STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(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 06/24/26 to 06/25/26.	D 000		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 4 of 5 sampled residents (#1, #2, #4, #5) had tuberculosis (TB) skin testing prior to admission in compliance with the control measures for the Commission for Public Health. The findings are: Review of the facility's undated Admissions policy revealed: -Admission policies were governed by the North Carolina Department of Health and Human Services. -The following must be provided /completed prior to admission, tuberculosis (TB) skin test, could be done at admission but prefer Step 1 prior to	D 234	Administrator/Marketing will ensure all residents have received their first TB test upon admission and SCUC/Designee will ensure all residents have received their second TB test in compliance with the control measures adopted by the commission of health services. SCUC/Designee will audit all resident chart for current residents, then at least 5 random resident charts monthly to ensure all have TB test in accordance of rule 10A NCAC 13F .0703(a) QI team will audit resident charts randomly to ensure all residents have TB test in accordance of rule 10A NCAC 13F .0703(a) any residents found not to have TB completed will receive as soon as possible.	8/9/2026

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 8/7/2026

Reviewed and Acknowledged 08/14/26 KC

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admission.
-If admitted from a nursing home or from another assisted living community, the resident must have in addition to the above information a record of the resident's vaccinations and TB screening.

1. Review of Resident #5's current FL-2 dated 07/17/25 revealed:
-Diagnoses included uncontrolled diabetes, diabetic ketoacidosis, acute encephalopathy, hypokalemia, hypernatremia, and acute kidney injury.
-His level of care was assisted living.

Review of Resident #5's Resident Register revealed he was admitted to the facility on 09/22/18.

Review of a 2 step tuberculosis (TB) test form from another facility revealed:
-Under 1st step TB, Resident #5's name was listed and the facility location was listed.
-There was no dated injected, site, nurse signature, date read or results documented.
-Under 2nd step TB test, the date injected was documented as 05/09/17, the site was documented as left forearm, there was a nurse signature, the date read was documented as 05/11/17 and the results were documented as 0 mm and there was a nurse signature.

Review of a facility's Tuberculin Skin Test report revealed:
-The TB skin test report contained Resident #5's name.
-Under 1st test date, was documented "given", see attached 1st step.
-The 2nd test date was documented as what appeared to be 08/13/18 to the left forearm, the lot number was included and the expiration date

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was documented as 08/19 with a nurse's signature, the result was documented as negative, 0 mm induration, with date read documented as 03/16/18 and a nurse's signature.

Review of a second Tuberculin Skin Test report revealed:
-The TB skin test report contained Resident #5's name.
-Under 1st test date, the date was documented as what appeared to be 08/19/18 to the right forearm, with a lot number and expiration date documented as 08/19, and the results were documented as "questionable positive, MD notified", and the date read was documented as 03/22/18 and there was a nurse's signature.
-The second test date was blank.

Interview with the Resident Care Coordinator (RCC) on 06/25/26 at 4:40pm revealed:
-The residents were to have a two-step TB skin test for admission to the facility.
-She was not sure why the dates on Resident #5's facility TB skin test reports appeared to be administered in August (8) and read in March (3), she thought the numbers that appeared as an eight on the TB skin tests were supposed to be a three.
-If Resident #5 had a questionable positive TB skin test, a chest x-ray should have been performed.

Refer to interview with the Administrator on 06/25/26 at 6:33pm.

2. Review of Resident #1's current FL-2 dated 01/17/26 revealed diagnoses included vascular dementia, glaucoma, hyperlipidemia, restless leg syndrome, calculus of kidney, type 2 diabetes mellitus, schizoaffective disorder, and calculus of

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gallbladder.

Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 04/03/24 from a skilled rehabilitation facility.

Review of Resident #1's tuberculosis (TB) skin tests revealed:
-There was documentation of a TB skin test placed on 02/03/21 and read as negative.
-There was no documentation of the date read or who read the TB skin test.
-There was documentation of a second TB skin test placed on 02/17/21 and read as negative.
-There was no documentation of the date read or who placed and read the second TB skin test.

Interview with the Administrator on 06/25/26 at 6:33pm revealed he did not notice the information for Resident #1's TB skin tests was incomplete including the dates the TB skin tests were read.

Refer to interview with the Administrator on 06/25/26 at 6:33pm.

3. Review of Resident #4's current FL-2 dated 01/19/26 revealed diagnoses included dementia with behaviors, transaminitis, encephalopathy, and anxiety.

Review of Resident #4's undated Resident Register revealed:
-The resident's date of admission was blank.
-The resident was admitted from her own residence.

Review of Resident #4's Emergency Information form revealed the resident was admitted to the facility on 07/25/22.

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Review of Resident #4's tuberculosis (TB) skin tests revealed:
-There was documentation of a TB skin test "ordered" on 07/12/22 and read as negative.
-There was no documentation of the dates placed or read.
-There was no documentation of who placed the skin test or read the results.
-There was no documentation of any other TB skin tests for Resident #4.

Interview with the Administrator on 06/25/26 at 6:33pm revealed:
-He recently (date not specified) identified that Resident #4 only had documentation of one TB skin test in her record when he was conducting a record audit.
-He had not noticed documentation for Resident #4's TB skin test was incomplete.
-He planned to start a new 2-step TB skin test process for the resident.

Refer to interview with the Administrator on 06/25/26 at 6:33pm.

4. Review of Resident #2's current FL-2 dated 10/04/25 revealed diagnoses included hypotension, shortness of breath, stage 3 chronic kidney disease, hyperlipidemia, and acidosis.

Review of Resident #2's Resident Register revealed he was admitted to the facility from a rehabilitation facility on 08/25/25.

Review of Resident #2's record revealed:
-There were 2 forms titled immunization details with no resident name on them.
-There was documentation a tuberculosis (TB) skin test was administered on 07/15/25.
-The results were documented as negative with

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D 234	Continued From page 5 no date the test was read. -There was documentation a 2nd TB skin test was administered on 07/23/25. -The results were documented as negative with no date the 2nd test was read. Interviews with the Administrator on 06/25/26 at 3:48pm and 6:33pm revealed: -Resident #2 came from another facility and was administered a 2-step TB test at that facility. -He received Resident #2's TB test results from the previous facility with no read date. -He did not notice that Resident #2 had no read dates for the 2-step TB tests; he only saw that the test was administered and the results were negative. Refer to interview with the Administrator on 06/25/26 at 6:33pm. _____ Interview with the Administrator on 06/25/26 at 6:33pm revealed: -The facility's Marketing Director was responsible to make sure new residents had a least one tuberculosis (TB) skin test prior to admission. -The Marketing Director position was currently vacant at the facility. -The Resident Care Coordinator (RCC) was responsible for making sure the residents had a second step TB skin test done after admission. -He and the RCC were responsible for monthly chart audits for the residents. -He had not noticed the TB skin tests for the residents did not have the complete information. -TB testing was important to prevent the spread of tuberculosis in the facility.	D 234		
D 273	10A NCAC 13F .0902(b) Health Care	D 273		

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D 273	Continued From page 6 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 interviews and record reviews, the facility failed to ensure health care coordination and follow-up for 2 of 5 sampled residents (#1, #5) including failing to notify a resident's primary care provider (PCP) of blood sugar readings outside of ordered parameters (#1) and failing to notify a resident's PCP of diet and speech therapy recommendations after the resident had a dysphagia consult (#5). The findings are: 1. Review of Resident #5's current FL-2 dated 07/17/25 revealed: -Diagnoses included uncontrolled diabetes, diabetic ketoacidosis, acute encephalopathy, hypokalemia, hypernatremia, and acute kidney injury. -His level of care was assisted living. -His diet order was regular, no concentrated sweets. Review of a physician's consultation report dated 04/15/26 revealed: -The reason for visit was dysphagia (difficulty swallowing). -Under assessment notes, aspiration with thin and nectar thick liquids. -Recommend mechanical soft diet with honey thick liquids and swallowing therapy with speech therapy recommended. -The physician's consultation sheet was signed by the speech therapist. -There were initials on the bottom right corner of	D 273	SCUC reviewed all recent (30 days) discharge summaries and orders and assure any orders needing to be referred to outside agencies or providers are completed. All referrals will be followed-up on immediately on ensure accuracy and correct documentation. SCUC and/or designee will review new orders x 5 days per week to ensure each order is referred to and appropriate agency if indicated. Administrator/Designee will audit all orders once per week x4 weeks, then once per month ongoing to assure any orders needing to be referred to outside agencies or providers are completed QI department will conduct quarterly audits of the facility to ensure compliance with rule area.	8/9/2026

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the physician's consultation report with a date of 06/09/26.

