STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL028002	A. BUILDING: _____ B. WING _____	R 05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THE OUTER BANKS	803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948

(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 and follow-up survey on May 20, 2026 through May 22, 2026.	D 000		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure a therapeutic diet was served as ordered for 1 of 4 sampled residents (#6) who had a physician's order for a mechanical soft diet (#6). The findings are: Review of the facilities therapeutic diet policy dated August 2020 revealed: -There were four diet options available to residents at the facility. -These included regular, no added salt, low cholesterol/low fat, and consistent carbohydrate. -The no added salt, low cholesterol/low fat and consistent carbohydrate diets were called therapeutic diets because they were used to help manage health and medical conditions. -The facility could also modify the no added salt, low cholesterol/low fat and consistent carbohydrate diets to accommodate chewing or swallowing challenges. -One of the modifications included mechanical	D 310	State Rule # and Rule: 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 residents' physician. Plan of Correction: After being made aware of this interruption in Spring Arbors' Standard practice, a mandatory In Service re-training for all cooks, servers and nursing staff was conducted on 5/26/2026 by the Director. The In-Service incorporated re-education of the North Carolina Adult Care Rules and Regulations on Therapeutic Diets. The Executive Director (ED) and Resident Care Director (RCD) conducted a comprehensive and thorough audit of all Diet Orders for each resident in the Community. Prevention of Re-occurrence Weekly ongoing In-Service reeducation and training have been scheduled for all team members on Therapeutic Diets. The Dietary Board has been updated by our ED and on-going the Food Service Director (FSD) and/or designee will be responsible for keeping it current. All dietary team members have been trained and reeducated on the diet board and the Extended Diet Menu. Monitoring Responsibility & Frequency: To ensure ongoing compliance in this rule area, the FSD/designee will maintain a Diet Board for all Therapeutic Diets for our residents and keep current diet orders readily available and visible for cooks. The Executive Director/designee will inspect the Diet orders for compliance at least weekly for 3 months. The Vice President of Operations (VPO) and Regional Director of Wellness, Quality & Education Nurse (QE Nurse)will spot check the Diet orders to assure compliance during their on-site visits to the community. Completion Date: 5/26/2026	5/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL028002	A. BUILDING: _____ B. WING _____	R 05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THE OUTER BANKS	803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948

(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 310	Continued From page 1	D 310		

soft preparation.
-A physician's order was required for every diet and texture modification.
-A copy of the physician's current diet order was kept in the kitchen posted on a board and updated regularly and placed in a diet order binder.
-Dietary staff must be familiar with each resident's complete diet order.
-Dietary staff were expected to prepare meals that followed the menu planned by the facilities dietician.

Review of Resident #6's current FL-2 dated 05/21/26 revealed:
-Diagnoses included hypothyroidism, osteoarthritis, depression, and dementia.
-There was a diet order for mechanical soft.

Review of Resident #6's signed physician order dated 05/21/26 revealed a diet order for a mechanical soft diet.

Review of Resident #6's service plan dated 04/02/26 revealed:
-There was a list of activities of daily activity (ADLs) assistance.
-There was a goal listed to optimize the resident's ability to complete activities of daily living, while providing the level of support required to maintain the resident's safety, dignity, and overall well-being.
-Resident #6 had meal assistance required was limited, the resident could feed herself but could require occasional assistance with cutting her food.

Observation of a list of residents on special diets posted in the kitchen on 05/21/26 at 8:25am revealed Resident #6 was on a mechanical soft

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL028002	A. BUILDING: _____ B. WING _____	R 05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THE OUTER BANKS	803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948

(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 310	Continued From page 2	D 310		

diet.

Observation of a therapeutic diet description of therapeutic diets on 05/21/26 at 8:26am revealed:
-The therapeutic diet description was posted in the kitchen.
-A mechanical soft diet was described as foods that were chopped, ground or softened for residents who have difficulty chewing, but can safely swallow.

Observation of the breakfast meal service on 05/21/26 from 8:00am to 8:23am revealed:
-Resident #6 was served scrambled eggs, sausage patties that were cut into approximately ½ inch pieces, and a piece of toast with butter applied by a personal care aide (PCA).
-The piece of toast with butter was cut in half.
-The resident was also served milk, orange juice, and water.
-According to the American Dietetic Association a mechanical soft diet should be moist, soft-textured and easily formed into a bolus (A bolus is food that is efficiently chewed and moistened into a soft, cohesive ball), meats and other foods should be ground or minced into small pieces no larger than ¼ of an inch, and all food items should be easy to chew.

Interview with a PCA on 05/21/26 at 12:15pm revealed:
-She had never been instructed by dietary staff to cut up Resident #6's food.
-She cut up her sausage patty this morning because the resident had a difficult time cutting her food.
-She served Resident #6 her breakfast plate and thought that the meal consistency was correct since it was delivered directly from the kitchen.
-She was not aware that Resident #6 was on a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL028002	A. BUILDING: _____ B. WING _____	R 05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THE OUTER BANKS	803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948

(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 310	Continued From page 3	D 310		

mechanical soft diet and did not know what a mechanical soft diet meant.

