STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079109	A. BUILDING: _____ B. WING _____	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHISPERING PINES ASSISTED LIVING	149 HIGHWAY 87 REIDSVILLE, NC 27320

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 06/11/26.	C 000		
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 2 of 3 sampled residents (#1, #2) regarding an order for a medication used to treat fluid retention and a medication used to treat diabetes (#1), and a medication used to treat involuntary, repetitive body movements (#2). The findings are: 1. Review of Resident #1's current FL2 dated 02/17/26 revealed diagnoses included hyponatremia, mild intellectual disability, and depression. a. Review of Resident #1's current FL2 dated	C 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079109	A. BUILDING: _____ B. WING _____	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHISPERING PINES ASSISTED LIVING	149 HIGHWAY 87 REIDSVILLE, NC 27320

(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
C 315	Continued From page 1 02/17/26 revealed an order for furosemide (used to treat fluid retention) 20mg once daily. Review of Resident #1's April 2026 medication administration record (MAR) revealed: -There was an entry for furosemide 20mg twice daily. -There was documentation that furosemide 20mg was administered at 8:00am and 8:00pm from 04/01/26-04/30/26. Review of Resident #1's May 2026 MAR revealed: -There was an entry for furosemide 20mg twice daily. -There was documentation that furosemide 20mg was administered at 8:00am and 8:00pm from 05/01/26-05/31/26. Review of Resident #1's June 2026 MAR from 06/01/26-06/11/26 revealed: -There was an entry for furosemide 20mg twice daily. -There was documentation that furosemide 20mg was administered at 8:00am and 8:00pm from 06/01/26-06/10/26 and at 8:00am on 06/11/26. Observation of Resident #1's medications on hand on 06/11/26 at 9:20am revealed a multidose package of medication with furosemide 20mg included in the am dose and the pm dose. Telephone interview with a pharmacist from the facility's contracted pharmacy on 06/11/26 at 12:08pm revealed: -The current order on file for Resident #1's furosemide was furosemide 20mg twice daily dated 09/04/25. -The pharmacy had not received the FL2 signed on 02/17/26 with an order for furosemide 20mg	C 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079109	A. BUILDING: _____ B. WING _____	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHISPERING PINES ASSISTED LIVING	149 HIGHWAY 87 REIDSVILLE, NC 27320

(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
C 315	Continued From page 2 once daily. -If he had received the FL2,he would have contacted Resident #1's cardiologist to see if he intended for the order to be changed, as it was the cardiologist who increased the furosemide to twice daily. Telephone interview with a representative from Resident #1's cardiologist's office on 06/11/26 at 2:28pm revealed: -Resident #1's order for furosemide 20mg was increased to twice daily on 08/28/25. -Resident #1 was last seen at their office on 04/20/26, and the furosemide order was not changed. Attempted telephone interview with Resident #1's primary care provider (PCP) on 06/11/26 at 12:29pm was unsuccessful. Refer to the interview with the medication aide (MA)/Supervisor-in-Charge (SIC) on 06/11/26 at 7:50am. Refer to the interview with the Administrator on 06/11/26 at 1:10pm. b. Review of Resident #1's current FL2 dated 02/17/26 revealed an order for humalog (used to control high blood sugar) 100 units three times daily before meals and take 5 units at bedtime for a finger stick blood sugar (FSBS) greater than 150. Review of Resident #1's April 2026 MAR revealed: -There was an entry for humalog U-100, inject 5 units three times daily for a FSBS greater than 150, scheduled for 8:00am, 12:00pm, and 5:00pm	C 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079109	A. BUILDING: _____ B. WING _____	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHISPERING PINES ASSISTED LIVING	149 HIGHWAY 87 REIDSVILLE, NC 27320

