Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054072	A. BUILDING: _____ B. WING _____	R 06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HONEY'S ASSISTED LIVING	1935 IDLEWILD DRIVE KINSTON, NC 28504

(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 06/11/2026
D 000	Initial Comments The Adult Care Licensure Section and the Lenoir County Department of Social Services conducted and annual and follow-up survey on June 09, 2026 and June 10, 2026.	D 000	Effective 6/11/26: Corrective Action for Identified Deficiency Immediately following the survey, all personal care items identified in resident rooms were removed and secured. Locked storage areas have been established on each unit for the storage of personal care items. Access to these storage areas is limited to authorized staff members, who are the only individuals with keys or approved access. The facility has revised its storage practices to require that all personal care items be stored in the designated locked storage area when not in active use. Staff are prohibited from leaving personal care items unattended in resident rooms or other unsecured locations. Supplies will be taken into resident rooms only while providing care and will be returned immediately to the secured storage area after the care is completed. Effective 6/15/ 2026 All direct care staff, medication aides, housekeeping staff, and supervisors have received education regarding the requirements of 10A NCAC 13F .0306(a)(5), facility policy for securing personal care items, and the importance of maintaining a safe environment for residents. The education included instruction on proper storage procedures, resident safety, infection prevention, and staff accountability. Any newly hired employees will receive this education during orientation before independently providing resident care.	
D 079	10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the Special Care Unit (SCU) was free of hazards in 7 resident rooms including disposable shaving razors, prescription medications/creams, over the counter pain patches, nasal spray, alcohol-based hand sanitizer and toiletries that were accessible to residents on the SCU. The findings are: Review of the facility's license revealed: -The facility was licensed as a Special Care Unit	D 079		

Reviewed and Acknowledged SJS 8/7/26

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D 079	Continued From page 1 (SCU) effective 01/01/26 for a capacity of 26 residents. -The expiration date of the facility's license was 12/31/26. Review of the facility's census on 06/09/26 revealed the facility's census in the SCU was 25 residents. Review of the facility's undated SCU Disclosure revealed: -The purpose of the SCU was to provide a safe, secure, familiar and consistent environment for the cognitively impaired resident by appropriately trained staff. -For safety of residents, each resident is provided lockable space within his/her room to store personal care and hygiene items to prevent ingestion of any chemicals that may be hazardous to the resident and the key would be maintained by the staff. Observation of resident room 22 on 06/09/26 at 8:45am revealed: -There was a 7.25 ounce aerosol air freshener on the resident's nightstand with a warning to keep out of reach of children, danger extremely flammable aerosol, may cause serious eye irritation, drowsiness, and -There was a 10 ounce bottle of lotion with a warning for external use only on the nightstand. -There was a 15 ounce bottle of conditioner with a warning for external use only on the nightstand. -There was an 8 ounce, 6 ounce, and 4 ounce bottle of wound cleanser on the nightstand with a warning to keep out of reach of children, if swallowed get medical help or contact a poison control center immediately. -There was a 7 ounce bottle of body mist spray on the nightstand with a warning to keep out of	D 079		

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D 079	Continued From page 2 reach of children. -There was a 35 ounce bottle of body wash on the nightstand with a warning for external use only. -There was a 25 count bottle of over-the-counter Famotidine 10mg in the top drawer of the nightstand with 12 pills in the bottle. -There was an unopened 1.5 ounce bottle of saline nasal spray with a warning to keep out of reach of children and a warning that the use of this dispense by more than one person may spread infection. -There was an over the counter package of Salonpas pain relieving patches that contained 20 patches with a warning for external use only, and to avoid contact with eyes, mucus membranes and rashes. Interview with the resident who resided in room 22 on 06/09/26 at 8:47am revealed: -She did not use any of the products that were found on and in her nightstand, staff used them for her. -She was not aware that there was a bottle of over the counter indigestion medicine, pain patches, or nasal spray in her nightstand drawer. -She could not remember ever using the over the counter indigestion medicine, pain patches, or nasal spray. Observation of resident room 21 on 06/09/26 at 8:53am revealed there was a prescription container of Zinc Oxide 20% ointment in the resident's top drawer of the nightstand. Based on observations, interviews, and record reviews it was determined that the resident who resided in room 21 was not interviewable. Observation of resident room 27 on 06/09/26 at	D 079		

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D 079	Continued From page 3 9:03am revealed: -There was an 8 ounce container of shampoo and body wash with a warning for external use only on top of the dresser. -There was a 5 ounce container of shaving cream with a warning to keep out of reach of children. -There was an 8.4 ounce container of lotion on top of the dresser. -There was an 8 ounce container of psoriasis medicated body wash with 3% salicylic acid with a warning to keep out of reach of children, and if swallowed get medical help or contact a poison control center on top of the dresser. -There was a 11 ounce container of salicylic acid 3% shampoo and conditioner with a warning to keep out of reach of children and if swallowed get medical help or contact a poison control center on top of the dresser. -There was a 1.05 pint container of petroleum jelly with a warning to keep out of reach of children, if swallowed, get medical help or contact a poison control center right away on top of the dresser. Based on observations, interviews, and record reviews it was determined that the resident who resided in room 27 was not interviewable. Observation of resident room 31 on 06/09/26 at 9:16am revealed: -There was a tube of zinc skin protectant paste, a spray bottle of skin cleanser, a tub of petroleum jelly, a bottle of over-the-counter dandruff shampoo, a bottle of odor eliminator and a bottle of baby shampoo/body wash on her bedside table. -The was a bottle of baby shampoo/body wash, there was a bottle of over-the counter body lotion, there was a tube of over-the counter body lotion, there was a bottle of over-the-counter saline and	D 079		

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D 079	Continued From page 4 a bottle of over-the counter hair conditioner. Interview with the resident that resided in room 31 on 06/09/26 at 9:16am revealed she always kept her toiletries in her room because they were hers and she did not want them to get missing. Interview with a medication aide (MA) on 06/09/26 at 9:33am revealed the resident that resided in room 31 was very particular about wanting to keep her items and had been allowed to keep them. Observation of resident room 30 bedroom on 06/09/26 at 9:19am revealed there was one disposable razor with double blades with the plastic safety guard in place on top of his dresser. Interview with the resident from room 30 on 06/10/26 at 8:02am revealed: -He had been at the facility for approximately 6 months. -He had an appointment on 06/09/26 and wanted to shave before his appointment. -He liked to shave at least every other day and was able to shave himself. -Staff did not watch him shave himself because he was capable of doing it himself. -Staff would provide him with a razor when he asked for one but did not ask for the razor to be returned. -Sometimes he would ask for a razor and keep it for when he felt like shaving. Interview with the Special Care Unit Coordinator (SCC) on 06/10/26 at 1:10pm revealed the resident in room 30 was very independent and was able to shave himself but should be supervised.	D 079		