Speech therapy notes were requested on 06/24/26 at 4:33pm and were not provided.

Interview with Resident #5 on 06/24/26 at 3:10pm revealed:
-He denied problems swallowing or choking when he ate or drink.
-He had some difficulty chewing due to new dentures.
-He followed no special diet.

Interview with a medication aide (MA) on 06/24/26 at 3:41pm revealed:
-If a resident had an appointment with an outside provider, the MAs faxed any orders to the pharmacy.
-If a resident had a diet change, the MAs made a copy of the order and gave the order to the Resident Care Coordinator (RCC) and the Dietary Manager.

Interview with the RCC on 06/25/26 at 4:40pm revealed:
-The initials dated 06/09/26 at the bottom of Resident #5's physician's consultation report for dysphagia dated 04/15/26 belonged Resident #5's primary care provider (PCP).
-Resident #5's dysphagia consultation sheet should have been given to a MA, and the MA should have notified her of the recommended diet change and Resident #5's PCP would have to write an order for the new recommended diet.
-Resident #5 did not have swallowing issues that she was aware of, but he preferred his medications to be in liquid form and did not like taking medications.
-The referral for swallowing therapy and speech

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therapy should have been given to the Transportation Coordinator to schedule.

Second interview with the RCC on 06/25/26 at 6:10pm revealed:
-She was not sure why Resident #5's PCP did not sign Resident #5's physician's consultation report for dysphagia dated 04/15/26 until 06/09/26.
-Resident #5's dysphagia consultation sheet should have been given to a MA, to her, and to Resident #5's PCP.
-Resident #5's PCP would need to write an order for the newly recommended diet for Resident #5 and for swallowing and speech therapy.
-She thought they had discussed and tried the new recommended diet for Resident #5, and he refused but she did not have documentation of the discussion or attempts.
-She was not sure what happened with the recommended swallowing and speech therapy for Resident #5.

Interview with the Administrator on 06/25/26 at 6:33pm revealed:
-When a resident had an outside provider visit, the transportation coordinator made of copy of the physician's consultation report and gave it to the MA on duty and the RCC.
-The MA could fax any orders to the pharmacy.
-The RCC should review and coordinate any new orders with the residents' PCP.
-The physician's consultation report should have been placed in the PCP's folder to review.
-If there were new orders or changes to orders, he received an email and he could not locate an email regarding Resident #5's recommended diet change or swallowing and speech therapy recommendations.

Attempted telephone interview with the Speech

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Therapist on 06/25/26 at 4:00pm was unsuccessful.

Attempted telephone interview with Resident #5's PCP on 06/25/26 at 3:41pm was unsuccessful.

2. Review of Resident #1's current FL-2 dated 01/17/26 revealed:
-Diagnoses included vascular dementia, glaucoma, hyperlipidemia, restless leg syndrome, calculus of kidney, type 2 diabetes mellitus, schizoaffective disorder, and calculus of gallbladder.
-There was an order to check blood sugar 3 times a day, notify primary care provider (PCP) if blood sugar was less than (<) 70 or greater than (>) 400.

Review of Resident #1's physician's orders sheet dated 05/05/26 revealed an order to check blood sugar 3 times a day, notify PCP if blood sugar was < 70 or > 450.

Review of Resident #1's physician's order dated 06/09/26 revealed:
-There was an order to clarify when the PCP should be notified for blood sugar readings.
-The order was clarified to notify the PCP if the resident's blood sugar was <70 or >450.

Review of Resident #1's April 2026 electronic medication administration record (eMAR) revealed:
-There was an entry to check blood sugar 3 times a day, notify PCP if <70 or >450.
-The resident's blood sugar was scheduled to be checked at 8:00am, 12:00pm, and 5:00pm.
-The resident's blood sugar was documented as 492 on 04/24/26 at 8:00am but there was no documentation that the resident's PCP was

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notified.
-The resident's blood sugar ranged from 55 - 504 from 04/01/26 - 04/30/26.

Review of Resident #1's May 2026 eMAR revealed:
-There was an entry to check blood sugar 3 times a day, notify PCP if <70 or >450.
-The resident's blood sugar was scheduled to be checked at 8:00am, 12:00pm, and 5:00pm.
-The resident's blood sugar was documented as 65 on 05/07/26 at 5:00pm, 54 on 05/21/26 at 5:00pm, and 60 on 05/27/26 at 5:00pm.
-The resident's blood sugar was documented as 407 on 05/04/26 at 12:00pm.
-There was no documentation the resident's PCP was notified on these 4 occasions.
-The resident's blood sugar ranged from 54 - 541 from 05/01/26 - 05/31/26.

Review of Resident #1's June 2026 eMAR revealed:
-There was an entry to check blood sugar 3 times a day, notify PCP if <70 or >450.
-The resident's blood sugar was scheduled to be checked at 8:00am, 12:00pm, and 5:00pm.
-The resident's blood sugar was documented as 51 on 06/18/26 at 5:00pm but there was no documentation that the resident's PCP was notified.
-The resident's blood sugar ranged from 51 - 444 from 06/01/26 - 06/24/26.

Review of Resident #1's facility progress notes revealed no documentation of Resident #1's PCP being notified of the blood sugars noted to be outside of the parameters on the April 2026 - June 2026 eMARs.

Interview with a medication aide (MA) on

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D 273	Continued From page 11 06/25/26 at 9:53am revealed: -The MAs were responsible for notifying the PCP of any blood sugar readings outside the ordered parameters. -The MAs used an electronic tablet to notify the provider through the contracted PCP's triage system of any blood sugars outside of the parameters. -The PCP's office then sent correspondence from the notification via fax or email to the Resident Care Coordinator (RCC). Interview with a second MA on 06/25/26 at 11:40am revealed: -The MAs were responsible for notifying the PCP of any blood sugar readings outside the ordered parameters. -The MAs usually sent messages to the PCP using the telehealth system. -The PCP's office responded back in the telehealth system either to the RCC or the Administrator. -She sometimes documented in a resident's record when she notified the PCP. Interview with Resident #1 on 06/25/26 at 5:57pm revealed: -The MAs checked his blood sugar, but he was not sure how often. -His blood sugar was too low sometimes and too high sometimes. -He felt "crappy" and shaky when his blood sugar was too low. -He sometimes got a headache when his blood sugar was too high. Interview with the RCC on 06/25/26 at 12:45pm revealed: -If a resident's blood sugar was out of the parameters ordered, the MAs were responsible	D 273		

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D 273	Continued From page 12 for notifying the PCP. -The MAs could either notify the PCP via telehealth using an electronic tablet, using an "omitted medications" form, or a physician's order form. -She was not aware Resident #1 had some blood sugar parameters out of the ordered parameters that had not been reported to the PCP. -She tried to check the eMARs monthly, but she had been busy and had not checked the eMARs since May 2026. Interview with the Administrator on 06/25/26 at 6:34pm revealed: -The MA on duty was responsible for notifying the PCP using a telehealth triage tablet of any blood sugars outside the ordered parameters. -The MAs should notify the PCP at the time the blood sugar reading was obtained. -He and/or the RCC completed monthly audits of eMARs. -He was not aware some of Resident #1's blood sugars outside of the parameters had not been reported to the PCP. -Resident #1's low and high blood sugars should have been reported to the PCP as ordered. -He was concerned that the resident's blood sugar could get too high or too low. -If that occurred, the resident could pass out or go into diabetic shock. Attempted telephone interview with Resident #1's PCP on 06/25/26 at 3:41pm was unsuccessful.	D 273		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support	D 280		

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LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

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D 280	Continued From page 13 (c) The facility shall assure that participation by a registered nurse, occupational therapist or 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) reviews and evaluations for 5 of 5 sampled residents (#1, #2, #3, #4, #5) with 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 medication administration through injection (#1, #3, #5), collecting and testing of fingerstick blood sugars (#1, #2, #5), ambulation (#4), transferring (#4), physical restraints (#3), oxygen administration and	D 280	Administrator has discussed rule area requirements with nurse that performs LHPS to assure a physical assessment of the resident includes a physical assessment as related to resident's diagnosis or current condition, evaluation of progress to care being provided and includes recommended changes as needed. SCUC/Designee retrained Medication Aides for implementation of new orders, documenting vitals and treatments as per physician's orders. SCUC will review MARs weekly to ensure implementation of new orders, documentation of vitals and treatments are being completed timely. Administrator and/or Designee will audit orders randomly to ensure written procedures, treatments or orders from a physician are implemented timely.	8/9/2026

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monitoring (#4), inhalation medication by machine (#4), applying and removing prosthetic devices (#4), care for pressure ulcers (#4), and suppositories (#4).