(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
C 315	Continued From page 3 -There was a second entry that was handwritten for the FSBS with the times of 8:00am, 12:00pm, 4:00pm, and 8:00pm. -There were three times Resident #1's FSBS was documented as greater than 150 at 8:00pm. Review of Resident #1's May 2026 MAR revealed: -There was an entry for humalog U-100, inject 5 units three times daily for a FSBS greater than 150, scheduled for 8:00am, 12:00pm, and 5:00pm -There was a second entry that was handwritten for the FSBS with the times of 8:00am, 12:00pm, 4:00pm, and 8:00pm. -There was one time Resident #1's FSBS was documented as greater than 150 at 8:00pm. Review of Resident #1's FSBS log dated 05/11/26-05/31/26 revealed Resident #1's FSBS was documented as being greater than 150 at 8:00pm on three occasions, and 5 units of humalog were documented as administered. Review of Resident #1's June 2026 MAR from 06/01/26-06/11/26 revealed: -There was an entry for humalog U-100, inject 5 units three times daily for a FSBS greater than 150, scheduled for 8:00am, 12:00pm, and 5:00pm -There was a handwritten entry for the FSBS with the times of 8:00am, 12:00pm, 4:00pm, and 8:00pm. -There was no documentation that Resident #1's FSBS was greater than 150 at 8:00pm. Observation of Resident #1's medications on hand on 06/11/26 at 9:20am revealed there was a bottle of humalog insulin dispensed on 10/20/25 with the directions to administer 5 units for FSBS	C 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079109	A. BUILDING: _____ B. WING _____	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHISPERING PINES ASSISTED LIVING	149 HIGHWAY 87 REIDSVILLE, NC 27320

(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
C 315	Continued From page 4 greater than 150 three times daily. Telephone interview with a pharmacist from the facility's contracted pharmacy on 06/11/26 at 12:08pm revealed: -The current order on file for Resident #1's humalog insulin was for 5 units to be administered before meals three times daily dated 10/02/26. -There was no order to administer the humalog insulin at bedtime. -He had not received the FL2 dated 02/17/26. Interview with Resident #1 on 06/11/26 at 7:24am revealed she checked her FSBS four times per day, and if her FSBS was more than 150, she was administered 5 units of humalog insulin. Attempted telephone interview with Resident #1's PCP on 06/11/26 at 12:29pm was unsuccessful. Refer to the interview with the MA/SIC on 06/11/26 at 7:50am. Refer to the interview with the Administrator on 06/11/26 at 1:10pm. 2. Review of Resident #2's current FL2 dated 02/17/26 revealed: -Diagnoses included schizoaffective disorder, chronic obstructive pulmonary disease, and schizophrenia. -There was an order for ingrezza (used to treat involuntary, repetitive body movements) 80mg, once daily. Review of Resident #2's April 2026, May 2026 and June 2026 from 06/01/26-06/11/26 medication administration record (MAR) revealed there was no entry for ingrezza 80mg once daily	C 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079109	A. BUILDING: _____ B. WING _____	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHISPERING PINES ASSISTED LIVING	149 HIGHWAY 87 REIDSVILLE, NC 27320

(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
C 315	Continued From page 5 and no documentation ingrezza 80mg was administered. Observation of Resident #2's medications on hand on 06/11/26 at 10:20am revealed there was no ingrezza 80mg on hand. Telephone interview with a pharmacist from the facility's contracted pharmacy on 06/11/26 at 12:08pm revealed: -Resident #2's FL2 dated 02/17/26 was not received at the pharmacy. -Resident #2 had an order for ingrezza that was discontinued in 2025 because the insurance did not authorize payment, and it was expensive. -Resident #2's ingrezza had not been filled since November 2024, when the insurance no longer authorized the medication. Attempted telephone interview with Resident #2's primary care provider (PCP) on 06/11/26 at 12:29pm was unsuccessful. Refer to the interview with the medication aide (MA)/Supervisor-in-Charge (SIC) on 06/11/26 at 7:50am. Refer to the interview with the Administrator on 06/11/26 at 1:10pm. _____ Interview with the medication aide (MA)/Supervisor-in-Charge (SIC) on 06/11/26 at 7:50am revealed: -She administered medications by comparing the medications on hand to the MAR. -The Administrator completed FL2s. Interview with the Administrator on 06/11/26 at 1:10pm revealed: -He or the Owner completed the FL2s by using	C 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079109	A. BUILDING: _____ B. WING _____	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHISPERING PINES ASSISTED LIVING	149 HIGHWAY 87 REIDSVILLE, NC 27320

(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
C 315	Continued From page 6 the resident's current MAR. -If there were any discrepancies in the FL2 and the MAR, it was a mistake. -He had been trying to make sure the FL2s were faxed to the pharmacy.	C 315		