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D 079	Continued From page 5 Observation of resident room 32 on 06/09/26 at 9:23am revealed: -There was a bottle alcohol based hand sanitizer, a solid over-the-counter (OTC) and a roll-on deodorant and an over-the-counter body lotion on her bedside nightstand. -There was a bottle of OTC mouth wash a bottle of OTC lotion, a bottle of OTC hair lotion, a bottle of shampoo/shower gel, a bottle of no rinse cleansing foam for hair and a can of room deodorizer spray. Observation of resident room 34 bedroom on 06/09/26 at 9:25am revealed: -There was a disposable razor with double blades with the plastic safety guard removed on the floor between his bed and his nightstand. -There were 2 disposable razors with double blades with the plastic safety guard removed in the top drawer of his nightstand. -There was a can of shaving cream on top of his nightstand and a can in the top drawer of the nightstand. -There was a tube of skin cream for moisturization in the top drawer of the nightstand. Interview with the resident in room 34 on 06/10/26 at 1:22pm revealed: -He was able to shave himself. -Staff would look in on him sometimes but did not stay with him while he shaved. -Staff did not ask him to return the razor after it was used. Interview with the Special Care Unit Coordinator (SCC) on 06/10/26 at 1:10pm revealed the resident in room 34 was usually independent and was able to shave himself but should be supervised.	D 079		

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D 079	Continued From page 6 Observation of the cabinet underneath the kitchen sink in the SCU dining area on 06/09/26 at 9:00am revealed: -There was a 10 ounce aerosol can of insect killer under the kitchen sink with a warning that the product was hazardous to humans, the user must wear a long sleeved shirt, long pants, shoes, and socks with chemical resistant gloves made of any water proof material. -There was a 32 ounce container of liquid bleach cleaner with a warning to keep out of reach of children and to keep out of eyes, if contact with eyes get medical attention. Observation of an unlocked utility closet on the SCU on 06/09/26 at 9:02am revealed there was a 6 liter container of liquid laundry detergent on top of the dryer that had a warning to keep out of reach of children, do not ingest, and avoid contact with eyes. Interview with a second personal care aide (PCA) on 06/09/26 at 9:07am revealed: -Toiletries and cleaning products were supposed to be locked in the storage closet to prevent residents from taking them and possibly ingesting the products. -PCAs and medication aides (MAs) were responsible for removing any toiletries or any other hazards from residents rooms, the PCAs completed a walk through of each resident's room at the beginning of their shift. -She was not aware of any residents that had a history of ingesting toiletires or chemicals. Interview with a personal care aide (PCA) on 06/09/26 at 9:07am revealed: -Toiletries and cleaning products were supposed to be locked in the storage closet to prevent residents from taking them and possibly ingesting	D 079		

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D 079	Continued From page 7 the products. -PCAs and medication aides (MAs) were responsible for removing any toiletries or any other hazards from residents' rooms, the PCAs completed a walk through of each resident's room at the beginning of their shift. -Sometimes she found a toiletry item in a resident's room and she removed it and placed it in the toiletry storage closet that was locked. -She informed the MA whenever she found a toiletry item in a resident's room. Interview with a second PCA on 06/09/26 at 9:40am revealed: -No resident had been given a razor to shave that morning. -Staff supervised residents when they shaved or the staff shaved the residents themselves. -Toiletries and razors were supposed to be kept locked up. -Some residents in the SCU kept their own toiletries because they were good with having their items to keep the residents independent. -There was no policy for the facility that toiletries had to be locked up in the SCU and the facility was more relaxed than other facilities she had worked for. -Razors needed to be locked up because not all residents in the SCU knew what they are doing and could hurt themselves. -Room checks were completed daily but she did not see the razors in the residents' rooms that morning. Interview with a medication aide (MA) on 06/09/26 at 9:12am revealed: -PCAs and MAs were supposed to check resident rooms at least once on their shift for any toiletries or other hazards. -There was a storage closet that remained locked	D 079		

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where toiletries were kept for residents.
-The PCAs were supposed to return the resident's toiletries back to the locked storage area after they completed personal care for a resident.

Interview with a second MA on 06/09/26 at 9:33am revealed:
-Some residents were able to shave themselves, but razors were supposed to be kept locked away.
-Toiletries were supposed to be locked in a cabinet.

Interview with the Special Care Unit Coordinator (SCC) on 06/09/26 at 9:27am revealed:
-Toiletries, chemicals, and dangerous objects were supposed to be locked up in the SCU storage closet.
-PCAs removed a resident's toiletries from the locked storage closet, provided personal care and were expected to return the toiletries to the storage closet.
-PCAs and MAs knew that there should not be any toiletries, chemicals or other hazardous items on the SCU due to the risk of a resident ingesting something harmful.
-There were not any residents on the SCU that had a history of ingesting anything hazardous.

Second interview with the SCC on 06/10/26 at 1:10pm revealed:
-Staff were expected to shave or at least supervise residents while they shaved so they did not hurt themselves.
-Razors should be disposed of after it has been used.
-Razors should be kept locked up when not being used.
-She was not aware staff allowed any resident to

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D 079	Continued From page 9 shave unsupervised. -There were no residents with wandering or aggressive behaviors or known to ingest items on SCU. Interview with the Resident Care Coordinator (RCC) on 06/10/26 at 3:59pm revealed: -Toiletries should be kept locked up in the SCU for fear residents could ingest toxins. -Residents were not allowed to be unsupervised with razors and should be thrown away by staff so no one harmed themselves. Interview with the Administrator on 06/09/26 at 3:25pm revealed: -There should not be any toiletries, over the counter medications, prescriptions, or chemicals accessible to residents on the SCU to prevent the risk of residents possibly ingesting them. -There was a locked storage unit on the SCU where staff were expected to keep toiletries locked up after using them to provide personal care. Second interview with the Administrator on 06/10/26 at 4:20pm revealed: -Residents in the SCU may seem okay but they were there because their cognition was affected in some way. -Staff should supervise residents the whole time they were shaving and dispose of the razor when they were done.	D 079		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer	D 125		