Interview with a medication aide (MA) on 05/21/26 at 12:10pm revealed:
-She and the PCAs usually cut up all residents' food because they thought it would be easier for the residents to manage eating with utensils.
-No one from the dietary staff had instructed her to cut up food for Resident #6.
-She was not aware that Resident #6 was on a mechanical soft diet.

Interview with the lead cook on 05/20/26 at 8:10am revealed:
-The facility did not have a dietary manager.
-He was the lead cook and was responsible for preparing residents meals.
-He thought that since he put butter on Resident #6's toast that it was soft enough for her to chew without cutting the toast.
-He served the resident two sausage patties and assumed the staff working on the special care unit (SCU) knew to chop her food into small pieces.
-He thought the staff on the SCU were responsible for cutting up Resident #6's food to ensure she was served a mechanical soft diet.

Interview with the Resident Care Coordinator (RCC) on 05/21/26 at 2:25pm revealed:
-Resident #6 was on a mechanical soft diet because she had difficulties swallowing.
-The lead cook should have prepared the correct diet for Resident #6; it was not the responsibility of the PCAs or MAs to prepare her a mechanical soft diet.
-Resident #6 was at risk of possibly choking when she was not served a mechanical soft diet.
-The lead cook should have followed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL028002	A. BUILDING: _____ B. WING _____	R 05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THE OUTER BANKS	803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948

(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 310	Continued From page 4 physician's order and prepared her meal as mechanically soft. Interview with the Administrator on 05/21/26 at 2:56pm revealed: -The lead cook was responsible for preparing Resident #6's meal per the physician's order which was mechanical soft. -The PCAs and MAs were not responsible to prepare the resident's meal, that responsibility was with the lead cook. -She expected the lead cook to follow physician orders and prepare Resident #6's meal correctly to prevent swallowing complications. Attempted telephone interview with Resident #6's primary care provider (PCP) on 05/22/26 at 10:31am was unsuccessful.	D 310	State Rule # and Rule: 10A NCAC 13 F.1004{a) Medication Administration (a) An adult care home shall ensure that the preparation and administration of medications, prescriptions and non-prescriptions, 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 Plan of Correction: Reeducation and training of all Med Techs/Nurses was conducted on the importance and process of reordering medications, managing family-provided medications and following all physicians' orders as prescribed - 5/25/2026. ED has informed all residents POA's of our community's medication policy to include escalation procedures when medications are not provided on time. RCD/ED have implemented monthly Med Tech/Nurse In-Services since recent survey. Prevention of Re-occurrence: Med Techs/Nurses are completing weekly medication cart audits to verify the availability of all prescribed medications. RCD/ED will continue to review these weekly med cart to ensure prompt availability of medications. Monitoring Responsibility & Frequency: RCD/ED will review medication administration records (MARs) randomly for three months to verify adherence to medication orders. On-going review and assessment of audit detections will continue to be addressed during our monthly Med Tech/ Nurse In-Services/ meetings with RCD/ED. Regional Director of Quality & Education Nurse will continue to be a resource to teach/retrain Med Techs with our RCD. Correction Completion Date: 5/25/2026	5/25/2026
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: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 4 residents (#7) observed during the medication pass including errors with a medication used to help reduce the frequency or severity of Parkinson's	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL028002	A. BUILDING: _____ B. WING _____	R 05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THE OUTER BANKS	803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948

(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 5	D 358		

related hallucinations and/or delusions, and a topical anti-fungal powder used to treat fungal and yeast infections of the skin (#7), and for 3 of 5 residents (#1, #4 and #5) sampled for record review including errors with medication used to treat elevated blood sugar (#1, #4), medication used for heart health, and a medication used to treat gastroesophageal reflux disease (#5).

The findings are:

Review of the facility's Medication Administration policy dated February 2022 revealed:
-The Medication Tech or Nurse administering medications must always control the medication cart keys.
-Medications must be administered within 1 hour before or after the time ordered.
-All medications must be checked against the Physician's order to ensure it is the right medication, right resident, right dosage, right time, and right route.
-Pre-pouring medication is not permitted.
-Proper documentation of each medication is to be done at the time of administration.
-If a medication is refused, the reason for the refusal is documented in the electronic medical administration record (eMAR).
-If the resident refuses the medication three times, notify the physician.
-All PRN "as needed" medications administered must be documented in the eMAR as to the reason it was given.
-Results of the PRN medications also must be documented.
-If the PRN medications are not effective more than twice, notify the physician.
-Always ensure there is an adequate supply of medications on hand.
-Reorder medications according to pharmacy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL028002	A. BUILDING: _____ B. WING _____	R 05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THE OUTER BANKS	803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948

(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 6	D 358		

policies and procedures.
-Weekly medication cart audits are completed to check expiration dates regularly, particularly on PRN medications.
-Be alert for side effects or adverse reactions and report to the Resident Care Coordinator and Physician immediately.
-Any variance in medication must be documented on the medication variance report-refer to policy on medication variance.
-Always wear gloves when administering eye drops, applying lotions or creams, vaginal or rectal suppositories and dispose of them immediately after using and wash your hands.
-All controlled substances must be kept under double lock.
-A controlled substance count is to be completed by the oncoming Medication Tech or Nurse and the Medication Tech or Nurse going off duty.
-The oncoming Medication Tech/Nurse is the one counting the controlled substances in the drawer.
-Both must sign the controlled substances count after they verify the count is correct.