The findings are:

1. Review of Resident #2's current FL-2 dated 10/04/25 revealed:
-Diagnoses included hypotension, shortness of breath, stage 3 chronic kidney disease (CKD III), hyperlipidemia and acidosis.
-The resident was semi-ambulatory, used a wheelchair, and required assistance with bathing and dressing.

Review of Resident #2's physician's order dated 04/28/26 revealed there was an order to check Resident #2's blood sugar daily.

Review of Resident #2's current assessment and care plan dated 09/18/25 revealed:
-The resident used a wheelchair.
-The resident had limited strength.
-The resident required extensive assistance with toileting, bathing, dressing, and grooming.
-The resident required limited assistance with eating, ambulation and transfers.

Review of Resident #2's current Licensed Health Professional Support (LHPS) review dated 05/28/26 revealed:
-The nurse documented the resident's LHPS tasks were collecting or testing fingerstick blood samples.
-The nurse documented the resident ambulated independently using his wheelchair.
-The resident had an order for fingerstick blood sugar (FSBS) daily.
-The resident took Jardiance. (Jardiance is a

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medication used to treat type 2 diabetes.)
-The recommendation was to continue to follow plan of care.
-There was no physical assessment related to the resident's LHPS task.
-There was no physical assessment related to the resident's skin or foot care for a resident with diabetes.
-There were no recommendations related to a physical assessment of the resident.

Refer to interview with the LHPS nurse on 06/25/26 at 5:13pm.

Refer to interview with the Resident Care Coordinator (RCC) on 06/25/26 at 5:37pm.

Refer to interviews with the Administrator on 06/25/26 at 5:25pm and 6:33pm.

2. Review of Resident #5's current FL-2 dated 07/17/25 revealed:
-Diagnoses included uncontrolled diabetes, diabetic ketoacidosis, acute encephalopathy, hypokalemia, hypernatremia, and acute kidney injury.
-There was an order to check finger stick blood sugar (FSBS) four times a day, with meals and at bedtime, call medical doctor (MD) if FSBS was less than (<) 60 or greater than (>) 500.
-There was an order for Novolog (a rapid-acting insulin used to treat diabetes) Flexpen, check FSBS before meals, inject subcutaneously (SQ) according to sliding scale, if > 200 = 2 units, > 250 = 3 units, > 300 = 4 units, > 350 = 5 units.
-There was an order for Novolog Flexpen 100units/ml, inject 3 units three times daily before meals, hold if FSBS is < 100, may check FSBS after meals if refusing and administer insulin (prime pen with 2 units prior to each use).

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-There was an order for Tresiba (an ultra-long-acting insulin to help manage blood sugar levels) 100units/ml, inject 20 units SQ every day.

Review of Resident #5's signed physician order sheet dated 02/11/26 revealed:
-There was an order for FSBS before meals and at bedtime, call MD if FSBS is < 60 or > 500.
-There was an order for Novolog Flexpen 100units/ml, sliding scale before meals, if > 200 = 2 units, > 250 = 3 units, > 300 = 4 units, >350 = 5 units.
-There was an order for Novolog Flexpen 100units/ml, inject 3 units three times daily before meals, hold if FSBS is < 120, may check FSBS after meals if refusing and administer insulin (prime pen with 2 units prior to each use).
-There was an order for Tresiba 100units/ml, inject 40 units every day, hold for FSBS < 100 (prime pen with 2 units prior to each use).

Review of an after-visit summary with Resident #5's endocrinologist dated 03/04/26 revealed there was an order for Gvoke Hypopen (a pre-mixed ready to use glucagon auto-injector used to treat severe low-blood sugar emergencies), inject as directed for hypoglycemia.

Review of Resident #5's previous quarterly Licensed Health Professional Support (LHPS) evaluation revealed:
-The date of the evaluation was 02/18/26.
-Vital signs per chart were documented as blood pressure-142/98, pulse-80, respirations-20, and temperature 98.6 F.
-Personal tasks currently present were identified as collecting and testing of finger stick blood samples and medication administration through

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injection.
-Under "review the health status/Physical Assessment as related to diagnosis/current condition, progress to care provided and recommended changes in care, the resident ambulated independently, he had FSBS ordered with a range of 56 to 561 this quarter; he received Tresiba and NovoLog.
-The recommendations were to continue to follow the plan of care.
-The LHPS personal care tasks provided were identified as insulin and FSBS.
-The LHPS evaluation was signed by the LHPS Registered Nurse (RN) on 02/18/26.
-The LHPS review by facility staff was signed by the Resident Care Coordinator (RCC) on 03/31/26.
-There was no physical assessment documented.

Review of Resident #5's most recent quarterly LHPS evaluation revealed:
-The date of the evaluation was 05/20/26.
-Vital signs per chart were documented as blood pressure-104/66, pulse-56, respirations-14, and temperature-96.6 F.
-Personal tasks currently present were identified as collecting and testing of finger stick blood samples and medication administration through injection.
-Under "review the health status/Physical Assessment as related to diagnosis/current condition, progress to care provided and recommended changes in care, the resident self-propelled in his wheelchair, he had FSBS ordered with a range of 52 to 511 this quarter, he had orders for Tresiba, NovoLog, and Gvoke.
-The recommendations were to continue to follow the plan of care.
-The LHPS personal care tasks provided were identified as insulin and FSBS.

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-The LHPS evaluation was signed by the LHPS RN on 05/20/26.
-The LHPS review by facility staff was signed by the RCC on 05/28/26.
-There was no physical assessment documented.

Refer to interview with the LHPS nurse on 06/25/26 at 5:13pm.

Refer to interview with the RCC on 06/25/26 at 5:37pm.

Refer to interviews with the Administrator on 06/25/26 at 5:25pm and 6:33pm.

3. Review of Resident #3's current FL-2 dated 10/14/25 revealed:
-Diagnoses included hypertension, diabetes mellitus, schizophrenia, and bipolar disorder.
-There was an order for Haloperidol (an anti-psychotic medication used to treat schizophrenia and severe behavioral problems) 100mg/ml, inject 1.5ml intramuscularly (IM) monthly.

Review of Resident #3's signed physician order sheet dated 02/16/26 revealed an order for Haloperidol 100mg/ml. inject 1.5ml=150mg IM monthly.

Review of Resident #3's signed physician restraint order dated 03/12/26 revealed an order for half length bed rails when in bed.

Review of Resident #3's previous quarterly Licensed Health Professional Support (LHPS) evaluation revealed:
-The date of the evaluation was 02/18/26.
-Vital signs per chart were documented as blood pressure-130/76, pulse-89, respirations-19,

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temperature-96.8 F.
-Personal care tasks currently present were identified as medication through injection.
-Under the review the health status and care provided/physical assessment as related to diagnoses/current condition, progress to care provided and recommended changes in care, the resident ambulated independently, she received Haloperidol injections by home health nurse, her electronic medication administration record (eMAR) revealed this was being held per provider, she received hospice.
-The recommendations were to continue to follow the plan of care.
-The LHPS care task provided was documented as injection.
-The LHPS evaluation was signed by the LHPS Registered Nurse (RN) on 02/18/26.
-The LHPS review by facility staff was signed by the Resident Care Coordinator (RCC) on 03/31/26.
-There was no physical assessment documented.

Review of Resident #3's previous quarterly LHPS evaluation revealed:
-The date of the evaluation was 05/20/26.
-Vital signs per chart were documented as blood pressure-125/70, pulse-84, respirations-18, temperature-96.8 F.
-Personal care tasks currently present were identified as physical restraint and/or alternatives to restraints, and medication through injection.
-Under the review the health status and care provided/physical assessment as related to diagnoses/current condition, progress to care provided and recommended changes in care, the resident ambulated independently, she received Haloperidol injections by home health nurse, last documented injection was 05/14/26, she had half bed rails, and she received hospice.

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-The recommendations were to continue to follow the plan of care.
-The LHPS care tasks provided were documented as injection and half bed rails.
-The LHPS evaluation was signed by the LHPS RN on 05/20/26.
-The LHPS review by facility staff was signed by the RCC on 05/28/26
-There was no physical assessment documented.

Refer to interview with the LHPS nurse on 06/25/26 at 5:13pm.

Refer to interview with the RCC on 06/25/26 at 5:37pm.

Refer to interviews with the Administrator on 06/25/26 at 5:25pm and 6:33pm.

