the morning shift and administered Resident #6's morning medications. -She was aware of Resident #6's refresh solution eye drops order. -She gave Resident #6 her refresh solution eye drops "later on" after the 8:00am medication pass on 05/13/26. -She did administer Resident #6's refresh solution eye drops despite Resident #6 saying she did not receive her refresh solution eye drops. -All medications should be documented as administered after she administered the medication. Interview with Resident #6's PCP on 05/14/26 at 10:39am revealed: -She expected Resident #6's refresh solution eye drops to be administered as ordered. -If Resident #6 did not receive her refresh solution eye drops as ordered she was at risk for experiencing dry eyes.	D 358		

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D 358	Continued From page 16 Interview with the SCUC on 05/14/26 at 12:07pm revealed she expected all medications to be documented as administered after MAs administered the medication. Interview with the Administrator on 05/14/26 at 4:43pm revealed she was not aware the MA administered Resident #6's refresh solution eye drops "later on" after the 8:00am medication pass on 05/13/26. Refer to the interview with a second MA on 05/14/26 at 4:55pm. Refer to the interview with the SCUC on 05/14/26 at 12:10pm. Refer to the telephone interview with the RCC on 05/14/26 at 5:13pm. Refer to the interview with the Administrator on 05/14/26 at 5:34pm. 2. Review of Resident #2's current FL2 dated 01/30/26 revealed diagnoses included hyperlipidemia, bilateral edema/lymphedema, type 2 diabetes, and hypertension. Review of Resident #2's signed physician orders dated 01/30/26 revealed there was an order for pravastatin (a medication used to reduce the risk of heart attack, stroke, and other cardiovascular complications) 40mg daily. Review of Resident #2's March 2026 electronic medication administration record (eMAR), April 2026 eMAR, and May 2026 eMAR from 05/01/26 to 05/12/26 revealed there was no entry or documentation for pravastatin 40mg daily.	D 358		

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D 358	Continued From page 17 Observation of Resident #2's medications on hand on 05/14/26 at 10:00am revealed there was a medication card of pravastatin 40mg, dispensed on 05/13/26 for 13 tablets with 13 tablets remaining available for administration. Interview with Resident #2 on 05/14/26 at 4:24pm revealed: -He was aware of his pravastatin 40mg order. -He thought he received his pravastatin 40mg. Telephone interview with a representative from the facility's contracted pharmacy on 05/14/26 at 3:48pm revealed: -The pharmacy received Resident #2's pravastatin 40mg order on 02/06/26. -Because the pravastatin 40mg order was manually written on the physician's orders and not pre-printed along with the rest of the listed medications, the pharmacy could not accept and dispense the order. -The pharmacy added medication order entries to the eMAR for the facility. Interview with Resident #2's Primary Care Provider (PCP) on 05/14/26 at 2:40pm revealed: -She expected Resident #2's pravastatin 40mg to be administered as ordered. -If Resident #2 had not received his pravastatin 40mg as ordered, he would be at risk for increased cholesterol levels. -Resident #2 had not had any updated labs since his pravastatin 40mg order was written on 01/30/26. Interview with the Special Care Unit Coordinator (SCUC) on 05/14/26 at 12:04pm revealed: -She was not aware of Resident #2's pravastatin 40mg order. -When Resident #2's pravastatin 40mg was	D 358		

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D 358	Continued From page 18 written on 01/30/26 she was not in the SCUC position. -She was not sure why Resident #2's pravastatin 40mg order was not added to the eMAR by the facility's contracted pharmacy. -She was not aware of why facility staff did not follow up on Resident #2's pravastatin 40mg order with the facilities contracted pharmacy. -She expected all medications to be administered as ordered. Telephone interview with the Resident Care Coordinator (RCC) on 05/14/26 at 5:17pm revealed: -She was aware of Resident #2's pravastatin 40mg order. -She was responsible for faxing Resident #2's pravastatin 40mg order to the facility's contracted pharmacy. -She forgot to assure the facility's contracted pharmacy added Resident #2's pravastatin 40mg order to the eMAR. Interview with the Administrator on 05/14/26 at 5:35pm revealed: -She was not aware of Resident #2's pravastatin 40mg order. -There was not a system in place to check behind the facility's contracted pharmacy adding orders to the eMAR. -She expected all medications to be administered as ordered. Refer to the interview with a second MA on 05/14/26 at 4:55pm. Refer to the interview with the SCUC on 05/14/26 at 12:10pm. Refer to the telephone interview with the RCC on	D 358		