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D 125	Continued From page 10 medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on observations,interviews and record reviews, the facility failed to ensure 1 of 6 staff who administered medications to residents passed a written medication aide exam within 60 days of completing their medication administration clinical skills validation (Staff C). The findings are: Review of the facility's Medication Aide (MA) Job Description dated 12/09/25 revealed MAs would sucessfully pass the written examination prior to or within 90 days after successful completion of the clinical skills validation. Review of the facility's undated Special Care Unit Disclosure Statement revealed individuals who administer medications would sucessfully pass the written examination prior to or within 90 days after successful completion of the clinical skills validation. Review of Staff C's personnel record revealed: -Staff C was hired as a personal care aide (PCA) on 07/25/25. -Staff C completed her 5 hour and 10 hour medication training on 04/02/26. -Staff C completed medication clinical skills	D 125	The facility acknowledges the deficiency and has implemented corrective actions to ensure compliance with 10A NCAC 13F .0403(a). Corrective Action for the Identified Employee Upon discovery of the deficiency, the employee was immediately removed from performing medication administration duties. Effective 6/11/26 The employee will not administer medications until all state-required qualifications have been successfully completed and verified. Documentation of the employee's qualifications and competency status has been reviewed and updated in the employee personnel file. A complete audit of all Medication Aide/Medication Technician personnel files was conducted on 6/16/2026 to verify that each employee completed the required state competency examination within the required time frame and met all regulatory qualifications. Any discrepancies identified during the audit will be addressed immediately, and affected employees will be removed from medication administration duties until compliant. On 06/16/2026 The facility has implemented a Medication Aide credential tracking system that documents: Date of Medication Aide course completion. Deadline for the required state competency examination. Date the competency examination is successfully completed. Registry verification and placement in the employee file. The Administrator and Resident Care Coordinator (or designee) will maintain a tracking log with reminder dates to ensure required testing is completed before the 60-day deadline. Medication administration assignments will only be made after verification that all state qualification requirements have been met.	06/11/2026

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validation on 04/02/26.
-There was no documentation regarding a medication aide (MA) test.

Review of a resident's electronic medication administration record (eMAR) for June 2026 revealed Staff C administered medications, including insulin, on 06/03/26, 06/06/26 and on 06/07/26.

Interview with Staff C on 06/10/26 at 3:50pm revealed:
-She was hired as a PCA in July of 2025.
-She completed MA training in April 2026 and began working as a MA.
-She administered medications each week when she was assigned.
-The MA test was to be taken online and it was her responsibility to schedule her MA test.
-She had not taken the MA test and did not know where to go to take the test.
-She did not know there was a time limit on when she needed to have the test completed.
-She asked the Administrator about taking the test approximately 2 weeks before but had not received an answer about taking the test.

Interview with the Resident Care Coordinator (RCC) on 06/10/26 at 3:58pm revealed:
-MA's needed to complete the MA test online within 60 days of training and skills validation.
-MA's were provided with the website to complete testing, study materials and assisted with scheduling the MA test during MA training.
-She followed up with MAs after training but has had a lot of work to do and Staff C was overlooked.

Interview with the Administrator on 06/10/26 at 3:40pm revealed:

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D 125	Continued From page 12 -She was unable to locate Staff C in the MA testing system as having completed the MA test. -She and the RCC were responsible for ensuring MAs complete the MA test and she assumed Staff C had taken her test. -She had been busy with admissions since she became Administrator in September 2025 and Staff C had "fallen through the crack".	D 125		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow up to meet the health care needs for 1 of 5 sampled residents including failing to notify the primary care provider when the resident's blood sugar was over 450 (#5). The findings are: Review of the facility's undated Diabetic Policy revealed: -It was the policy of the facility to provide appropriate care and services to residents that have a diagnosis of diabetes. -Medication aides (MAs) were expected to carry out finger stick glucose testing as ordered by a resident's primary care provider (PCP). -If blood glucose was 500 or above, administer insulin as ordered and contact the PCP. -Observe the resident for signs and symptoms of hyperglycemia.	D 273	The facility acknowledges the deficiency and has implemented corrective actions to ensure compliance with 10A NCAC 13F .0902(b). The facility shall assure that appropriate referral and follow-up are completed to meet the routine and acute healthcare needs of all residents. Effective 6/17/2026: Any outstanding physician orders, referrals, laboratory work, diagnostic testing, or specialist appointments were completed or scheduled as appropriate. Documentation was updated to accurately reflect all referrals, physician notifications, recommendations, and follow-up actions. The Resident Care Coordinator (RCC)completed a review of all current residents requiring physician referrals, specialty consultations, laboratory testing, diabetic monitoring, or other healthcare follow-up to verify that all recommendations had been completed and documented appropriately. Effective 6/18/2026 The facility has implemented a Healthcare Referral and Follow-Up Tracking Log to monitor all physician referrals, laboratory orders, diagnostic testing, specialist appointments, emergency department follow-up, hospital follow-up, and other healthcare recommendations until completion.	

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	HAL054072	A. BUILDING: _____ B. WING _____	R 06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HONEY'S ASSISTED LIVING	1935 IDLEWILD DRIVE KINSTON, NC 28504

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D 273	Continued From page 13 -Call the PCP or 911 if needed. -Follow orders for sliding scale insulin (SSI) as prescribed by the PCP. -Contact the resident's PCP for any blood glucose reading outside the parameters. -If the resident has parameters listed other than what is outlined in the facility's policy, follow the individual orders for the resident from the PCP. Review of the facility's undated Blood Glucose Monitoring and Reporting Policy revealed: -The facility should provide blood glucose monitoring as ordered by a physician or licensed healthcare provider. -Staff shall promptly document all blood glucose readings, recognize signs of abnormal blood glucose levels, and report concerns to the appropriate supervisor and healthcare provider in a timely manner. -Blood glucose monitoring should be performed according to physician orders and the resident's individualized care plan. -Staff shall immediately notify the Supervisor, Resident Care Coordinator (RCC), or healthcare provider when a blood glucose reading is outside the range established by the resident's physician or healthcare provider by triage or telephone, a resident exhibits signs or symptoms of hypoglycemia or hyperglycemia, or when any concerns arise regarding the resident's diabetic condition or treatment plan. -Staff should documented the date and time of testing, blood glucose reading, interventions provided if instructed, and notifications made to supervisors. -Documentation should be recorded on the medication administration record (MAR), triage, progress notes, or other approved facility documentation. -Blood glucose monitoring records and physician	D 273	The Resident Care Coordinator will review the tracking log daily to ensure all referrals and follow-up appointments are completed timely and documented in the resident record. Effective 06/19/2026 All licensed staff, Medication Aides, and direct care staff have received education regarding the requirements of 10A NCAC 13F .0902(b) and the facility's policies for timely physician notification, healthcare referrals, follow-up care, documentation, and monitoring of residents' routine and acute healthcare needs. Effective 06//24/2026 Staff also completed diabetic care training, which included: Recognition of signs and symptoms of hypoglycemia and hyperglycemia. Blood glucose monitoring procedures. Proper response to abnormal blood glucose results. Physician notification guidelines. Documentation requirements. Emergency response procedures. Facility protocols for diabetic management and follow-up care. Effective 06/222026 Staff were re-educated on the facility's established protocols to ensure timely communication with healthcare providers and prompt implementation of physician orders and recommendations. Effective 06/11/2026 The Administrator will review all hospital returns, emergency department visits, physician recommendations, and diabetic incidents to verify appropriate follow-up actions have occurred.	