4. Review of Resident #1's current FL-2 dated 01/17/26 revealed:
-Diagnoses included vascular dementia, glaucoma, hyperlipidemia, restless leg syndrome, calculus of kidney, type 2 diabetes mellitus, schizoaffective disorder, and calculus of gallbladder.
-There was an order to check blood sugar 3 times a day, notify primary care provider (PCP) if blood sugar was less than (<) 70 or greater than (>) 400.
-There was an order for Novolog insulin inject 6 units subcutaneously (SQ) 3 times a day with meals, hold of blood sugar is < 150. (Novolog is rapid-acting insulin that lowers blood sugar.)
-There was an order for Lantus insulin inject 32 units SQ at bedtime, hold if blood sugar is < 100. (Lantus is long-acting insulin that lowers blood sugar.)

Review of Resident #1's physician orders sheet

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D 280	Continued From page 21 dated 05/05/26 revealed: -There was an order to check blood sugar 3 times a day, notify PCP if blood sugar was < 70 or > 450. -There was an order for Novolog insulin inject 10 units SQ with meals, hold if resident does not eat. -There was an order for Novolog sliding scale insulin in addition to scheduled Novolog 3 times a day with meals according to the following scale: 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401 - 450 = 12 units; and > 450 = call PCP. -There was an order for Lantus insulin inject 32 units at bedtime for blood sugar > 120, if 80 - 120 give 16 units, and if < 70 do not give Lantus insulin. Review of Resident #1's physician's order dated 06/23/26 revealed an order to discontinue scheduled Novolog insulin 10 units with meals. Review of Resident #1's April 2026 - June 2026 electronic medication administration records (eMARs) revealed: -There was documentation that the resident's blood sugar was checked 3 times daily scheduled at 8:00am, 12:00pm, and 5:00pm. -There was documentation the resident was administered Novolog and Lantus insulin. -The resident's blood sugar ranged from 51 - 541 from April 2026 - June 2026. Review of Resident #1's current assessment and care plan completed 04/21/26 revealed: -The resident was documented as ambulatory and he used a walking cane. -The resident was documented as being occasionally incontinent of bowel and bladder. -The resident was documented as sometimes disoriented, forgetful and needed reminders.	D 280		

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D 280	Continued From page 22 -The resident required supervision by staff with ambulation. -The resident required limited assistance by staff with eating, toileting, bathing, dressing, grooming, and transferring. Interview with Resident #1 on 06/25/26 at 5:57pm revealed: -He received insulin every day, but he was not sure how often. -The medication aides (MAs) checked his blood sugar, but he was not sure how often. -His blood sugar was too low sometimes and too high sometimes. -He felt "crappy" and shaky when his blood sugar was too low. -He sometimes got a headache when his blood sugar was too high. Review of Resident #1's current Licensed Health Professional Support (LHPS) review dated 04/20/26 revealed: -LHPS tasks checked off for Resident #1 included medication administration through injection and collecting and testing of fingerstick blood sugars. -The resident's vital signs "per chart" were documented as blood pressure - 119/66, pulse - 82, respirations - 18, temperature - 98.0, and weight - 125 pounds. -There was no date documented to indicate when the vital signs were obtained. -The section to document the physical assessment noted the resident had an order for blood sugar checks and the resident took Novolog and Lantus insulins. -There was no physical assessment related to any of Resident #1's LHPS tasks. -The section for recommendations noted to continue to follow plan of care. -The section to indicate if staff was competency	D 280		

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validated for the resident's LHPS tasks noted to see personnel file.
-The LHPS review was completed by the facility's contracted LHPS nurse and also signed by the Resident Care Coordinator (RCC).

Refer to interview with the LHPS nurse on 06/25/26 at 5:13pm.

Refer to interview with the Resident Care Coordinator (RCC) on 06/25/26 at 5:37pm.

Refer to interviews with the Administrator on 06/25/26 at 5:25pm and 6:33pm.

5. Review of Resident #4's current FL-2 dated 09/04/25 revealed:
-Diagnoses included dementia with behaviors, transaminitis, encephalopathy, and anxiety.
-The resident was documented as constantly disoriented and non-ambulatory.
-The resident was documented as incontinent of bowel and bladder.
-The resident required assistance with bathing and dressing.

Review of Resident #4's current assessment and care plan completed 09/08/25 revealed:
-The resident was documented as non-ambulatory.
-The resident had limited range of motion in her upper extremities.
-The resident had daily incontinence of bowel and bladder.
-The resident was always disoriented, had significant memory loss, and must be directed.
-The resident was totally dependent on staff assistance with eating, toileting, ambulation, bathing, dressing, grooming, and transferring.

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D 280	Continued From page 24 Review of Resident #4's physician's order dated 01/30/26 revealed an order for Oxygen 2 liters per minute (LPM) as needed for shortness of breath. (Supplemental oxygen is used to help with breathing difficulties.) Review of Resident #4's physician's order dated 03/18/26 revealed an order for Dulcolax 10mg suppositories, insert 1 suppository rectally as needed if no bowel movement in 3 days. (Dulcolax is used for constipation.) Review of Resident #4's physician's order dated 02/11/26 revealed: -There was an order for Duoneb 1 vial via nebulizer every 6 hours as needed for shortness of breath. -There was an order for Bunny Boots apply to bilateral heels to prevent skin breakdown. (Bunny Boots are specialized orthopedic boots designed to protect the heel, reduce pressure, and prevent foot drop by maintaining the foot in a neutral position.) Review of Resident #4's April 2026 - June 2026 electronic medication administration records (eMARs) revealed: -There was an entry for Dulcolax 10mg suppositories insert 1 suppository rectally as needed if no bowel movement in 3 days. -One Dulcolax suppository was documented as administered on 06/15/26 at 2:48pm and was noted to be effective. -There was an entry for Duoneb give 1 vial via nebulizer every 6 hours as needed for wheezing/congestion. -There was an entry for Oxygen at 2 LPM as needed for shortness of breath. -There was an entry for Bunny Boots staff is to apply Bunny Boots to prevent skin breakdown to bilateral heels.	D 280		

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LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(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 25 Review of Resident #4's hospice provider note dated 05/27/26 revealed the resident had no further skin breakdown. Review of Resident #4's current Licensed Health Professional Support (LHPS) review dated 04/20/26 revealed: -LHPS tasks checked off for Resident #4 included care for pressure ulcers. -There were no other tasks listed. -Ambulation using assistive devices, transferring non-ambulatory residents, inhalation medication by machine, oxygen administration and monitoring, and suppositories were not documented as tasks for Resident #4. -The resident's vital signs "per chart" were documented as blood pressure - 115/60, pulse - 78, respirations - 18, temperature - 97.4. -There was no date documented to indicate when the vital signs were obtained. -The section to document the physical assessment noted the resident resided in the special care unit, had an order for Bunny Boots, and staff reported unable to obtain weight due to being bed bound. -There was no physical assessment related to any of Resident #4's LHPS tasks. -The section for recommendations noted to continue to follow plan of care. -The section to indicate if staff was competency validated for the resident's LHPS tasks noted to see personnel file. -The LHPS review was completed by the facility's contracted LHPS nurse and also signed by the Resident Care Coordinator (RCC). Based on observations, interviews, and record reviews, it was determined that Resident #4 was not interviewable.	D 280		

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D 280	Continued From page 26 Refer to interview with the LHPS nurse on 06/25/26 at 5:13pm. Refer to interview with the RCC on 06/25/26 at 5:37pm. Refer to interviews with the Administrator on 06/25/26 at 5:25pm and 6:33pm. _____ Telephone interview with the facility's contracted Licensed Health Professional Support (LHPS) nurse on 06/25/26 at 5:13pm revealed: -When completing the LHPS evaluations, she reviewed the residents' records to obtain the FL-2 date, injection dates and home health dates. -She reviewed the facility's vital signs book to obtain vital signs for the LHPS form. -She did not check the residents' vital signs. -She completed a physical assessment on the residents she needed to see. -For diabetic residents, she tried to look at their feet most of the time. -She asked the residents if they had opened wounds or if their toenails needed trimming if a resident did not want to take their shoes and socks off. -She did not assess injections sites. -She did not document physical assessments unless there was something that needed to be mentioned. -The facility staff had not asked her to do anything different for the LHPS. -She was trained by another nurse not to document too much information on the LHPS form. Interview with the Resident Care Coordinator (RCC) on 06/25/26 at 5:37pm revealed: -She was responsible for reviewing the residents'	D 280		