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D 358	Continued From page 19 05/14/26 at 5:13pm. Refer to the interview with the Administrator on 05/14/26 at 5:34pm. 3. Review of Resident #1's current FL2 dated 05/07/26 revealed: -Diagnoses included type 2 diabetes mellitus, essential hypertension, cerebral infarction due to cerebral venous thrombosis, and gastro-esophageal reflux disease (GERD). -She was intermittently confused. -There was an order to check Finger Stick Blood Sugar (FSBS) before meals and at bedtime. Review of a signed physician order for Resident #1 dated 01/20/26 revealed an order for insulin aspart U-100 insulin pen; 100 unit/mL (3mL); inject 32 units under the skin 3 times daily before meals; hold if FSBS was less than 120. Review of Resident #1's March 2026 electronic medication administration record (eMAR) revealed: -There was an entry to check FSBS before meals and at bedtime. -There was an entry to administer insulin aspart U-100 insulin pen; 100 unit/mL (3mL); inject 32 units under the skin 3 times daily before meals; hold if FSBS was less than 120. -There was documentation that Resident #1's FSBS was less than 120 on 7 occasions and the insulin was not held with examples as followed; on 03/01/26 at 07:30am, FSBS was 116 and 32 units insulin aspart were administered; on 03/02/26 at 07:30am, FSBS was 91 and 32 units insulin aspart were administered; on 03/02/26 at 05:30pm, FSBS was 83 and 32 units insulin aspart were administered.	D 358		

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D 358	Continued From page 20 Review of Resident #1's April 2026 eMAR revealed: -There was an entry to check FSBS before meals and at bedtime. -There was an entry to administer insulin aspart U-100 insulin pen; 100 unit/mL (3mL); inject 32 units under the skin 3 times daily before meals; hold if FSBS was less than 120. -There was documentation that Resident #1's FSBS was less than 120 on 6 occasions and the insulin was not held with examples as followed; on 04/01/26 at 07:30am, FSBS was 118 and 32 units insulin aspart were administered; on 04/11/26 at 07:30am, FSBS was 114 and 32 units insulin aspart were administered; on 04/14/26 at 07:30am, FSBS was 87 and 32 units insulin aspart were administered. -There was documentation that Resident #1's FSBS was above 120 on 4 occasions, but zero units of insulin were administered with examples as followed; on 04/29/26 at 11:30am, FSBS was 165 and 0 units insulin aspart were administered; on 04/29/26 at 05:00pm, FSBS was 161 and 0 units of insulin aspart were administered; on 04/30/26 at 07:30am, FSBS was 226 and 0 units insulin aspart were administered. Review of Resident #1's May 2026 eMAR from 05/01/26 to 05/13/26 revealed: -There was an entry to check FSBS before meals and at bedtime. -There was an entry to administer insulin aspart U-100 insulin pen; 100 unit/mL (3mL); inject 32 units under the skin 3 times daily before meals; hold if FSBS was less than 120. -There was documentation that Resident #1's FSBS was above 120 on 14 occasions, but zero units of insulin were administered with examples as followed; on 05/01/26 at 11:30am, FSBS was 360 and 0 units insulin aspart were administered;	D 358		