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D 273	Continued From page 14	D 273		

notifications should be reviewed through the facility's Quality Assurance Program to ensure compliance with state regulations and quality resident care.

Review of Resident #5's FL2 dated 01/06/26 revealed:
-Diagnoses included type 2 diabetes, dementia, chronic kidney disease, and hyperlipidemia.
-Her level of care was Special Care Unit (SCU).
-The resident was ambulatory and intermittently disoriented.
-There was an order for Humalog 100 unit/ml Kwik pen, inject 10 units per sliding scale (SS) finger stick blood sugar (FSBS) 0-150 inject 0 units, 151-200 inject 3 units, 201-250 inject 5 units, 251-300 inject 7 units, 301-350 inject 9 units, 351-400 inject 11 units, and if FSBS is greater than 400 call the resident's primary care provider (PCP) (Humalog is a fast acting insulin).

Review of Resident #5's signed physician's order sheet dated 01/08/26 revealed:
-There was an order for FSBS three times a day before meals.
-There was an order for Humalog 100 unit/ml Kwik pen, inject 10 units per SS three times a day, 151-200 inject 3 units, 201-250 inject 5 units, 251-300 inject 7 units, 301-350 inject 9 units, 351-400 inject 11 units, FSBS greater than 400 call the resident's PCP.

Review of Resident #5's signed physician's order sheet dated 04/23/26 revealed:
-There was an order for FSBS four times a day before meals and at bedtime (7:30am, 11:30am, 5:30pm, and 8:00pm).
-There was an order for Humalog 100 unit/ml Kwik pen, inject 5 units three times a day with meals at 7:45am, 11:45am, and 5:45pm.

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D 273	Continued From page 15 -There was an order to notify the resident's PCP if his FSBS was greater than 450. Review of Resident #5's May 2026 electronic medication administration record (eMAR) revealed: -There was an entry to check FSBS four times a day, before meals and at bedtime. -See as needed (PRN) orders if FSBS is less than 70 or greater than 450. -There was an entry to notify the PCP if FSBS was greater than 450. -FSBS was documented as 469 at 8:00pm on 05/04/26. -FSBS was documented as 500 at 8:00pm on 05/06/26. -FSBS was documented as 460 at 5:30pm on 05/08/26. -FSBS was documented as 483 at 8:00pm on 05/14/26. -There was no documentation on the eMAR that the PCP was notified on four occasions when Resident #5's FSBS was greater than 450. Review of Resident #5's electronic progress notes revealed there was no documentation of notification to the resident's PCP of FSBSs greater than 450 for the month of May 2026. Review of Resident #5's Triage communication notes to the PCP of notification that the resident's FSBSs were greater than 450 four times in May 2026. Review of Resident #5's June 2026 eMAR revealed: -There was an entry to check FSBS four times a day, before meals and at bedtime. -See as needed (PRN) orders if FSBS is less than 70 or greater than 450.	D 273		

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D 273	Continued From page 16 -There was an entry to notify the PCP if FSBS was greater than 450. -FSBS was documented as 500 at 5:30pm on 06/05/26. -There was no documentation on the eMAR that the PCP was notified on one occasion when Resident #5's FSBS was greater than 450. Review of Resident #5's electronic progress notes revealed there was no documentation of notification to the resident's PCP of FSBSs greater than 450 for the month of June 2026. Review of Resident #5's triage communication notes to the PCP of notification that the resident's FSBSs were greater than 450 one time in June 2026. Interview with a medication aide (MA) on 06/10/26 at 3:45pm revealed: -When Resident #5's FSBS was greater than 450 he followed the PCP's orders and notified the PCP or triage because there was a physician order to notify the PCP when the resident's FSBS was greater than 450. -He documented on the electronic progress note when he notified the PCP or triage when the resident's FSBS was greater than 450 because it was a physician order. Interview with the Resident Care Coordinator (RCC) on 06/10/26 at 3:59pm revealed: -MAs were expected to follow the PCP orders. -MAs usually spoke with a provider through the triage program and obtained directions from the triage provider. -There were triage notes in the resident's chart that showed the provider was notified of FSBSs greater than 450. -She was not sure why there were four times in	D 273		

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D 273	Continued From page 17 May 2026 and one time in June 2026 that there was no documentation that Resident #5's PCP was notified of a FSBS greater than 450. -The MAs should have communicated with the PCP because they were expected to follow physician orders, and each time the PCP was notified the resident had a FSBS greater than 450 the MAs should have documented their communication with the PCP or triage. Interview with the Administrator on 06/10/26 at 4:20pm revealed: -The MAs knew they were expected to document any communication with a resident's provider. -The facility had some technological issues with the eMAR system and a representative came to the facility yesterday to work on fixing the problem. -If the MAs were unable to document in the electronic medical record system, they should have contacted her or the RCC to inform them of the problem. -She and the RCC had additional ways to contact the PCP or triage to ensure that the provider received the message that Resident #5's FSBS was greater than 450. Attempted telephone interview with Resident #5's PCP on 06/10/26 at 2:40pm was unsuccessful.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or	D 276		

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D 276	Continued From page 18 orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure implementation of physician orders to meet the health care needs for 1 of 5 sampled residents who had an order to check the resident's blood pressure and pulse once a day (#3). The findings are: Review of Resident #3's FL2 dated 05/11/26 revealed: -Diagnoses included congestive heart failure, atrial fibrillation, pulmonary embolism, and hypertension. -There was an order to check the resident's blood pressure and pulse once daily and to notify the primary care provider (PCP) if the resident's pulse was less than 60. Review of Resident #3's May 2026 eMAR revealed: -There was an entry to check the resident's blood pressure and pulse once daily and to notify the PCP if the resident's pulse was less than 50. -There was no documentation of the residents' blood pressure or pulse at 8:00am on 05/17/26, 05/19/26, or 05/31/26. Interview with a medication aide (MA) on 06/10/26 at 2:49pm revealed: -When a resident had an order to notify the resident's PCP if the resident's pulse was less than 50, MAs notified the PCP by telephone or	D 276	Effective 06/11/2026 The facility acknowledges the deficiency and has implemented corrective actions to ensure compliance with 10A NCAC 13F .0902(c)(3) & (4). The facility shall ensure that resident assessments, observations, monitoring, and documentation are completed as ordered by the physician and in accordance with each resident's individualized care needs. The resident's physician orders were immediately reviewed to verify the required frequency for blood pressure and blood glucose monitoring. Blood pressure and blood glucose monitoring were resumed immediately in accordance with the physician's orders. The physician was notified, if indicated, and documentation was completed in the resident's medical record. The Resident Care Coordinator (RCC) and Administrator (or designee) completed an audit o n 06/14/2026 of all residents with physician orders for blood pressure monitoring, blood glucose monitoring, vital signs, weights, or other ongoing clinical monitoring to verify that ordered monitoring was being completed and documented as required. Any discrepancies identified during the audit were corrected immediately, and physician orders were reviewed for accuracy. Effective 06/15/2026 The Resident Care Coordinator or designee will review the MAR, TAR, and monitoring records daily to identify any missed documentation or incomplete physician orders. Any missed monitoring or documentation will be investigated immediately, corrected when appropriate, and reported to the Administrator for follow-up. Effective 06/11/2026 Shift-to-shift communication will include review of residents requiring daily monitoring to ensure continuity of care. All licensed staff, Medication Aides, and direct care staff have been educated on the requirements of 10A NCAC 13F .0902(c)(3) & (4) and the facility's policies regarding physician-ordered monitoring and documentation.	06/11/2026