1. The medication error rate was 6% as evidenced by 2 errors out of 32 opportunities during the 8:00am medication pass on 05/21/26.

Review of Resident #7's current FL-2 dated 04/10/26 revealed:
-Diagnoses included Parkinson's Disease, hallucinations, hyperlipidemia, and hypertension.
-There was a notation, patient is awaiting grant approval for Nuplazid to take for her hallucinations.

a. Review of Resident #7's signed physician's order sheet dated 05/19/26 revealed an order for Nuplazid (a medication used to treat hallucinations and/or delusions associated with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL028002	A. BUILDING: _____ B. WING _____	R 05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THE OUTER BANKS	803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948

(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 7	D 358		

Parkinson's Disease) 10mg, take one tablet every day.

Observation of the 8:00am medication pass on 05/21/26 revealed:
-The medication aide (MA) prepared and administered 4 oral medications to Resident #7 at 7:44am.
-Nuplazid 10mg was not administered to Resident #7 with her 8:00am medications.

Interview with the medication aide (MA) on 05/21/26 at 7:42am revealed:
-There was no Nuplazid 10mg on the medication cart for Resident #7.
-Resident #7's Nuplazid refill had been requested, and she was waiting on the refill from the pharmacy.

Review of Resident #7's May 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for Nuplazid 10mg, take one tablet every day for Parkinson's, scheduled for 8:00am.
-Nuplazid 10mg was documented as administered at 8:00am on 05/01/26 through 05/15/26.
-Nuplazid 10mg was documented as not administered at 8:00am on 05/16/26 through 05/21/26, with the exception documented as waiting on pharmacy for each occasion.

Observation of Resident #7's medications on hand on 05/21/26 at 11:06am revealed:
-There was an empty manufacturer labeled bottle of Nuplazid 10mg with a prescription label with Resident #7's name.
-The prescription labeled bottle of Nuplazid 10mg for Resident #7 had a filled date of 04/08/26 for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL028002	A. BUILDING: _____ B. WING _____	R 05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THE OUTER BANKS	803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948

(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 8	D 358		

thirty tablets to take one tablet every day.
-There was a yellow handwritten post-it type note attached Resident #7's empty Nuplazid 10mg bottle, that refill was ordered on 05/17/26 and would be delivered on 05/22/26.

Interview with Resident #7 on 05/22/26 at 10:20am revealed:
-She took several medications for Parkinson's Disease.
-She took a medication for hallucinations related to Parkinson's Disease that was very expensive and had to be filled at a specialty pharmacy instead of the facility's contracted pharmacy.
-She was not aware of the facility being out of any of her medications.
-She said the Nuplazid was very helpful in controlling hallucinations related to Parkinson's.
-She denied having any recent hallucinations.

Telephone interview with a pharmacist with the facility's contracted pharmacy on 05/22/26 at 9:37am revealed:
-An order was received for Nuplazid 10mg for Resident #7 on 04/18/26, to take one tablet every day.
-The order for Resident #7's Nuplazid 10mg was profiled only and not dispensed for Resident #7.
-The facility's contracted pharmacy did not carry Nuplazid.
-She was not certain what type of side effects Resident #7 would experience related to being without the Nuplazid.

Telephone interview with a pharmacy service representative with Resident #7's specialty pharmacy on 05/21/26 at 10:21am revealed:
-Nuplazid 10mg was last dispensed for Resident #7 on 04/10/26, take one tablet daily for a 30-day supply.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL028002	A. BUILDING: _____ B. WING _____	R 05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THE OUTER BANKS	803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948

(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 9	D 358		

-A new request was received from the facility for Resident #7 on 05/18/26 for a refill on Nuplazid 10mg, take one daily, and 30 tablets were scheduled to be delivered on 05/22/26.

Second interview with the MA on 05/21/26 at 11:08am revealed:
-Resident #7 was recently admitted to the facility and they were still trying to get her medications organized.
-The MAs were responsible for ordering medication refills for the residents, and she usually requested refills when there was a one-week supply of medication remaining.
-Resident #7's Nuplazid was filled at an outside pharmacy and had been requested by another staff, and they were waiting on the medication to be delivered.
-Medication cart audits were performed weekly by the MAs.
-Mediation cart audits consisted of looking for expired medications and making sure medications were available for the residents.
-If a resident's medication did not arrive in a day or two from the pharmacy, then she contacted the pharmacy to check the status.
-The was a note on the empty Nuplazid bottle for Resident #7 that the medication would be delivered on 05/22/26.

Interview with the Resident Care Coordinator (RCC) on 05/21/26 at 1:49pm revealed:
-The MAs were responsible for requesting medication refills for the residents.
-If a medication refills request was sent to the contracted pharmacy before 4:00pm, the medication usually came in that night.
-He expected medication refills to be requested when a resident had a one week supply remaining.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL028002	A. BUILDING: _____ B. WING _____	R 05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THE OUTER BANKS	803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948

(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 10	D 358		

-Resident #7's Nuplazid came from a specialty pharmacy due to the medication's cost, and the resident received a grant for the Nuplazid.