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D 358	Continued From page 21 on 05/01/26 at 05:00pm, FSBS was 287 and 0 units insulin aspart were administered; on 05/02/26 at 07:30am, FSBS was 222 and 0 units insulin aspart were administered. Observation of medications on hand for Resident #1 on 05/14/26 at 11:37am revealed there were 4 unopened insulin aspart U-100 pens, and one opened pen dated 05/12/26 with approximately 200 of 200 units remaining. Interview with Resident #1 on 05/14/26 at 9:46am revealed: -Her FSBS readings were usually high, but she could recall them being low on several occasions. -Facility staff would usually tell her the FSBS readings but not tell her how many units of insulin she was to receive or if the insulin was to be held. -She felt her diabetes was not well-controlled. Telephone interview with a representative from the facility's contracted pharmacy on 05/14/26 at 3:44pm revealed: -Resident #1 had an order dated 01/20/26 for insulin aspart U-100 insulin pen; 100 unit/mL (3mL); inject 32 units under the skin 3 times daily before meals; hold if FSBS was less than 120. -Resident #1's insulin apart was dispensed on 03/24/26 (15mL), 04/17/26 (15mL) and 05/12/26 (15mL). -Five pens containing 3mL/200units each, were dispensed on each date and expired 28 days after opening. Interview with Resident #1's primary care provider (PCP) on 05/14/26 at 10:38am revealed: -She was not aware that Resident #1's insulin was not being held or administered as ordered. -She expected staff to hold Resident #1's insulin as ordered.	D 358		

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D 358	Continued From page 22 -She visited the facility once weekly and reviewed FSBS values and eMARs each time she visited Resident #1. -If facility staff did not administer Resident #1's insulin correctly, there was the potential for either hypoglycemia or hyperglycemia. Interview with a medication aide (MA) on 05/14/26 at 10:52am revealed: -She was aware of Resident #1's insulin orders to hold if her FSBS was below 120. -She administered the correct number of insulin units to Resident #1 and held her insulin when her FSBS was below 120. -Resident #1's eMAR had separate spaces to enter the FSBS reading and the number of units of insulin administered, and staff's initials were auto populated. -She may have inadvertently clicked on the wrong drop-down box when Resident #1's insulin was supposed to be administered on 05/01/26 at 11:30am, on 05/04/26 at 07:30am and 11:30am, and on 05/05/26 at 07:30am. Interview with a second MA on 05/14/26 at 2:36pm revealed: -She was aware of Resident #1's insulin orders. -She administered medications according to the eMAR orders. -She held Resident #1's insulin based on her FSBS readings but could not recall if the eMAR prompted additional commands to show the medication was held. Interview with the Resident Care Coordinator (RCC) on 05/14/26 at 5:12pm revealed: -She was aware of Resident #1's insulin orders. -She was not aware that Resident #1's insulin was being administered incorrectly. -She expected staff to administer or hold	D 358		

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D 358	Continued From page 23 Resident #1's insulin according to parameters. Interview with the Administrator on 05/14/26 at 5:33pm revealed: -She was not aware of Resident #1's insulin orders or parameters. -She was not aware that Resident #1's insulin was not being held as ordered. -She expected MAs to document the number of insulin units administered to residents as ordered and to hold insulin based on parameters. Refer to the interview with a second MA on 05/14/26 at 4:55pm. Refer to the interview with the SCUC on 05/14/26 at 12:10pm. Refer to the telephone interview with the RCC on 05/14/26 at 5:13pm. Refer to the interview with the Administrator on 05/14/26 at 5:34pm. 4. Review of Resident #5's current FL2 dated 05/05/26 revealed diagnoses included diabetes mellitus, hypertension and a history of myocardial infarction. Review of Resident #5's progress notes revealed: -There was documentation Resident #5 was in the hospital from 01/24/26 to 03/04/26 and was readmitted to the facility on 03/04/26. -There was documentation Resident #5 was in the hospital from 03/20/26 to 05/08/26 and was readmitted to the facility on 05/08/26. a. Review of Resident #5's current FL2 dated 05/05/26 revealed there was an order for metoprolol succinate (a medication used to treat	D 358		