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D 276	Continued From page 19 triage by telephone. -If instructions were provided by the PCP or staff with triage they were expected to follow those instructions. Interview with the Resident Care Coordinator (RCC) on 06/10/26 at 3:59pm revealed: -MAs were expected to follow PCP parameters and notify the PCP if it was in the order. -She did not know why Resident #3's blood pressure and heart rate were not recorded once in April 2026 and three times in May 2026. -The MAs were supposed to notify the resident's PCP and call triage if needed to obtain instructions. Interview with the Administrator on 06/10/26 at 4:19pm revealed: -She was not sure why MAs had not documented the residents' blood pressure and heart rate as ordered by the resident's PCP. -MAs should have documented the residents' blood pressure and heart rate on the eMAR. -If the resident refused or the resident was not available to check his blood pressure or heart rate there should have been documentation on the exceptions on the eMAR. Attempted telephone interview with the resident's PCP on 06/10/26 at 1:53pm and 3:20pm were unsuccessful.	D 276	Education included: Completing blood pressure and blood glucose monitoring exactly as ordered. Accurate and timely documentation on the MAR, TAR, or designated monitoring record. Reporting abnormal findings promptly to the healthcare provider according to facility policy. Following diabetic care protocols and physician orders without omission. The importance of complete documentation to ensure resident safety, continuity of care, and regulatory compliance. Effective 06/11/2026 The Resident Care Coordinator or designee will conduct audits of residents with physician-ordered blood pressure and blood glucose monitoring.	
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or	D 280		

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D 280	Continued From page 20 physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the quarterly licensed health professional support (LHPS) evaluations for 1 of 1 residents (#1) with a continuous glucose monitoring device, LHPS tasks were completed and included a physical assessment, evaluation of care provided, and recommendations based on the physical assessment and evaluation of the resident including tasks for the placement and monitoring of a continuous glucose monitoring (CGM) device that detects trends and tracks patterns in the detection of episodes of low blood glucose and high blood glucose. The findings are:	D 280	Effective 06/15/2026The facility acknowledges the deficiency and has implemented corrective actions to ensure compliance with 10A NCAC 13F .0903(f)(c). The facility shall ensure that all Licensed Health Professional Support (LHPS) forms accurately reflect each resident's delegated nursing tasks, including all equipment and procedures required to meet the resident's healthcare needs. 06/22/2026 The resident's LHPS form was immediately reviewed by the licensed nurse. The LHPS form was revised to include the blood glucose monitoring device and all related delegated nursing tasks as required by the resident's physician's orders and individualized care needs. The revised LHPS documentation was reviewed for accuracy, signed by the licensed nurse, and placed in the resident's clinical record. Direct care staff providing delegated tasks were informed of the updated LHPS plan. The licensed nurse completed a comprehensive review of all current LHPS forms to verify that each delegated nursing task, including blood glucose monitoring devices, diabetic care equipment, treatments, and other delegated procedures, was accurately documented. Any omissions or inaccuracies identified during the review were corrected immediately. All new admissions, residents with changes in physician orders, and quarterly LHPS reviews will include verification that the LHPS form reflects all current delegated tasks and equipment. Any changes to physician orders affecting delegated nursing tasks will result in an immediate review and update of the LHPS documentation.	06/15/2026

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D 280	Continued From page 21 Review of the manufacturer's quick reference guide for the Free Style Libre 3 continuous glucose monitoring (CGM) system revealed: -The Freestyle Libre 3 CGM system is a real time CGM device with alarms capability indicated for the management of diabetes in persons 4 or older. -It is intended to replace blood glucose testing for diabetes treatment decisions, unless otherwise indicated. -The system also detects trends and patterns and aids in the detection of episodes of hyperglycemia and hypoglycemia, facilitating both acute and long-term therapy adjustments. -Interpretation of the system readings should be based on the glucose trends and several sequential readings over time. -The system is also intended to autonomously communicate with digitally connected devices. -The system can be used alone or in conjunction with these digitally connected devices where the user manually controls actions for therapy decisions. Review of Resident #1's FL2 dated 01/08/26 revealed diagnoses included type 2 diabetes with hyperglycemia (high blood sugar) and polyneuropathy, chronic pain syndrome, acute myocardial infraction, chronic obstructive pulmonary disease, and pulmonary embolism. Review of Resident #1's previous quarterly Licensed Health Professional Support Evaluation (LHPS) revealed: -Personal tasks currently present were identified as collecting and testing of finger stick blood samples and medication administration through injections. -The resident was observed walking in the	D 280		

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D 280	Continued From page 22 hallways with her rollator. -She was alert and pleasant. -Her blood glucose was tested twice a day and as needed (PRN) and ranged from 99 to 350 in this quarter. -She received insulin for her blood glucose management and she tolerated it well. -She had a no concentrated sweets diet. -She had no reported wounds. -Her skin was dry and intact. -She was followed by the podiatrist in the community. -She had no concerns. -Recommendations were to continue current plan of care. -Facility staff competency was validated for blood glucose monitoring and subcutaneous injections. -The LHPS evaluation was signed by the LHPS Registered Nurse (RN) on 01/29/26. -There was no assessment that identified placement of the continuous glucose monitor sensor or checking blood glucose using a continuous glucose monitoring device. Review of Resident #1's most recent quarterly LHPS dated 04/28/26 revealed: -Personal tasks currently present were identified as collecting and testing of finger stick blood samples, medication administration through injections, and oxygen administration and monitoring. -The resident was observed sitting on the edge of the bed. -The resident was alert and pleasant. -She had her blood glucose tested twice a day, and PRN and her blood glucose ranged from 84 to 392 this quarter. -She received insulin for her blood glucose management and tolerated it well. -She was on a no concentrated sweets diet.	D 280		