Interview with the Administrator on 05/21/26 at 1:53pm revealed:
-Resident #7's family member was responsible for her Nuplazid.
-Resident #7 received a grant for the Nuplazid and her family did not use the facility's contracted pharmacy.
-Since Resident #7 received a specialty grant for the Nuplazid, there was nothing the facility could do to get her medication sooner.

Second interview with the Administrator on 05/21/26 at 3:17pm revealed:
-One of the facility's Licensed Practical Nurses (LPN) had contacted the specialty pharmacy to request a Nuplazid refill for Resident #7 on 05/17/26 and was told the Nuplazid would be delivered on 05/22/26.
-Resident #7's Nuplazid would be sent to the resident's family member, and the family member would bring the medication to the facility for Resident #7.

Attempted telephone interview with Resident #7's primary care provider (PCP) on 05/22/26 at 10:02am was unsuccessful.

Attempted telephone interview with Resident #7's neurologist on 05/21/26 at 3:19pm was unsuccessful.

b. Review of Resident #7's signed physician's order sheet dated 05/19/26 revealed an order for Nystop (Nystop is a brand name for nystatin powder, a prescription strength anti-fungal medication used to treat fungal and yeast

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL028002	A. BUILDING: _____ B. WING _____	R 05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THE OUTER BANKS	803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948

(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 11 infections of the skin)100,000units/gram powder, apply to affected area in the morning, noon, and at bedtime for skin irritation. Observation of the 8:00am medication pass on 05/21/26 revealed: -The medication aide (MA) prepared and administered 4 oral medications to Resident #7 at 7:44am. -Nystatin powder was not administered to Resident #7 with her 8:00am medications. Interview with the medication aide (MA) on 05/21/26 at 7:42am revealed she did not have nystatin powder on the medication cart for Resident #7. Review of Resident #7's May 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Nystop Powder 100,000 units/gram, apply to affected area in the morning, noon, and at bedtime for skin. -Nystop powder was documented as not administered at 8:00am on 05/21/26, with the exception documented as resident refused. Observation of Resident #7's medications on hand on 05/21/26 at 11:08am revealed there was no nystatin powder on the medication cart for Resident #7. Interview with Resident #7 on 05/22/26 at 10:02am revealed: -She used a powder for yeast in the skin folds of her suprapubic area. -She let the MAs know when she needed the powder. -She had not been without the powder that she was aware of.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL028002	A. BUILDING: _____ B. WING _____	R 05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THE OUTER BANKS	803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948

(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 12 -She did not think she needed the powder currently. Telephone interview with the pharmacist from the facility's contracted pharmacy provider on 05/22/26 at 9:37am revealed: -An order was received for Resident #7 for nystatin powder 100,000 units/gram to apply to affected area morning, noon and at bedtime on 04/21/26. -Resident #7's nystatin powder order was profiled only and not dispensed because the resident used a local retail pharmacy for the nystatin powder. Telephone interview with a pharmacist from Resident #7's local retail pharmacy on 05/21/26 at 10:53am revealed: -Nystatin 100,000 units/gram powder was dispensed for Resident #7 on 12/03/25 and on 02/16/26 for a quantity of 60 grams each time to apply morning, noon and at bedtime. -She was unable to say how long 60 grams of nystatin powder would last Resident #7, depending on how large of an area it was applied to. -Nystatin powder was used to treat fungal skin infections. -Being without the nystatin powder could cause the infection to not heal completely or could lead to worsening of the infection. -There had been no request for nystatin powder for Resident #7 since the medication was dispensed in February 2026. Second interview with the MA on 05/21/26 at 11:08am revealed: -Resident #7 was recently admitted to the facility and they were still trying to get her medications organized.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL028002	A. BUILDING: _____ B. WING _____	R 05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THE OUTER BANKS	803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948

(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	D 358		

-Resident #7 came to the facility with outside medications.
-The MAs were responsible for ordering medication refills for the residents, and she usually requested refills when there was a one-week supply of medication remaining.
-Medication cart audits were performed weekly by the MAs.
-Mediation cart audits consisted of looking for expired medications and making sure medications were available for the residents.
-If a resident's medication did not arrive in a day or two from the pharmacy, then she contacted the pharmacy to check the status.
-She had documented in error that Resident #7 refused the nystatin powder during the 8:00am medication pass on 05/21/26.
-She was not sure why there was no nystatin powder on the medication cart available for Resident #7.

Interview with a second MA on 05/22/26 at 2:07pm revealed:
-The MAs or the LPNs were responsible for requesting medication refills from the pharmacy.
-Most medications could be requested electronically through the eMAR system.
-If a resident used an outside pharmacy, staff called for the refill or sent a fax request.
-She requested refills when a resident was down to 5 or 6 doses of medication remaining.
-If the resident had a topical medication such as a powder or cream, she ordered when there was about half remaining.
-The MA should report to the oncoming MA that a medication refill was ordered or needed.
-She contacted the pharmacy if a day or two passed and the medication did not come in.