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D 358	Continued From page 24 hypertension) 25mg take one-half tablet daily. Review of Resident #5's May 2026 electronic medication administration record (eMAR) from 05/01/26 to 05/13/26 revealed: -There was an order entry beginning on 05/09/26 for metoprolol succinate tablet 25mg ER take one-half tablet (12.5mg) daily scheduled for administration at 8:00am. -There was documentation metoprolol succinate was administered from 05/09/26 to 05/13/26. Observation of the medications on hand for Resident #5 on 05/14/26 at 12:50pm revealed there was no metoprolol succinate available for administration on the medication cart. Telephone interview with a representative from Resident #5's pharmacy on 05/14/26 at 4:30pm revealed: -The pharmacy last dispensed metoprolol succinate 50mg once daily on 02/27/26 for a quantity of 30 tablets which was a 30-day supply. -The metoprolol succinate 50mg was a previous order prior to an order change. -The pharmacy had not dispensed metoprolol succinate 25mg. Telephone interview with a representative from the facility's contracted pharmacy on 05/14/26 at 4:07pm revealed: -The pharmacy only profiled Resident #5's medications on the eMAR until 05/14/26 when a request was made for the pharmacy to dispense Resident #5's medications. -Profiling a resident's medication meant putting an order entry or "placeholder" on the eMAR. -Resident #5's medications were never dispensed by the facility's contracted pharmacy because they needed physician orders or prescriptions to	D 358		

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D 358	Continued From page 25 dispense the medications. -Resident #5's medications were dispensed by a different pharmacy. Interview with Resident #5 on 05/14/26 at 4:23pm revealed: -He did not know his medications by name but he thought staff administered all his medications. -Sometimes the facility ran out of his medications for one or two days. Interview with Resident #5's primary care provider (PCP) on 05/14/26 at 10:45am revealed: -She became the PCP for Resident #5 on 05/08/26 when Resident #5 returned from the hospital. -She had not had a chance to review Resident #5's record or look at any of Resident #5's medications. Interview with a medication aide (MA) on 05/14/26 at 12:50pm revealed: -She had requested a medication refill for Resident #5's metoprolol succinate because it was not available for administration on the medication cart. -She did not know Resident #5's metoprolol succinate was not available to administer until 05/14/26. Interview with the Special Care Unit Coordinator (SCUC) on 05/14/26 at 5:02pm revealed: -She did not know Resident #5 was out of metoprolol succinate until one of the MAs told her on 05/14/26. -She called the pharmacy and a representative from the pharmacy told her they did not dispense medications for Resident #5 because Resident #5 was "profile only" in their system. -MAs were expected to call or fax Resident #5's	D 358		

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D 358	Continued From page 26 pharmacy to request refills when Resident #5 was out of a medication. Interview with the Administrator on 05/14/26 at 5:33pm revealed she did not know Resident #5 was out of metoprolol succinate and did not have any available to administer on the medication cart. Refer to the interview with a second MA on 05/14/26 at 4:55pm. Refer to the interview with the SCUC on 05/14/26 at 12:10pm. Refer to the telephone interview with the RCC on 05/14/26 at 5:13pm. Refer to the interview with the Administrator on 05/14/26 at 5:34pm. b. Review of Resident #5's current FL2 dated 05/05/26 revealed there was an order for atorvastatin (a medication used to treat high cholesterol) 10mg daily. Review of Resident #5's May 2026 eMAR from 05/01/26 to 05/12/26 revealed: -There was an order entry beginning on 05/08/26 for atorvastatin tablet 10mg take one tablet at bedtime scheduled for administration at 8:00pm. -There was documentation atorvastatin was administered from 05/08/26 to 05/12/26. Observation of the medications on hand for Resident #5 on 05/14/26 at 12:50pm revealed there was no atorvastatin available for administration on the medication cart. Telephone interview with a representative from	D 358		

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	HAL080026	A. BUILDING: _____ B. WING _____	R 05/14/2026