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D 280	Continued From page 23 -There were no reported wounds. -Her lung sounds were clear today. -Her skin was warm and intact. -She was followed by podiatry, and her feet were in good condition. -She had no concerns at this time. -Recommendations were to continue current plan of care. -Facility staff competency was validated for blood glucose monitoring, subcutaneous injection, and oxygen. -The LHPS evaluation was signed by the LHPS RN on 04/28/26. -There was no assessment that identified placement of the continuous glucose monitor sensor or checking blood glucose using a continuous glucose monitoring device. Review of Resident #1's signed physician's order sheet dated 01/08/26 revealed there was an order to check finger stick blood sugar (FSBS) two times a day. Review of Resident #1's primary care provider's (PCP) visit notes dated 01/15/26 revealed: -The resident had insulin-dependent diabetes and experienced hyperglycemia. -Her insulin regimen included Lantus (a long-acting insulin used to treat elevated blood glucose) 50 units once daily and Humalog (a rapid acting insulin used to treat elevated blood glucose) 100 units in the morning and 85 units at dinner. -Her blood sugars were monitored three times a day and at bedtime using a Freestyle Libre continuous glucose monitor (CGM), and they have been stable since admission to the facility. -Assessment: the patient has insulin-dependent diabetes mellitus with occasional hyperglycemia, managed with multi-component insulin regimen	D 280		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HONEY'S ASSISTED LIVING	1935 IDLEWILD DRIVE KINSTON, NC 28504

(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 280	Continued From page 24 including basal (Lantus) and prandial (Humalog) as well as Farxiga (an oral medication used to manage type two diabetes). -Her blood sugars have been stable since her recent admission to the facility. -Plan, continue current diabetes management, including Lantus 50 units daily, Humalog 100 units with breakfast and 85 units with dinner and Farxiga. -Continue monitoring blood sugars three times a day and at bedtime via her Freestyle Libre CGM. -Titrate insulin as needed based on blood sugar trends. -Order refills for her Freestyle supplies to ensure effective glucose management. Review of a signed physician's order sheet for Resident #1 dated 03/12/26 revealed an order to check blood sugar twice a day. Review of Resident #1's previous endocrinologist's visit notes dated 03/19/26 reveal: -Decrease Lantus to 30 units daily in the morning. Change Humulin R U-500 to 100 units before first meal of the day and 75 units before dinner plus additional sliding scale; if glucose is between 150-200, add additional 5 units to mealtime dose if glucose is between 201-250, add additional 10 units to mealtime dose if glucose is between 251-300, add additional 15 units to mealtime dose if glucose is between 301-350, add additional 20 units to mealtime dose if glucose is greater than 351, add additional 25 units to mealtime dose. -Freestyle Libre 3 sensor, change every 15 days. Review of Resident #1's signed physician's order	D 280		

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D 280	Continued From page 25 sheet dated 04/23/26 revealed: -There was an order to check blood sugar two times a day before meals as needed. -There was an order for Freestyle Libre 3 sensor, change sensor every 15 days. -There was an order for Humulin R 500units, check blood sugar before breakfast and dinner, 151-200= 5units, 201-250= 10units, 251-300= 15 units, 301-350= 20 units, 351-400= 25 units, 401-450= 30 units, greater than 450= 35 units. -There was an order to check blood sugar as needed for signs/symptoms of high/low blood sugar. Review of a signed physician's order sheet for Resident #1 dated 05/28/26 revealed: -There was an order to discontinue Humulin R 500 units three times a day and sliding scale insulin (SSI). -There was an order to start Humalog U-200, inject 75 units three times a day before meals plus SSI, 151-200= 5units, 201-250= 10units, 251-300= 15 units, 301-350= 20 units. 351-400= 25 units, 401-450=30 units, greater than 450= 35 units (max dose of 250 units in 24 hours). -Blood glucose checks three times a day before meals and at bedtime. -Blood glucose checks at 2:00am (CGM) for 2 weeks. Review of Resident #1's April 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Freestyle Libre 3 sensor, change sensor every 15 days, scheduled for 2:00pm. -Freestyle Libre 3 sensor was documented as changed on 04/09/26 at 2:00pm. -Freestyle Libre 3 sensor was documented on 04/24/26 as "Resident Refused" and the	D 280		

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D 280	Continued From page 26 exception was documented as "stated it was changed yesterday". Review of Resident #1's May 2026 eMAR revealed: -There was an entry for Freestyle Libre 3 sensor, change sensor every 15 days, scheduled for 2:00pm. -Freestyle Libre 3 sensor was documented as not changed on 05/09/26 at 2:00pm with the exception documented as "no sensor in stock". -Freestyle Libre 3 was documented as changed on 05/24/26 at 2:00pm. Review of Resident #1's June 2026 eMAR revealed: -There was an entry for Freestyle Libre 3 sensor, change sensor every 15 days, scheduled for 2:00pm. -Freestyle Libre 3 sensor was documented as not changed on 06/08/26 with the exception documented as not on cart, will be in tonight. Interview with Resident #1 on 06/10/26 at 9:10am revealed: -The medication aides (MAs) changed her Freestyle Libre 3 sensor. -Her Freestyle Libre 3 was changed yesterday afternoon, 06/09/26 by the MA. Observation of Resident #1's medications on hand on 06/10/26 at 9:46am revealed: -There was a manufacturer labeled box containing one Freestyle Libre 3 Sensor with a prescription label attached with Resident #1's name and directions to change sensor every 15 days for a quantity of two and a dispense date of 06/08/26. -There was a handwritten note on the prescription label "2 of 2".	D 280		

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D 280	Continued From page 27 Interview with a MA on 06/10/26 at 9:03am revealed: -The MAs changed Resident #1's Freestyle Libre 3 sensor. -She changed Resident 1's Freestyle Libre 3 sensor yesterday. -She had not been trained by staff at the facility or the LHPS nurse on how to change a CGM. -She knew how to change and monitor the Freestyle Libre 3 sensor because she had a family member that wore a CGM. Telephone interview with the LHPS RN on 06/10/26 at 3:20pm revealed: -She conducted the LHPS evaluations for the facility's residents quarterly, after hospitalizations, or if there were significant changes. -For the LHPS evaluation, she reviewed the resident's record, FL2, eMAR, care plan, and provider visit notes. -She also discussed the resident with the MA or the Resident Care Coordinator (RCC) and did an assessment. -If a resident was diabetic, she assessed their skin and feet, reviewed their blood glucose readings, and made sure there was primary care provider (PCP) notification for blood glucose readings outside of parameters. -If a resident had a CGM, she made note of the CGM and identified the task as blood sugar checks by fingerstick and CGM. -Resident #1's last two LHPS evaluations were done by a part-time nurse that helps them out. -Resident #1's CGM should have been identified on her LHPS evaluations. Interview with the RCC on 06/10/26 at 4:00pm revealed: -The MAs at the facility changed the residents'	D 280		