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D 280	Continued From page 27 LHPS evaluations. -If there was something missing from the LHPS, she made a note for it to be addressed on the next quarterly review. -She knew the LHPS nurse completed a physical assessment on the residents. -She was not aware the physical assessment should be documented on the LHPS. -She was not aware the physical assessment was not documented on the residents' LHPS evaluations. Interviews with the Administrator on 06/25/26 at 5:25pm and 6:33pm revealed: -The RCC was responsible for checking the LHPS evaluations to ensure they were completed to include documentation of a physical assessment. -He was aware the LHPS Nurse was supposed to do a physical assessment of the residents. -The LHPS identified resident tasks and was completed by the nurse.	D 280		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult 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	D 344		

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D 344	Continued From page 28 record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medication orders were clarified for 1 of 5 sampled residents (#1) related to failing to clarify and unclear order for long-acting insulin. The findings are: Review of Resident #1's current FL-2 dated 01/17/26 revealed: -Diagnoses included vascular dementia, glaucoma, hyperlipidemia, restless leg syndrome, calculus of kidney, type 2 diabetes mellitus, schizoaffective disorder, and calculus of gallbladder. -There was an order for Lantus insulin inject 32 units at bedtime, hold if blood sugar is less than (<)100. (Lantus is long-acting insulin that lowers blood sugar.) Review of Resident #1's physician orders sheet dated 05/05/26 revealed: -There was an order for Lantus insulin inject 32 units at bedtime for blood sugar greater than (>) 120, if 80 - 120 give 16 units, and if < 70 do not give Lantus insulin. -The order did not specify how much Lantus to administer when the resident's blood sugar was 70 - 79. Review of Resident #1's physician's orders and progress notes revealed no documentation the primary care provider (PCP) was contacted to clarify the Lantus order.	D 344	SCUC/designee will compare physician's orders once per week x 4 weeks, then once per month ongoing to medication administration record to ensure residents receive medications as ordered. For physicians orders that need clarification the physician will be contacted by the Med Aide. Facility will document clarification of orders in resident chart SCUC/Administrator will audit resident charts at least quarterly to ensure admission/readmission forms have orders clarified as needed.	8/9/2026

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D 344	Continued From page 29	D 344		

Review of Resident #1's May 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for Lantus insulin inject 32 units at bedtime for blood sugar > 120, if 80 - 120 give 16 units at bedtime instead, if < 70 do not give nighttime dose.
-Lantus insulin was scheduled at 8:00pm.
-The resident's blood sugar was documented as 73 on 05/24/26 and 16 units of Lantus were documented as administered but the order did not specify how much insulin to administer for a blood sugar of 73.

Review of Resident #1's June 2026 eMAR revealed:
-There was an entry for Lantus insulin inject 32 units at bedtime for blood sugar > 120, if 80 - 120 give 16 units at bedtime instead, if < 70 do not give nighttime dose.
-Lantus insulin was scheduled at 8:00pm.
-The resident's blood sugar was documented as 70 on 06/14/26 and no Lantus was documented as administered but the order did not specify if the Lantus should have been held or administered for a blood sugar of 70.

Observation of Resident #1's medications on hand on 06/25/26 at 9:48am revealed:
-There was a Lantus insulin pen with a date opened of 06/20/26.
-The part of the label with the instructions had been torn off.

Interview with a medication aide (MA) on 06/25/26 at 12:20pm revealed:
-She had not noticed there were no clear instructions on how to administer Resident #1's Lantus if the blood sugar was between 70 - 79.
-Either the MAs or the Resident Care Coordinator

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D 344	Continued From page 30 (RCC) could clarify medication orders. -They could contact the provider and the pharmacy to help with getting clarification. Interview with the RCC on 06/25/26 at 12:45pm revealed: -The MAs should administer or hold the Lantus according to the order. -She had not noticed there were no clear instructions for administering Lantus if the resident's blood sugar was 70 - 79. -She or the MAs were responsible for clarifying medication orders. Interview with the Administrator on 06/25/26 at 6:34pm revealed: -The RCC was responsible for clarifying medication orders. -The MAs should notify the RCC immediately of any discrepancies with medication orders. -Resident #1's order for Lantus should have been clarified. Attempted telephone interview with Resident #1's PCP on 06/25/26 at 3:41pm was unsuccessful.	D 344		
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.	D 358		

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D 358	Continued From page 31 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 2 of 3 residents (#6, #7) observed during the medication pass including errors with injectable medications used to treat elevated blood sugar (#7) and an oral medication used to treat elevated blood sugar (#6); and for 3 of 5 residents (#1, #2, #5) sampled for record review including errors with medications to treat elevated blood sugar (#1, #5), and a medication used to treat mild to moderate pain (#2). The findings are: Review of the facility's undated medication administration policy revealed medications, prescription and non-prescription, and treatments will be administered in accordance with the prescribing practitioner's orders. 1. The medication error rate was 11% as evidenced by 3 errors out of 26 opportunities during the 8:00am medication pass on 06/25/26. a. Review of Resident #7's current FL-2 dated 04/28/26 revealed: -Diagnoses included type 2 diabetes mellitus, vascular dementia, hyperlipidemia, and hypothyroidism. -There was an order for Humalog (a rapid acting insulin used to treat elevated blood sugar), 7 units within 15 minutes after meals, hold if patient eats less than 50% of meal or for fingerstick blood sugar (FSBS) less than 70. -Her level of care was Special Care Unit (SCU). Review of Resident #7's signed physician order sheet dated 04/28/26 revealed an order for	D 358	Administrator/Designee will retrain SCUC/medication aides on medication administration policies to include following physician orders as written, reviewing new orders on MAR and medications errors. For any med error identified, the PCP will be notified and med error report completed. SCUC/Designee reviewed last 30 days of Discharge Summaries to assure MARs match physician's orders. Administrator/SCUC will observe a minimum of 4 medication passes monthly x3 and then randomly thereafter to ensure medication is administered as ordered.	8/9/2026

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D 358	Continued From page 32 Humalog KwikPen 100units/ml, inject 7 units subcutaneous (SQ) within 15 minutes after meals (prime pen with 2 units prior to each use-pen expires 28 days after opening), hold dose if patient eats less than 50% of meal or for FSBS less than 70. Review of the manufacturer's package insert for use of the Humalog Kwikpen revealed: -Preparing Humalog Kwikpen, check the Humalog label to make sure it is the right type of insulin. -Always use a new needle for each injection to to help ensure sterility and prevent blocked needles. -Step one, pull the pen cap straight off, wipe the rubber seal with an alcohol swab, do not twist the cap, do not remove the Kwikpen label (Humalog should look clear and colorless, do not use if it is thick, cloudy, colored, or has particles or clumps in it). -Step two, pull off the paper tab from the outer needle shield. -Step three, push the capped needle straight onto the pen and turn the needle forward until it is tight. -Step four, pull off the outer needle shield and throw it away. -Priming the Humalog Kwikpen; prime before each injection, priming ensures the pen is ready to dose and removes air that may collect in the cartridge during normal use, if you do not prime before each injection, you may get too much or too little insulin. -Step five, turn the dose knob to select 2 units. -Step six, hold your pen with the needle pointing up, tap the cartridge holder gently to collect air bubbles at the top. -Step seven, hold your pen with needle pointing up, push the dose knob in until it stops, and 0 is seen in the dose window, hold the dose knob in	D 358		

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and count to 5 slowly, a stream of insulin should be seen from the needle, if you do not see a stream of insulin, repeat steps five to seven no more than 4 times, if you still do not see a stream of insulin, change the needle and repeat steps five to seven.
-Step eight, turn the dose knob to select the number of units you need to inject, the dose indicator should line up with your dose.

Observation of the 8:00am medication pass on 06/25/26 revealed:
-Resident #7's blood sugar was 139 at 7:33am.
-The medication aide (MA) administered 7 units of Humalog Kwikpen insulin into Resident #7's left upper arm at 7:34am.
-The MA did not prime the Humalog KwikPen with 2-units prior to use to remove any air bubbles and to make sure the insulin was flowing through the needle.

Review of Resident #7's June 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for Humalog Kwikpen 100units/ml, inject 7 units SQ within 15 minutes after meals (prime pen with 2 units prior to each use-pen expires 28 days after opening), hold dose if patient eats less than 50% of meal or for fingerstick blood sugar less than 70, scheduled at 7:00am, 12:00pm, and 5:00pm.
-Humalog Kwikpen 7 units was documented as administered at 7:00am on 06/01/26 through 06/25/26 and FSBS ranged from 139 to 397.
-Humalog Kwikpen 7 units was documented as administered at 12:00pm on 06/01/26 through 06/24/26 and FSBS ranged from 148 to 369.
-Humalog Kwikpen 7 units was documented as administered at 5:00pm on 06/01/26 through 06/24/26 and FSBS ranged from 137 to 287.