Interview with the Resident Care Coordinator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL028002	A. BUILDING: _____ B. WING _____	R 05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THE OUTER BANKS	803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948

(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 14	D 358		

(RCC) on 05/21/26 at 1:49pm revealed:
-The MAs were responsible for requesting medication refills for the residents.
-If a medication refills request was sent to the contracted pharmacy before 4:00pm, the medication usually came in that night.
-He expected medication refills to be requested when a resident had a one week supply remaining.
-Resident #7's family provided her nystatin powder.
-He expected the MAs to contact Resident #7's family member to notify that she needed the nystatin powder before she ran out.

Interview with the Administrator on 05/21/26 at 1:53pm revealed:
-Resident #7's family member took care of Resident 7's medications.
-The MAs were responsible to contact Resident #7's family member to notify when refills were needed.
-She expected medications to be in the facility and available for the residents as ordered.

Attempted telephone interview with Resident #7's primary care provider (PCP) on 05/22/26 at 10:02am was unsuccessful.

2. Review of Resident #4's current FL-2 dated 06/08/25 revealed:
-Diagnoses included diabetes type II, congestive heart failure, and coronary artery disease.
-There was an order to check finger stick blood sugar (FSBS) four times a day before meals and at bedtime with a continuous glucose monitor (CGM).
-There was an order to inject Humalog Kwikpen 100u/ml 10 units three times a day with meals and to hold the Humalog injection if FSBS was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL028002	A. BUILDING: _____ B. WING _____	R 05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THE OUTER BANKS	803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948

(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 15 less than 80 (Humalog is a fast acting insulin used to improve blood glucose control in type 2 diabetes). Review of Resident #4's March 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Humalog Kwikpen 100u/ml, inject 10 units subcutaneously three times a day with meals for blood sugar, hold if blood sugar is less than 80. -Humalog 10 units was documented as held on 03/19/26 at 12:00pm when the resident's FSBS was documented as 103, with an exception documented as blood sugar of 103. -Humalog 10 units was documented as held on 03/20/26 at 5:00pm when the resident's FSBS was documented as 85, with an exception documented as blood sugar of 85. -Humalog 10 units was documented as held on 03/30/26 at 12:00pm when the resident's FSBS was documented as 95, with an exception documented as blood sugar of 95. Review of Resident #4's April 2026 eMAR revealed: -There was an entry for Humalog Kwikpen 100u/ml, inject 10 units subcutaneously three times a day with meals for blood sugar, hold if blood sugar is less than 80. -Humalog 10 units was documented as held on 04/05/26 at 12:00pm when the resident's FSBS was documented as 80, with an exception documented as blood sugar of 80. -Humalog 10 units was documented as held on 04/06/26 at 12:00pm when the resident's FSBS was documented as 93 and at 5:00pm when the resident's FSBS was documented as 97, with an exception documented as blood sugar of 97. -Humalog 10 units was documented as held on	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL028002	A. BUILDING: _____ B. WING _____	R 05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THE OUTER BANKS	803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948

(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 16	D 358		

04/12/26 at 5:00pm when the resident's FSBS was documented as 84, with an exception documented as blood sugar of 84.
-Humalog 10 units was documented as held on 04/23/26 at 5:00pm when the resident's FSBS was documented as 94, with an exception documented as blood sugar of 94.
-Humalog 10 units was documented as held on 04/25/26 at 12:00pm when the resident's FSBS was documented as 93, with an exception documented as blood sugar of 93.
-Humalog 10 units was documented as held on 04/30/26 at 12:00pm when the resident's FSBS was documented as 92, with an exception documented as blood sugar of 92.

Review of Resident #4's May 2026 eMAR revealed:
-There was an entry for Humalog Kwikpen 100u/ml, inject 10 units subcutaneously three times a day with meals for blood sugar, hold if blood sugar is less than 80.
-Humalog 10 units was documented as held on 05/08/26 at 5:00pm when the resident's FSBS was documented as 86, with an exception documented as blood sugar of 86.
-Humalog 10 units was documented as held on 05/14/26 at 5:00pm when the resident's FSBS was documented as 135, with an exception documented as blood sugar of 135.
-Humalog 10 units was documented as held on 05/19/26 at 5:00pm when the resident's FSBS was documented as 80, with an exception documented as blood sugar of 80.

Attempted interview with Resident #4's primary care provider on 05/22/26 at 10:31am was unsuccessful.