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D 358	Continued From page 27 Resident #5's pharmacy on 05/14/26 at 4:30pm revealed the pharmacy last dispensed atorvastatin 10mg once daily on 02/27/26 for a quantity of 30 tablets which was a 30-day supply. Telephone interview with a representative from the facility's contracted pharmacy on 05/14/26 at 4:07pm revealed: -The pharmacy only profiled Resident #5's medications on the eMAR until 05/14/26 when a request was made for the pharmacy to dispense Resident #5's medications. -Profiling a resident's medication meant putting an order entry or "placeholder" on the eMAR. -Resident #5's medications were never dispensed by the facility's contracted pharmacy because they needed physician orders or prescriptions to dispense the medications. -Resident #5's medications were dispensed by a different pharmacy. Interview with Resident #5 on 05/14/26 at 4:23pm revealed: -He did not know his medications by name but he thought staff administered all his medications. -Sometimes he ran out of medications for one or two days. Interview with Resident #5's PCP on 05/14/26 at 10:45am revealed: -She became the PCP for Resident #5 on 05/08/26 when Resident #5 returned from the hospital. -She had not had a chance to review Resident #5's chart or look at any of Resident #5's medications. Interview with a MA on 05/14/26 at 12:50pm revealed: -She had requested a medication refill for	D 358		

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D 358	Continued From page 28 Resident #5's atorvastatin because it was not available for administration on the medication cart. -She did not know Resident #5's atorvastatin was not available to administer until 05/14/26. Interview with a second MA on 05/14/26 at 4:54pm revealed he noticed on 05/13/26 that Resident #5 did not have atorvastatin available for administration on the medication cart and he had requested a medication refill from the pharmacy on 05/13/26. Interview with the SCUC on 05/14/26 at 5:02pm revealed: -She did not know Resident #5 was out of atorvastatin until one of the MAs told her on 05/14/26. -She called the pharmacy and a representative from the pharmacy told her they did not dispense medications for Resident #5 because Resident #5 was "profile only" in their system. -MAs were expected to call or fax Resident #5's pharmacy to request refills when Resident #5 was out of a medication. Interview with the Administrator on 05/14/26 at 5:33pm revealed she did not know Resident #5 was out of atorvastatin and did not have any available to administer on the medication cart. Refer to the interview with a second MA on 05/14/26 at 4:55pm. Refer to the interview with the SCUC on 05/14/26 at 12:10pm. Refer to the telephone interview with the RCC on 05/14/26 at 5:13pm.	D 358		

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D 358	Continued From page 29 Refer to the interview with the Administrator on 05/14/26 at 5:34pm. c. Review of Resident #5's current FL2 dated 05/05/26 revealed there was an order for cetirizine (a medication used to treat allergy symptoms) 10mg daily. Review of Resident #5's May 2026 eMAR from 05/01/26 to 05/12/26 revealed: -There was an order entry beginning on 05/09/26 for cetirizine tablet 10mg take one tablet daily scheduled for administration at 8:00am. -There was documentation cetirizine was administered from 05/09/26 to 05/13/26. Observation of the medications on hand for Resident #5 on 05/14/26 at 12:50pm revealed there was no cetirizine available for administration on the medication cart. Telephone interview with a representative from Resident #5's pharmacy on 05/14/26 at 4:30pm revealed the pharmacy last dispensed cetirizine 10mg once daily on 02/27/26 for a quantity of 30 tablets which was a 30-day supply. Telephone interview with a representative from the facility's contracted pharmacy on 05/14/26 at 4:07pm revealed: -The pharmacy only profiled Resident #5's medications on the eMAR until 05/14/26 when a request was made for the pharmacy to dispense Resident #5's medications. -Profiling a resident's medication meant putting an order entry or "placeholder" on the eMAR. -Resident #5's medications were never dispensed by the facility's contracted pharmacy because they needed physician orders or prescriptions to dispense the medications.	D 358		