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D 358	Continued From page 34 Refer to interview with the MA on 06/25/26 at 8:58am. Refer to interview with the Resident Care Coordinator (RCC) on 06/25/26 at 9:09am. Refer to interview with the Administrator on 06/25/26 at 9:29am. Refer to telephone interview with Resident #7's primary care provider (PCP) on 06/25/26 at 4:29pm. b. Review of Resident #7's current FL-2 dated 04/28/26 revealed: -Diagnoses included type 2 diabetes mellitus, vascular dementia, hyperlipidemia, and hypothyroidism. -There was an order for Lantus (a long-acting insulin used to treat elevated blood glucose) 100units/ml, inject 26 units subcutaneously (SQ) every day, hold for fingerstick blood sugar (FSBS) less than 70. -Her level of care was Special Care Unit (SCU). Review of Resident #7's signed physician order sheet dated 04/28/26 revealed an order for Lantus Solostar 100units/ml, inject 26 units SQ every morning (prime pen with 2 units prior to each use-use within 28 days once opened), hold for glucose less than 70. Review of the manufacturer's package insert for use of the Lantus Solostar pen revealed: -Step one, remove the pen cap with clean hands, and check the insulin reservoir to make sure the insulin is clear and colorless and has no particles-if not, use another pen. -Step two, wipe the pen tip (rubber seal) with an	D 358		

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D 358	Continued From page 35 alcohol swab, remove the protective seal from the new needle, line the needle up straight with the pen and screw the needle on, do not make the needle too tight, if you have a push on needle, keep it straight and push it on, after you have attached the needle, take off the outer needle cap and save it (you will need to remove the needle after your injection), remove the inner needle cap and throw it away. -Step three, perform a safety test, dial a test dose of 2 units, hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle, this will help you get the most accurate dose, press the injection button all the way in and check to see that insulin comes out of the needle, the dial will automatically go back to zero after you perform the test, if no insulin comes out, repeat the test 2 more times, if there is still no insulin coming out, use a new needle and do the safety test again. -Always perform the safety test before each injection. -Never use the pen if no insulin comes out after using a second needle. -Step four, make sure the window shows "0" and then select then dose, otherwise you will inject more insulin than you need and that can affect your blood sugar, dial back up or down if you have dialed the wrong amount, check if you have enough insulin in the reservoir, if you cannot dial the dose you want, it may be because you don't have enough insulin left, you cannot dial more than 80 units because the pen has a safety stop, if your dose is more than 80 units, you will need to redial the rest of your dose, if you don't have enough insulin for the rest of your dose, you will need to use a new pen. Observation of the 8:00am medication pass on 06/25/26 revealed:	D 358		

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-Resident #7's blood sugar was 139 at 7:33am.
-The medication aide (MA) administered 26 units of Lantus insulin into Resident #7's right upper arm at 7:34am.
-The MA did not prime the Lantus Solostar pen with 2-units prior to use to remove any air bubbles and to make sure the insulin was flowing freely through the needle.

Review of Resident #7's June 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for Lantus Solostar 100units/ml, inject 26 units every morning (prime pen with 2 units before each use-use within 28 days once opened), hold for FSBS less than 70 scheduled at 8:00am.
-Lantus Solostar 100units/ml 26 units was documented as administered at 8:00am on 06/01/26 through 06/25/26 and FSBS ranged from 139 to 397.

Refer to interview with the MA on 06/25/26 at 8:58am.

Refer to interview with the Resident Care Coordinator (RCC) on 06/25/26 at 9:09am.

Refer to interview with the Administrator on 06/25/26 at 9:29am.

Refer to telephone interview with Resident #7's primary care provider (PCP) on 06/25/26 at 4:29pm.

_____

Interview with the medication aide (MA) on 06/25/26 at 8:58am revealed:
-She knew insulin pens were to be primed before use.
-Priming an insulin pen consisted of placing the

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needle on the insulin pen and dialing 2 units of insulin and pressing the injector and then dialing the pen to the prescribed number of insulin units to be administered.
-She always primed insulin pens before use.
-She insisted that she primed both Resident #7's Lantus and Humalog pens before administering the medications on the morning medication pass and that she did it quickly and that was why it was not witnessed.
-She knew the purpose of priming an insulin pen was to remove any air bubbles from the insulin pen.

Interview with Resident Care Coordinator (RCC) on 06/25/26 at 9:09am revealed:
-All MAs were trained to prime insulin pens prior to each use.
-She was certain the MA primed the insulin pens prior to administering Resident #7's Lantus and Humalog during the am medication pass.
-Priming an insulin pen was important to make the full dose of insulin units were delivered with each injection.

Interview with the Administrator on 06/25/26 at 9:29am revealed:
-The MAs were trained to prime insulin pens.
-Priming an insulin pen consisted of dialing the pen to 2 units, pressing the injector then dialing the pen to the prescribed number of insulin units.
-The MA observed during the morning medication pass was very thorough and always primed the insulin pens and he felt it was possible the surveyor was distracted while the MA was preparing Resident #7's Lantus and Humalog.
-Priming an insulin pen was important to remove any air bubbles that may prevent the insulin form flowing.

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Telephone interview with Resident #7's primary care provider (PCP) on 06/25/26 at 4:29pm revealed:
-She treated Resident #7 for type 2 diabetes.
-Resident #7 received Lantus insulin, a long-acting insulin and Humalog insulin which is a short acting insulin to cover blood sugar increases with meals.
-Both type insulin pens should be primed to make sure Resident #7 received her full insulin dose.
-If Resident #7 did not receive her full dose of each insulin it could cause hyperglycemia or elevated blood sugar.
-Symptoms of hyperglycemia included confusion which could be hard to differentiate a cause since Resident #7 also had a diagnosis of dementia.

c. Review of Resident #6's current FL2 dated 10/14/25 revealed:
-Diagnoses included diabetes, hypertension, bilateral hearing loss, and hypercholesterolemia.
-There was an order for Glipizide (used to lower and control blood sugar in adults with type 2 diabetes) 5mg, take one tablet daily.

Review of Resident #6's signed physician order sheet dated 02/10/26 revealed an order for Glipizide 5mg, take one tablet every day.

Observation of the 8:00am medication pass on 06/25/26 revealed:
-The medication aide (MA) pulled a medication bubble card for Resident #6's Glipizide 5mg and there were no remaining Glipizide tablets in the medication card.
-The medication bubble card was labeled with a prescription label containing Resident #6's name for Glipizide 5mg, take one tablet every day for a quantity of 28 tablets with a start date of 05/29/26.
-The medication bubble card for Resident #6's

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Glipizide 5mg had 27 bubbles that had been punched numbered from 28 to 2, the bubble for 1 was intact but there was no Glipizide in the #1 bubble.
-The MA prepared and administered seven oral medications for Resident #6 that did not include Glipizide 5mg at 7:09am.

Review of Resident #6's June 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for Glipizide 5mg, take one tablet every day scheduled at 8:00am.
-Glipizide 5mg was documented as administered at 8:00am on 06/01/26 through 06/24/26.
-Glipizide 5mg was documented as not administered at 8:00am on 06/25/26 with the exception documented as physically unable to take, "card short one pill from the pharmacy, final dose in batch".

Telephone interview with the quality control pharmacy technician with the facility's contracted pharmacy provider on 06/25/26 at 4:15pm revealed:
-Glipizide 5mg was dispensed for Resident #6 on 05/29/26 for 28 tablets, take one tablet daily for a 28-day supply on 05/29/26.
-Resident #6's Glipizide 5mg was delivered to the facility with the facility's batch fill medications on 06/24/26 for 28 tablets to take one tablet daily for a 28-day supply to start on 06/26/26.
-A call was received from the facility earlier today at 10:15am requesting an additional Glipizide 5mg tablet for Resident #6 which was dispensed.

Interview with the MA on 06/25/26 at 7:05am revealed:
-There was a tablet missing from Resident #6's Glipizide 5mg bubble card.