Refer to interview with a medication aide (MA) on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL028002	A. BUILDING: _____ B. WING _____	R 05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THE OUTER BANKS	803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948

(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 17 05/22/26 at 2:07pm. Refer to interview with the Resident Care Coordinator (RCC) on 05/22/26 at 2:25pm. Refer to interview with the Administrator on 05/22/26 at 2:56pm. 3. Review of Resident #1's current FL-2 dated 08/11/25 revealed: -Diagnoses included diabetes type 2, hypertension and chronic kidney disease. -There was an order to inject 10 units of Humalog each morning, hold if finger stick blood sugar (FSBS) was less than 170, administer 10 units of Humalog if FSBS was 170 or greater. Review of a signed physician order dated 04/07/26 revealed: -There was an order for Humalog KwikPen (U-100) Insulin 100 unit/mL subcutaneous, administer per sliding scale (SSI). -Check blood sugar prior to administering Humalog. -For blood glucose 0-150 administer no units, 151-200 administer 2 units with meal, 201-250 administer 4 units with meal, 251-300 administer 6 units with meal, 301-350 administer 8 units with meal, 351-400 administer 10 units with meal, any blood sugar number above 400 call the primary care provider (PCP) and hold Humalog if the resident is not eating. Review of Resident #1's April 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Humalog Kwikpen 100/ML, give before meals per SSI, 151-200 administer 2 units, 201-250 administer 4 units, 251-300 administer 6 units, 301-350 administer 8	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL028002	A. BUILDING: _____ B. WING _____	R 05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THE OUTER BANKS	803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948

(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 18	D 358		

units, 351-400 administer 10 units.
-If blood sugar is greater than 400 call the PCP and hold Humalog if the resident is not eating.
-There was an entry of a blood sugar of 229 at 12:00pm on 04/18/26.
-There was no documentation that Humalog was administered, when 4 units of Humalog should have been administered.
-There was an entry of a blood sugar of 251 at 8:00am on 04/21/26.
-There was an entry that 4 units of Humalog were administered, when 6 units of Humalog should have been administered.

Review of Resident #1's May 2026 eMAR revealed:
-There was an entry for Humalog Kwikpen 100/ML, give before meals per SSI, 151-200 administer 2 units, 201-250 administer 4 units, 251-300 administer 6 units, 301-350 administer 8 units, 351-400 administer 10 units.
-If blood sugar is greater than 400 call the PCP and hold Humalog if the resident is not eating.
-There was an entry of a blood sugar of 203 at 8:00am on 05/08/26.
-There was an entry that 2 units of Humalog were administered, when 4 units of Humalog should have been administered.

Attempted interview with Resident #1's PCP on 05/22/26 at 10:31am was unsuccessful.

Refer to interview with a medication aide (MA) on 05/22/26 at 2:07pm.

Refer to interview with the Resident Care Coordinator (RCC) on 05/22/26 at 2:25pm.

Refer to interview with the Administrator on 05/22/26 at 2:56pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL028002	A. BUILDING: _____ B. WING _____	R 05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THE OUTER BANKS	803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948

(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 19	D 358		

Interview with a medication aide (MA) on 05/22/26 at 2:07pm revealed:
-MAs were expected to follow the PCP orders.
-When a resident had a SSI, the MA was supposed to compare the blood sugar reading with the directions on the SSI on the electronic health record to ensure the correct number of units of Humalog were administered.
-It was important to administer the correct number of units of Humalog to ensure the residents did not receive too much or too little insulin as directed by the PCP.

Interview with the Resident Care Coordinator (RCC) on 05/22/26 at 2:25pm revealed:
-He was not aware that Resident #1 and #4 had been administered the incorrect number of units of Humalog.
-MAs were expected to follow the resident's PCP orders because it was a PCP order.
-He did not understand why a MA would make the mistake of administering the incorrect number of units of Humalog because he was available in person or by phone if a MA had a question.

Interview with the Administrator on 05/22/26 at 2:56pm revealed:
-MAs were expected to follow PCP orders.
-There should not be any mistakes on the number of units of Humalog administered to a diabetic resident.

4. Review of Resident #5's current FL2 dated 08/07/25 revealed diagnoses included Alzheimer's Disease, hyperlipidemia, gastroesophageal reflux, chronic kidney disease, and obstructive sleep apnea.

a. Review of Resident #5's signed physician's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL028002	A. BUILDING: _____ B. WING _____	R 05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THE OUTER BANKS	803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948

(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 20 order sheet dated 09/23/25 revealed an order for aspirin (low-dose aspirin can be used to help prevent blood clots and help prevent the risk of heart attacks and strokes) enteric coated (EC) 81mg tablet, take one tablet twice daily for heart health. Review of Resident #5's March 2026 electronic medication administration record (eMAR) revealed: -There was an entry for aspirin EC 81mg, take one tablet twice daily for heart health, scheduled at 10:00am and 6:00pm. -Aspirin EC 81mg was documented as administered at 10:00am on 03/01/26 through 03/04/26. -Aspirin EC 81mg was documented as not administered at 10:00am on 03/05/26, with the exception documented as "out of medication, ordered 03/04/26". -Aspirin EC 81mg was documented as administered at 10:00am on 03/05/26 through 03/20/26. -Aspirin EC 81mg was documented as not administered at 10:00am on 03/21/26 with the exception documented as "patient refused medication". -Aspirin EC 81mg was documented as administered at 10:00am on 03/22/26 through 03/31/26. -Aspirin EC 81mg was documented as administered at 6:00pm on 03/01/26 through 03/03/26. -Aspirin EC 81mg was documented as not administered at 6:00pm on 03/04/26 and 03/05/26, with the exception documented as "not available, reordered from pharmacy". -Aspirin EC 81mg was documented as administered at 6:00pm on 03/06/26 through 03/31/26.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL028002	A. BUILDING: _____ B. WING _____	R 05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THE OUTER BANKS	803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948