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D 280	Continued From page 28 CGMs when needed. -LHPS evaluations were performed by RNs with the facility's contracted pharmacy. -She reviewed the residents' LHPS evaluation to make sure it matched the residents' care plan. -She had not noticed that Resident #1's CGM was not mentioned on her LHPS evaluation. -She was not aware that placement and monitoring of CGM required a LHPS task. Interview with the Administrator on 06/10/26 at 4:19pm revealed: -The RN with the facility's contracted pharmacy performed the residents' LHPS evaluations. -Staff reviewed the residents' LHPS evaluations to make sure the tasks matched the care plan. -She was not aware that placement and monitoring of a CGM was required to be included in the assessment portion of the quarterly LHPS evaluation by the LHPS RN. -Resident #1's LHPS tasks included glucose monitoring, and she felt that covered the CGM as well.	D 280		
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 interviews and record reviews, the	D 358		

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D 358	Continued From page 29 facility failed to administer medications according to provider orders for 1 of 5 sampled residents (#1) for a medication used to treat elevated blood glucose levels. The findings are: Review of the facility's undated Diabetic Policy revealed: -Carry out finger stick glucose testing as ordered by the primary care provider. -If the result is below 60, hold the scheduled dose of insulin. -Give 4 ounces of the house supplement or orange juice. -Observe for signs and symptoms of hypoglycemia. -Repeat the fingerstick blood testing in 30 minutes. -Contact the primary care provider and notify of low blood sugar, follow orders given at that time whether to try additional steps to raise blood sugar or if blood sugar is raised should insulin be given. -A normal blood sugar is 70 to 120. -If the blood glucose is 500 or above administer insulin as ordered and contact the primary care provider. -Observe for signs and symptoms of hyperglycemia and intervene as appropriate. -Call the primary care provider and 911 as needed. -Follow orders for sliding scale insulin as prescribed by the primary care provider. -Contact the primary care provider for any blood glucose reading outside of parameters. -If the individual resident has parameters listed other than what is outlined in the policy, follow the individual orders from the primary care provider.	D 358	The facility acknowledges the deficiency and has implemented corrective actions to ensure compliance with 10A NCAC 13F .1004. The facility shall ensure that all medications are administered safely, accurately, and documented in accordance with physician orders, accepted standards of practice, and state regulations. Effective 06/11/2026 The resident's Medication Administration Record (MAR), physician orders, and medication documentation were immediately reviewed to identify and correct the deficiency. Any missed documentation or discrepancies were investigated, corrected when appropriate, and the resident's physician was notified if clinically indicated. The resident's medication regimen was reviewed to ensure all medications were being administered as ordered. The Resident Care Coordinator (RCC), Administrator, or licensed nurse/designee completed a facility-wide audit of resident MARs and physician orders to verify that medications were being administered and documented correctly. Effective 06/12/2026 The facility has implemented a medication administration review process to verify that physician orders are accurately transcribed to the MAR and that medications are administered and documented as ordered. Medication Aides and licensed staff will review the MAR at the beginning and end of each shift to ensure all scheduled medications have been administered and documented. Any medication variance, omission, or documentation concern will be reported immediately to the Resident Care Coordinator or Administrator for investigation and follow-up. The Administrator and Resident Care Coordinator are responsible for ensuring ongoing compliance with medication administration requirements through oversight, education, and routine audits.	

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D 358	Continued From page 30 Review of Resident #1's FL2 dated 01/08/26 revealed diagnoses included type 2 diabetes with hyperglycemia (high blood sugar) and polyneuropathy, chronic pain syndrome, acute myocardial infraction, chronic obstructive pulmonary disease, and pulmonary embolism. Review of Resident #1's previous endocrinology visit notes dated 03/19/26 revealed an order to change Humulin R 500 (Humulin R 500 is a concentrated rapid acting insulin delivering 500 units per ml) to 100 units before first meal of the day and 75 units before dinner plus additional sliding scale; if glucose is between 150-200, add additional 5 units to mealtime dose if glucose is between 201-250, add additional 10 units to mealtime dose if glucose is between 251-300, add additional 15 units to mealtime dose if glucose is between 301-350, add additional 20 units to mealtime dose if glucose is greater than 351, add additional 25 units to mealtime dose. Review of Resident #1's signed physician's order sheet dated 04/23/26 revealed: -There was an order to check blood sugar two times a day before meals as needed. -There was an order for Humulin R 500units 100units before breakfast and 75 units before dinner. -There was an order for Humulin R 500units, check blood sugar before breakfast and dinner, 151-200= 5 units, 201-250= 10 units, 251-300= 15 units, 301-350= 20 units, 351-400= 25 units, 401-450= 30 units, greater than 450=35 units. -There was an order to check blood sugar as needed for signs/symptoms of high/low blood sugar.	D 358		

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D 358	Continued From page 31 Review of a signed physician's order sheet for Resident #1 dated 05/28/26 revealed: -There was an order to discontinue Humulin R 500 units three times a day and sliding scale insulin (SSI). -There was an order to start Humalog U-200 (a concentrated rapid acting insulin delivering 200units per ml), inject 75 units three times a day before meals plus SSI, 151-200= 5 units, 201-250= 10units, 251-300= 15 units, 301-350= 20 units. 351-400= 25 units, 401-450= 30 units, greater than 450= 35 units (max dose of 250 units in 24 hours). -Blood glucose checks three times a day before meals and at bedtime. -Blood glucose checks at 2:00am (CGM) for 2 weeks. Review of Resident #1's April 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Humulin R 500unit/ml sliding scale, check blood sugar before breakfast and dinner, 151-200= 5 units, 201-250= 10 units, 251-300= 15 units, 301-350= 20 units, 351-400= 25 units, 401-450= 30 units, greater than 450= 35 units, scheduled at 7:30am and 5:30pm. -Humulin R 500 SSI was documented as not administered at 7:30am on 04/07/26 and on 04/08/26 with the exception documented as "withheld per DR/RN orders" and "same insulin/different dose" and there was no blood glucose documented. -Humulin R 500 SSI was not documented as administered at 7:30am and 5:30pm on 04/14/26, initials were documented at both the 7:30am and 5:30pm entry but there was no documentation of the blood glucose or number of insulin units administered.	D 358		