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D 358	Continued From page 40 -She had not had this happen before and was not sure what to do except document that the resident was unable to take the Glipizide. -This was the final day for the current batch of Resident #6's medications including the Glipizide, so she was unable to pop another Glipizide tablet from the medication bubble card. -The new batch of medications would be placed on the medication cart tonight to start the next day. -She checked the medication overstock cabinet after a prompt from the surveyor and there was no Glipizide in the medication overstock cabinet. Second interview with the MA on 06/25/26 at 9:02am revealed: -She started working at the facility in December 2025 and worked part-time and mainly worked in the special care unit (SCU). -She documented in the eMAR system that Glipizide was not available for Resident #6. -The new batch of medications started tomorrow, and she was unsure if the new batch of medications were currently in the facility or if the medications would be delivered tonight. -She knew Resident #6 took Glipizide to control his blood sugar and that it was important to receive his medications. -This type of situation had never come up and she was not sure what the protocol was for missing the medication. -The batch medications were placed on the medication cart by the night shift MAs and felt the night shift MAs checked the medication cards as they were placed on the medication cart. -She would notify the Resident Care Coordinator (RCC) about the missing Glipizide for Resident #6. Interview with the RCC on 06/25/26 at 9:09am	D 358		

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D 358	Continued From page 41 revealed: -Sometimes the adhesive on the medication bubble cards did not seal well and medications fell out. -If medication was not available for a resident, the MAs were to check the medication overstock cabinet first. -If the medication could not be located in the medication overstock cabinet, the MA could pull from the new batch fill medications, complete a form for the pharmacy and the pharmacy would send an additional tablet to replace the tablet removed from the next batch cycle. -If the next batch fill medications were not in the facility to pull from, the MAs could contact the pharmacy for additional medications. -The facility's contracted pharmacy provider was next door and the medication could be delivered same day, or facility staff could walk over and pick it up. -The MAs were to check the medication cards when received to make sure all the medications were in the package. Interview with the Administrator on 06/25/26 at 9:29am revealed: -If medication was not available for a resident, the MA should check the medication overstock cabinet first. -If medication was not available in the overstock cabinet, the MA should notify the RCC to see if additional medication could be somewhere else on the medication cart or in the next batch fill medications if available. -If medication still could not be located, the MA should contact the pharmacy for the needed dose, as the pharmacy was next door and the medication could be received in a timely manner. -When medications arrived, staff should be looking at the medication cards to make sure the	D 358		

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medication cards were intact and all the medications were present before placing the medication on the medication cart.
-The MA was one of his new employees and maybe was not familiar with how to obtain additional medication for a resident if needed.

Third interview with the MA on 06/25/26 at 2:25pm revealed:
-A dose of Glipizide 5mg was pulled from the new batch fill medications and administered to Resident #6 around 9:45am today.
-The pharmacy had been contacted for a replacement Glipizide 5mg for Resident #6.

Interview with Resident #6's primary care provider (PCP) on 06/25/26 at 4:29pm revealed:
-She treated Resident #6 for type 2 diabetes.
-She prescribed Glipizide for Resident #6 to control his blood sugar.
-Going without Glipizide could cause Resident #6's blood sugar to be elevated, causing hyperglycemia.
-Symptoms of hyperglycemia varied from resident to resident and she did not have any concerns about one missed dose of Glipizide.

2. Review of Resident #5's current F-FL-2 dated 07/17/25 revealed:
-Diagnoses revealed uncontrolled diabetes, diabetic ketoacidosis, acute encephalopathy, hypokalemia, hypernatremia, and acute kidney injury.
-There was an order for Novolog (a rapid-acting insulin used to treat diabetes) Flexpen, check fingerstick blood sugar (FSBS) before meals, inject subcutaneously (SQ) according to sliding scale, if greater than (>) 200 = 2 units, >250 = 3 units, >300 = 4 units, >350 = 5 units.
-There was an order for Tresiba (an

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ultra-long-acting insulin to help manage blood sugar levels) 100/ml, inject 20 units SQ every day.

a. Review of Resident #5's signed physician order sheet dated 02/11/26 revealed an order for Novolog Flexpen 100units/ml, sliding scale before meals, if greater (>) than 200 = 2 units, >250 = 3 units, >300 = 4 units, >350 = 5 units, may administer after meals if refused before.

Review of Resident #5's April 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for Novolog Flexpen 100units/ml, sliding scale before meals, if greater (>) than 200= 2 units, >250= 3 units, >300= 4 units, >350= 5 units, may administer after meals if refused before, scheduled at 7:30am, 11:30am, and 4:30pm.
-On 04/21/26 at 11:30am, Novolog Flexpen 5 units was documented as administered for a FSBS of 350, 4 units should have been administered.
-On 04/28/26 at 7:30am, Novolog Flexpen 3 units was documented as administered for a FSBS of 250, 2 units should have been administered.

Review of Resident #5's May 2026 eMAR revealed:
-There was an entry for Novolog Flexpen 100units/ml, sliding scale before meals, if greater (>) than 200= 2 units, >250= 3 units, >300= 4 units, >350= 5 units, may administer after meals if refused before, scheduled at 7:30am, 11:30am, and 4:30pm.
-On 05/03/26 at 4:30pm, Novolog Flexpen 2 units was documented as administered for a FSBS of 200, 0 units should have been administered.
-On 05/10/26 at 4:30pm, Novolog Flexpen 3 units

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was documented as administered for a FSBS of 243, 2 units should have been administered.
-On 05/16/26 at 4:30pm, Novolog Flexpen 5 units was documented as administered for a FSBS of 350, 4 units should have been administered.

Interview with a medication aide (MA) on 06/25/26 at 11:32am revealed:
-The MAs could see the full medication orders on the eMAR.
-Sliding scale insulin was administered according to a resident's blood sugar reading.
-She may have administered the incorrect amount of sliding scale insulin to Resident #5 because she thought the greater than (>) sign meant equal and above.

Interview with the Resident Care Coordinator (RCC) on 06/25/26 at 4:55pm revealed:
-She expected all sliding scale insulin to be administered as ordered per their FSBS.
-If a MA had any questions or did not understand an order, she expected them to notify her.
-She felt the MAs needed to be re-educated on the administration of sliding scale insulin.
-It was important for the residents to receive their medications as ordered.

Interview with the Administrator on 06/25/26 at 6:51pm revealed:
-He thought the sliding scale insulin entries for Resident #5 were typo errors.
-He expected the MAs to review sliding scale insulin orders thoroughly by reading the orders and re-reading the orders after the insulin was drawn up.
-It was important for the residents to receive the accurate amount of insulin to regulate their blood sugar.
-EMAR audits were performed monthly by the

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D 358	Continued From page 45 RCC and himself to make sure medications were administered as ordered. Attempted telephone interview with Resident #5's primary care provider (PCP) on 06/25/26 at 3:41pm was unsuccessful. b. Review of Resident #5's signed physician order sheet dated 02/11/26 revealed an order for Tresiba 100units/ml, inject 40 units SQ every day, hold for fingerstick blood sugar (FSBS) less than (<) 100. Review of Resident #5's April 2026 electronic medication administration record (eMAR) revealed; -There was an entry for Tresiba 100units/ml, inject 40 units SQ every day, hold for FSBS < 100, scheduled at 8:00am. -Tresiba 100units/ml was documented as not administered at 8:00am on 04/29/26, with the FSBS documented as 101 and the exception was documented as "withheld per DR orders". Review of Resident #5's May 2026 eMAR revealed; -There was an entry for Tresiba 100units/ml, inject 40 units SQ every day, hold for FSBS < 100, scheduled at 8:00am. -Tresiba 100units/ml was documented as not administered at 8:00am on 05/24/26, with the FSBS documented as 110 and the exception was documented as "withheld per DR orders". Interview with a medication aide (MA) on 06/225/26 at 11:32am revealed: -The MAs could see the full medication orders on the eMAR. -Resident #5's Tresiba was administered according to his blood sugar reading.	D 358		

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D 358	Continued From page 46 -She was not sure why Resident #5's Tresiba was held when his blood sugar was above 100. Interview with the Resident Care Coordinator (RCC) on 06/25/26 at 4:55pm revealed: -She expected all medications with parameters to be administered as ordered. -If a MA had any questions or did not understand an order, she expected them to notify her. -She felt the MAs needed to be re-educated on the administration of Tresiba. -It was important for the residents to receive their medications as ordered. Interview with the Administrator on 06/25/26 at 6:51pm revealed: -He expected the MAs to review orders thoroughly by reading the orders and re-reading the orders. -It was important for the residents to receive their medications as ordered. -EMAR audits were performed monthly by the RCC and himself to make sure medications were administered as ordered. Attempted telephone interview with Resident #5's primary care provider (PCP) on 06/25/26 at 3:41pm was unsuccessful. 3. Review of Resident #1's current FL-2 dated 01/17/26 revealed diagnoses included vascular dementia, glaucoma, hyperlipidemia, restless leg syndrome, calculus of kidney, type 2 diabetes mellitus, schizoaffective disorder, and calculus of gallbladder. Review of Resident #1's physician orders sheet dated 05/05/26 revealed an order for Novolog sliding scale insulin in addition to scheduled Novolog 3 times a day with meals according to	D 358		

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the following scale: 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401 - 450 = 12 units; and > 450 = call primary care provider (PCP). (Novolog is rapid-acting insulin used to lower blood sugar.)