(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 21 Telephone interview with a pharmacist with the facility's contracted pharmacy on 05/22/26 at 9:48am revealed: -Aspirin EC 81mg was dispensed for Resident #5 on 01/23/26 for a quantity of 30 tablets to take one twice daily for a 15-day supply. -Aspirin EC 81mg was next dispensed for Resident #5 on 03/05/26, on 03/20/26, and 04/01/26, for a quantity of 30 tablets to take one tablet twice a day for a 15-day supply each time. -She was not sure why Aspirin EC was not dispensed for Resident #5 between 01/23/26 and 03/04/26 unless another pharmacy was being utilized. Refer to interview with a medication aide (MA) on 05/22/26 at 2:07pm. Refer to interview with the Licensed Practical Nurse (LPN) on 05/21/26 at 2:51pm. Refer to interview with the Resident Care Coordinator (RCC) on 05/22/26 at Refer to interview with the Administrator on 05/22/26 at 3:17pm. Attempted telephone interview with Resident #5's hospice primary care provider on 05/22/26 at 10:59am was unsuccessful. b. Review of Resident #5's signed physician order sheet dated 09/23/25 revealed an order for pantoprazole (pantoprazole is used to reduce stomach acid) 40mg, take one tablet daily for gastroesophageal reflux disease (GERD). Review of Resident #5's March 2026 electronic medication administration record (eMAR)	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL028002	A. BUILDING: _____ B. WING _____	R 05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THE OUTER BANKS	803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948

(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 22 revealed: -There was an entry for pantoprazole 40mg, take one tablet daily for GERD, scheduled at 6:00am. -Pantoprazole 40mg was documented as administered at 6:00am on 03/01/26 and on 03/02/26. -Pantoprazole 40mg was documented as not administered at 6:00am on 03/03/26, with the exception documented as "waiting on refill". -Pantoprazole was documented as administered at 6:00am on 03/04/26. -Pantoprazole 40mg was documented as not administered at 6:00am on 03/05/26 and on 03/06/26, with the exception documented as "waiting on refill" on both occasions. -Pantoprazole was documented as administered at 6:00am on 03/07/26 through 03/31/26. Review of Resident #5's April 2026 eMAR revealed: -There was an entry for pantoprazole 40mg, take one tablet daily for GERD scheduled at 6:00am. -Pantoprazole 40mg was documented as administered at 6:00am on 04/01/26 through 04/20/26. -Pantoprazole 40mg was documented as not administered at 6:00am on 04/21/26 through 04/26/26, with the exception documented as 'waiting on pharmacy for refill" on 04/21/26, "waiting on refill" for 04/22/26, "waiting on pharmacy" for 04/23/26, "not available" on 04/24/26, "waiting on refill" for 04/25/26, and for 04/26/26. -Pantoprazole 40mg was documented as administered at 6:00am on 04/27/26. -Pantoprazole 40mg was documented as not administered at 6:00am on 04/28/26 through 04/30/26, with the exception documented as "waiting on pharmacy for refill" on each occasion.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL028002	A. BUILDING: _____ B. WING _____	R 05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THE OUTER BANKS	803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948

(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 23 Telephone interview with a pharmacist from the facility's contracted pharmacy provider on 05/22/26 at 9:48am revealed: -Pantoprazole 40mg was dispensed for Resident #5 on 01/23/26 for quantity of 15 tablets to take one daily for a 15-day supply. -Pantoprazole 40mg was next dispensed for Resident #5 on 03/06/26, on 03/20/26, and on 04/01/26 for a quantity of 15 tablets to take one tablet daily for a 15-day supply on each occasion. -Pantoprazole 40mg was dispensed for Resident #5 on 04/22/26 for a quantity of 30 tablets to take one tablet daily, for a 30-day supply. -An order was received on 04/30/26 to discontinue Resident #5's pantoprazole 40mg. -She was not sure why pantoprazole 40mg was not dispensed for Resident #5 between 01/23/26 and 03/06/26 unless another pharmacy was being utilized. Refer to interview with a medication aide (MA) on 05/22/26 at 2:07pm. Refer to interview with the Licensed Practical Nurse (LPN) on 05/21/26 at 2:51pm. Refer to interview with the Resident Care Coordinator (RCC) on 05/22/26 at Refer to interview with the Administrator on 05/22/26 at 3:17pm. Attempted telephone interview with Resident #5's hospice primary care provider on 05/22/26 at 10:59am was unsuccessful. _____ Interview with a medication aide (MA) on 05/22/26 at 2:07pm revealed: -The MAs or the LPNs were responsible for requesting medication refills from the pharmacy.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL028002	A. BUILDING: _____ B. WING _____	R 05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THE OUTER BANKS	803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948

(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 24	D 358		

-Most medications could be requested electronically through the eMAR system.
-If a resident used an outside pharmacy, staff called for the refill or sent a fax request.
-She requested refills when a resident was down to 5 or 6 doses of medication remaining.
-If the resident had a topical medication such as a powder or cream, she ordered when there was about half remaining.
-The MA should report to the oncoming MA that a medication refill was ordered or needed.
-She contacted the pharmacy if a day or two passed and the medication did not come in.