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D 358	Continued From page 32 Review of Resident #1's May 2026 eMAR revealed: -There was an entry for Humulin R 500unit/ml sliding scale, check blood sugar before breakfast and dinner, 151-200= 5 units, 201-250= 10 units, 251-300= 15 units, 301-350= 20 units, 351-400= 25 units, 401-450= 30 units, greater than 450= 35 units, scheduled at 7:30am and 5:30pm with a stop date of 05/29/26 at 8:00pm. -Humulin R 500 SSI was documented as not administered at 7:30am on 05/13/26 with the exception documented as "med not on cart" and "needs to be reordered". -Humulin R 500 SSI was not documented as administered on 05/17/26 at 7:30am, the entry was initialed but there was no documentation of the blood glucose or the number of insulin units. -Humulin R 500 SSI was not documented as administered on 05/18/26 at 5:30pm, the entry was initialed but there was no documentation of blood glucose or the number of insulin units. -Humulin R 500 SSI was not documented as administered on 05/19/26 at 7:30am, the entry was initialed but there was no documentation of the blood glucose or the number of insulin units. -Humulin R 500 SSI was not documented as administered at 5:30pm on 05/28/26 at 5:30pm, the entry was initialed but there was no documentation of the blood glucose or the number of insulin units. -There was a second entry for Humalog 200unit/ml, check blood sugar three times a day, give sliding scale insulin (SSI) 151-200=5units, 201-250= 10 units, 251-300= 15 units, 301-350= 20 units, 351-400= 25 units, 401-450= 30 units, if greater than 450= 35 units, scheduled at 7:45am, 11:45am and 5:45pm with a start date of 05/30/26 and a note "suspended 05/29/26 to 06/02/26". -Humalog 200unit/ml SSI was not documented as	D 358		

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D 358	Continued From page 33 administered on 05/30/26 and 05/31/26 at 7:45am, 11:45am, and 5:45pm, with no exception documented and the entries were blank. Review of an eCare Triage note for Resident #1 dated 05/29/26 and time stamped 2:01pm revealed: -The reporting person was a pharmacist with the facility's contracted pharmacy. -The message was "hey we got the Humalog U200 in today and will be sending it out on delivery tonight, I was reviewing the order again and I'm nervous it will be too much with the sliding scale. Can we hold the order until next Tuesday and see how she does first with the transition to the rapid acting? -Response from a nurse practitioner, "noted the above is fine, follow-up with the primary care provider (PCP) on the next visit day, notify of any acute changes, will share with the PCP". Observation of Resident #1's medications on hand on 06/10/26 at 9:50am revealed there were two 3 milliliter pens of Humalog 200u/ml labeled with Resident #1's name and a sticker with date opened documented as 06/07/26 and a dispose of date documented as 07/05/26. Telephone interview with a pharmacist with the facility's contracted pharmacy on 06/10/26 at 1:33pm revealed: -An order was received for Resident #1 for Humulin R 500units/ml, administer 100 units before breakfast and 75 units before dinner, plus additional sliding scale insulin on 03/20/26. -Resident #1's sliding scale insulin order for 03/20/26 was for blood glucose of 150-200= 5 units, 201-250= 10 units, 251-300= 15 units, 301-350= 20 units, 351-400= 25 units, 401-450= 30 units, if greater than 450= 35 units.	D 358		

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D 358	Continued From page 34 -Humulin R 500U/ml was dispensed for Resident #1 on 01/05/26 for 12mls (4 pens) and on 02/09/26 for 12mls (4 pens). -The facility contacted the pharmacy on 02/27/26 and requested that the pharmacy stop sending Humulin R 500U/ml for Resident #1 because she brought quite a bit of medication with her when she was admitted to the facility in January 2026. -Humulin R 500u/ml was next dispensed for Resident #1 on 05/12/26 for 12 mls (4 pens). -An order was received for Resident #1 on 05/29/26 to discontinue Humulin R 500u/ml and to start Humalog U-200, inject 75 units three times a day before meals plus sliding scale insulin. -Resident #1's new sliding scale insulin order for 05/29/26 was for blood sugar inject 151-200= 5 units, 201-250= 10 units, 251-300=15 units, 301-350= 20 units, 351-400= 25 units, 401-450= 30 units, greater than 450= 35 units. -Humalog 200units/ml was dispensed for Resident #1 for 12mls (4 pens) on 05/28/26 and on 06/05/26. -Humalog is a rapid acting insulin and missing doses could cause elevated blood glucose levels. Interview with a medication aide (MA) on 06/10/26 at 9:03am revealed: -The MAs or the Resident Care Coordinator (RCC) were responsible for requesting medication refills for the residents. -Medications were batch filled for the residents. -Insulin should be requested when a resident was down to two pens. -She did not know why there were blanks on Resident #1's sliding scale insulin on her eMAR. -She was not aware of Resident #1 not having Humalog available for administration. -If a medication was not administered to a resident, there should always be an exception	D 358		

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D 358	Continued From page 35 documented. Interview with a second MA on 06/10/26 at 3:45pm revealed: -The MAs were responsible to request medication refills for the residents. -He requested refills when a resident had 5 or 6 doses of medication remaining if the medications were not batch filled. -He always checked a resident's insulin pen supply when he did the daily refrigerator temperature checks to make sure there were insulin pens on hand. -Medication cart audits were performed once or twice a month. -The medication cart audit consisted of looking for expired medications, making sure medications were available and making medications were labeled. -Medications and blood sugar readings should always be documented on the resident's eMAR. -There were times when information entered in the eMAR system was not saved. -There should never be blanks on the residents' eMAR Interview with the Resident Care Coordinator (RCC) on 06/10/26 at 4:00pm revealed: -The MAs were responsible for ordering medication refills for the residents. -She did medication cart audits monthly either at the first of the month or end of the month to make sure the residents' medications were available, to check for expired or undated medications, and to make sure insulin pens were dated. -Insulin refills should be requested when a resident had 4 insulin pens remaining. -If a medication was not administered there should always be a reason documented as to why the medication was not given.	D 358		

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HONEY'S ASSISTED LIVING	1935 IDLEWILD DRIVE KINSTON, NC 28504

(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 36 -She or the Administrator did eMAR audits monthly to look for things like medication refusals, missed doses of medications. -She was not aware there were times when Resident #1's sliding scale insulin was not documented, -She expected medications to be administered to the residents as ordered. Interview with the Administrator on 06/10/26 at 4:19pm revealed: -The MAs or the Care Mangers were responsible for ordering refills for the residents' medications. -The RCC did monthly medication cart audits to make sure medications were available, looking for expired or discontinued medications, and to make sure insulin was dated and a pharmacist with the facility's contracted pharmacy did quarterly medication cart audits. -There should never be blanks on the residents' eMAR. -If a medication was not administered there should always be an exception documented as to why. -There had been internet issues with the eMAR system since a new medication cart was added. -The eMAR system was not in sync and medications would scan but not be documented as administered. -She thought this was possibly why there were blanks on Resident #1's sliding scale insulin. -She and the RCC did monthly eMAR audits to look for blanks, missed or refused medications. -The facility had recently received an influx of new admissions and there had not been time to conduct the monthly eMAR audits. Attempted telephone interview with Resident #5's PCP on 06/10/26 at 2:40pm was unsuccessful.	D 358		