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D 358	Continued From page 30 -Resident #5's medications were dispensed by a different pharmacy. Interview with Resident #5 on 05/14/26 at 4:23pm revealed: -He did not know his medications by name but he thought staff administered all his medications. -Sometimes he ran out of medications for one or two days. Interview with Resident #5's PCP on 05/14/26 at 10:45am revealed: -She became the PCP for Resident #5 on 05/08/26 when Resident #5 returned from the hospital. -She had not had a chance to review Resident #5's record or look at any of Resident #5's medications. Interview with a MA on 05/14/26 at 12:50pm revealed: -She had requested a medication refill for Resident #5's cetirizine because it was not available for administration on the medication cart. -She did not know Resident #5's cetirizine was not available to administer until 05/14/26. Interview with the SCUC on 05/14/26 at 5:02pm revealed: -She did not know Resident #5 was out of cetirizine until one of the MAs told her on 05/14/26. -She called the pharmacy and a representative from the pharmacy told her they did not dispense medications for Resident #5 because Resident #5 was "profile only" in their system. -MAs were expected to call or fax Resident #5's pharmacy to request refills when Resident #5 was out of a medication.	D 358		

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D 358	Continued From page 31 Interview with the Administrator on 05/14/26 at 5:33pm revealed she did not know Resident #5 was out of cetirizine and did not have any available to administer on the medication cart. Refer to the interview with a second MA on 05/14/26 at 4:55pm. Refer to the interview with the SCUC on 05/14/26 at 12:10pm. Refer to the telephone interview with the RCC on 05/14/26 at 5:13pm. Refer to the interview with the Administrator on 05/14/26 at 5:34pm. Interview with a second MA on 05/14/26 at 4:55pm revealed he and the other MAs completed audits sometimes where they compared a physician order list to the medications on the cart. Interview with the Special Care Unit Coordinator (SCUC) on 05/14/26 at 12:10pm revealed: -She completed chart audits once a week or once every 2 weeks. -MAs completed medication cart and eMAR audits once a week. -She or the Resident Care Coordinator (RCC) faxed new orders directly to the facility's contracted pharmacy. -The facility's contracted pharmacy added orders to the eMAR. -Staff did not have the ability to add orders to the eMAR. -She expected all medications to be administered as ordered.	D 358		

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D 358	Continued From page 32 Telephone interview with the Resident Care Coordinator (RCC) on 05/14/26 at 5:13pm revealed: -The MAs normally reordered medications. -The MAs were responsible to administer medications as ordered. -MAs received training on the 6 rights of medication administration when hired. -All MAs were trained, by a registered nurse (RN), to document administration of a medication after they administered the medication themselves. -The facility's contracted pharmacy completed eMAR audits quarterly and the MAs completed medication cart audits weekly and submitted forms to the RCC. -She expected all medications to be documented as administered after MAs administered the medication. -She was responsible for checking to ensure the facility's contracted pharmacy added all orders to the eMAR. -She expected all medications to be administered as ordered and if a medication was not administered she expected the eMAR to reflect that. -She expected MAs to let her know when a resident was out of a medication and to notify the pharmacy. Interview with the Administrator on 05/14/26 at 5:34pm revealed: -She expected the MAs to reorder medications when there were seven doses remaining of a medication. -The MAs were able to reorder medications through the eMAR system. -She expected all medications to be administered as ordered and if a medication was not administered she expected the eMAR to reflect that.	D 358		

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D 358	Continued From page 33 -She expected MAs to contact the RCC, the SCUC, the pharmacy or the PCP if they did not understand medication orders. -When there was a change in medication orders, she expected the RCC and SCUC to teach MAs regarding the change. -She expected all medications to be documented as administered after MAs administered the medication. -The MAs were responsible to reorder medications. The facility failed to ensure medications were administered as ordered for 5 of 7 residents including a resident who was ordered insulin that was not held and administered according to parameters, placing the resident at risk for hyperglycemia or hypoglycemia (#1), a resident who was not administered a medication used to control involuntary movements, placing the resident at increased risk for falls (#7), and a resident who was not administered a laxative, placing the resident at risk for constipation (#6). This failure was detrimental to the health, safety and welfare of the residents which constitutes a Type B Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 05/14/26 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED June 28, 2026.	D 358		