Interview with the Licensed Practical Nurse (LPN) on 05/21/26 at 2:51pm revealed:
-The LPNs or the MAs were responsible for requesting refills from the pharmacy for the residents.
-She requested refills 3 to 4 days before the medication ran out.
-Medication refills could be requested electronically through the eMAR system.
-If a medication did not arrive within 48 hours, she contacted the pharmacy for a status.
-Medication cart audits were performed weekly by the LPNs or the MAs.
-Medication cart audits included making sure medications were available, looking for expired medications, looking for loose medications, making sure the narcotic count was correct, and making sure any opened packaging was labeled and dated.
-She was not sure why Resident #5 had missed medications.
-At one time Resident #5's medications were provided by hospice.

Interview with the Resident Care Coordinator (RCC) on 05/22/26 at 2:37pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL028002	A. BUILDING: _____ B. WING _____	R 05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THE OUTER BANKS	803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948

(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 25 -The MA or LPN on the medication cart were responsible to request refills for the residents. -Refills should be requested when there was one week of medication remaining. -Medication refills could be requested electronically. -If the medication refill request was placed with the pharmacy before 4:00pm, the medication sometimes came the same evening or at least by the next day. -If the requested medication was not received by the next day, then the pharmacy should be contacted for the status of the medication. -The LPN or MA should communicate with the oncoming LPN or MA if a medication refill was needed or missing. Interview with the Administrator on 05/22/26 at 3:17pm revealed: -If the residents' medications were not batch filled, then the LPN or the MA were responsible for requesting medication refills. -She expected the MA or LPN to follow-up with the pharmacy if a medication was not received in 24 to 48 hours. -Resident #5 did have a recent change in hospice providers and that may have affected the availability of some of his medications. -She expected the residents' medications to be available for administration.	D 358		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL028002	A. BUILDING: _____ B. WING _____	R 05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THE OUTER BANKS	803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948

(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 451	Continued From page 26 accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to notify the county department of social services (DSS) of an injury requiring a medical evaluation for 1 of 5 sampled residents (#3). The findings are: Review of Resident #3's current FL-2 dated 09/16/25 revealed diagnoses included epilepsy, morbid obesity, and osteoarthritis of the left knee. Review of an Incident and Accident report (I/A) dated 05/15/26 revealed: -Resident #3 had an unwitnessed fall in her bedroom on 05/15/26 at 4:00pm. -The resident was found lying on the floor on her back and reported that she fell backward from a standing position and hit her head. -The resident complained of significant pain in the back of her head and there was a large knot at the back of her head. -The resident's vital signs were taken and the resident was transported to the local emergency department (ED). -There was documentation that the local DSS was notified of the fall on 05/22/26 at 2:00pm by the Administrator. Review of an After Visit Summary report from the local ED dated 05/15/26 revealed:	D 451	State Rule# and Rule: 10A NCAC 13F .1212 (a) Reporting of Accidents and Incidents (a)An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. Plan of Correction: Immediately upon these findings by the survey team the Executive Director (ED) emailed Dare County DSS incident report. Prevention of Re-occurrence: ED and/or designee will be responsible for notifying the county department of social services of any accident or incident that results in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. ED and/or designee will email copy of incident report to Dare County DSS. Monitoring Responsibility & Frequency: ED and/or designee will continuously monitor all incident reports that involve injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. All Incidents that required submission to Dare County DSS will be sent to the Regional Director of Wellness, Quality & Education and Regional VP of Operations for review and approval prior to submitting. ED and/or designee will email copy of incident report to Dare County DSS. Director of Wellness, Quality & Education Nurse and/or Regional VP of Operations will continue to oversee and review incident reports that are required to be reported to Dare County DSS in a timely manner. Correction Completion Date: 5/22/2026	5/22/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL028002	A. BUILDING: _____ B. WING _____	R 05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THE OUTER BANKS	803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948

(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 451	Continued From page 27 -The resident was seen for a fall. -The resident was diagnosed with an accidental fall. Interview with the Resident Care Coordinator (RCC) on 05/22/26 at 2:25pm revealed: -When a resident had a fall and needed to be evaluated at the local ED the medication aide (MA) working on that shift would complete an I/A report by hand or electronically. -The MA was expected to place a copy of the I/A report in his mailbox. -He checked the electronic health system each morning and checked his mailbox. -When he observed an I/A report in the electronic health system or his mailbox, he completed a brief note to the resident's PCP that he faxed. -He then forwarded the I/A report to the Administrator. Interview with the Administrator on 05/22/26 at 2:56pm revealed: -When a MA and the RCC completed any portion of an I/A Report, she received an email alert that an I/A Report had been submitted. -The RCC was responsible for notifying the resident's PCP if there was an incident or accident that required evaluation at the local ED. -She was responsible for notifying the local DSS office of the I/A Report. -She was not sure how the I/A Report was not sent to the PCP and local DSS on 05/15/26. -She was not aware that the I/A Report had not been sent to the PCP or DSS until 05/22/26 when the state surveyor asked for a copy of the I/A Report.	D 451		