Review of Resident #1's May 2026 electronic medication administration records (eMARs) revealed:
-There was an entry for Novolog 3 times a day with meals according to the following scale: 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401 - 450 = 12 units; and > 450 = call PCP.
-The resident's blood sugar was documented as 194 on 05/09/26 at 12:00pm and no insulin was documented as administered but 2 units were ordered.
-The resident's blood sugar ranged from 54 - 541 from 05/01/26 - 05/30/26.

Review of Resident #1's June 2026 eMAR revealed:
-There was an entry for Novolog 3 times a day with meals according to the following scale: 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401 - 450 = 12 units; and > 450 = call PCP.
-The resident's blood sugar was documented as 163 on 06/03/26 at 12:00pm and no insulin was documented as administered but 2 units were ordered.
-The resident's blood sugar ranged from 51 - 444 from 06/01/26 - 06/24/26.

Interview with Resident #1 on 06/25/26 at 5:57pm revealed:
-His blood sugar was checked, but he was not sure how often.
-He received insulin, but he was not sure how

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often.
-His blood sugar was too low sometimes and too high sometimes.
-He felt "crappy" and shaky when his blood sugar was too low.
-He sometimes got a headache when his blood sugar was too high.

Interview with a medication aide (MA) on 06/25/26 at 11:40am revealed:
-She usually administered Resident #1's Novolog sliding scale at the same time she administered the scheduled Novolog insulin.
-If Resident #1's Novolog sliding scale insulin was administered, the site and the number of units administered would be documented on the eMAR.
-She was not sure why Novolog was not administered on those two occasions.

Interview with a second MA on 06/25/26 at 12:22pm revealed:
-If Resident #1's Novolog sliding scale insulin was administered, the site and the number of units administered would be documented on the eMAR.
-She was not sure why Novolog was not administered on those two occasions.

Interview with the Resident Care Coordinator (RCC) on 06/25/26 at 12:45pm revealed:
-The MAs should follow the sliding scale order and administer the correct number of units for Resident #1's Novolog sliding scale insulin.
-She was not aware of any errors with Resident #1's Novolog sliding scale insulin.
-She tried to check the eMARs monthly, but she had been busy and had not checked the eMARs since May 2026.

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D 358	Continued From page 49 Interview with the Administrator on 06/25/26 at 6:34pm revealed: -The MAs should follow the sliding scale insulin order as written. -The MAs should document the number of units when they administered Resident #1's Novolog sliding scale insulin. -It was important to administer the correct amount of insulin to make sure the resident's blood sugar was regulated. -He and/or the RCC completed monthly audits of eMARs, including sliding scale insulin documentation. -He was not aware Resident #1's sliding scale was not administered as ordered. Attempted telephone interview with Resident #1's PCP on 06/25/26 at 3:41pm was unsuccessful. 4. Review of Resident #2's current FL-2 dated 10/04/25 revealed diagnoses included hypotension, shortness of breath, stage 3 chronic kidney disease, hyperlipidemia and acidosis. Review of Resident #2's signed physician order dated 05/27/26 revealed there was an order for Acetaminophen 500mg, take 2 tablets to equal 1000mg twice a day. (Acetaminophen is used to treat mild to moderate pain.) Review of Resident #2's June 2026 electronic medication administration record (eMAR) revealed: -There was an entry for, Acetaminophen 500mg, take 2 tablets to equal 1000mg twice daily, scheduled at 8:00am and 8:00pm. -On 06/12/26, Acetaminophen was documented as not administered at 8:00am and 8:00pm with an exception documented stating "physically unable to take".	D 358		

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D 358	Continued From page 50 -On 06/13/26, Acetaminophen was documented as not administered at 8:00am with an exception documented stating "physically unable to take" and a note stating, "not on cart on order". -On 06/13/26, Acetaminophen was documented as not administered at 8:00pm with an exception documented at stating "physically unable to take". -On 06/14/26, Acetaminophen was documented as not administered at 8:00am and 8:00pm with an exception documented stating "physically unable to take". -On 06/15/26, Acetaminophen was documented as not administered at 8:00am with an exception documented stating "out of facility". On 06/15/26, Acetaminophen was documented as not administered at 8:00pm with an exception documented stating "physically unable to take". Interview with Resident #2 on 06/24/26 at 4:02pm revealed: -He took Acetaminophen twice a day for aches and pains. -He had not missed any doses of Acetaminophen other than 06/15/26 because he was out of the facility for an appointment. -He felt pain all the time, whether he took Acetaminophen or not. Interview with a medication aide (MA) on 06/25/26 at 9:40am revealed: -She administered medication to Resident #2 on 06/13/26, 06/14/26 and 06/15/26 at 8:00am. -She documented that Resident #2 was physically unable to take the Acetaminophen because the medication was not on the cart. -She called the facility's contracted pharmacy on 06/13/26 regarding Resident #2's Acetaminophen but did not recall what she was told. -When a medication was not on the cart, the MA was supposed to call the facility's contracted	D 358		

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pharmacy to get the medication sent to the facility.
-Cart audits were done by MAs weekly with rotating MAs conducting the audits and different resident audits done weekly.
-Cart audits were done to check for medication availability, and the date medications were opened.
-She was unsure when Resident #2's last cart audit was done.
-Resident #2 did not complain of increased pain during the time the Acetaminophen was not administered.
-She was unsure why Resident #2's Acetaminophen was not on the cart.
-Acetaminophen was a batch medication that arrived in the weekly cycle of refilled medication.

Second interview with a MA on 06/25/26 at 4:36pm revealed:
-She was not aware that 60 tablets of Resident #2's Acetaminophen were sent back to the facility's contracted pharmacy on 06/01/26.
-She did not send Resident #2's Acetaminophen back to the facility's contracted pharmacy.
-The night shift staff usually handled returning medications to the pharmacy.

Interview with a second MA on 06/25/26 at 10:18am revealed:
-She administered medication to Resident #2 on 06/12/26 at 8:00am.
-She documented that Resident #2 was physically unable to take the Acetaminophen because the medication was not in the building.
-Resident #2's Acetaminophen was not on the cart when she came in on the morning of 06/12/26.
-She did not remember if she called the facility's contracted pharmacy to request Resident #2's

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Acetaminophen be filled.
-She was supposed to call the facility's contracted pharmacy to request that Resident #2's Acetaminophen be sent to the facility.
-She informed night shift staff that Resident #2's Acetaminophen was not in the cart but would probably arrive that night.
-She did not know if Resident #2 complained of increased pain after missing 4 days of the Acetaminophen.
-Acetaminophen was a medication that arrived in the weekly cycle of refilled medications.
-MAs conducted cart audits weekly; a different MA conducted an audit of different residents' medications weekly.
-She did not know why Resident #2's Acetaminophen was not in the facility from 06/12/26 to 06/15/26.

Second interview with the second MA on 06/25/26 at 4:47pm revealed:
-She was not aware 60 tablets of Resident #2's Acetaminophen was sent back to the facility's contracted pharmacy on 06/01/26.
-She did not know why Resident #2's Acetaminophen was sent back to the facility's contracted pharmacy.
-MAs could send medication back to the facility's contracted pharmacy without approval.
-Most times, night shift staff completed the pharmacy sheets and sent medication back to the facility's contracted pharmacy.

Interview with the Resident Care Coordinator (RCC) on 06/25/26 at 4:55pm revealed:
-She was not aware Resident #2 was not administered Acetaminophen, and it was not in the facility on 06/12/26, 06/13/26, 06/14/26 and 06/15/26.
-She did not know why Resident #2's

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Acetaminophen was not in the facility from 06/12/26 to 06/15/26.
-She thought Resident #2 paid for the Acetaminophen out of pocket and that may have been the issue with the medication not being in the building 06/12/26 to 06/15/26.
-When a medication was not on the cart, the MA was supposed to notify the facility's contracted pharmacy.
-MAs conducted cart audits weekly, 3 residents weekly based on a list that she prepared.
-She prepared the list of residents for cart audits based on residents that had medication changes or hospital visits.
-Resident #2's last card audit was 06/10/26 and there was no documentation of low supply of Acetaminophen.
-Cart audits focused on checking expiration dates on house stock medications and checking physicians orders and comparing them to the cart to make sure that the medications were in the facility.
-MAs signed after completing the cart audits stating that all medications were in the facility for the residents that the audits were conducted on.
-Medications were to be ordered when they ran low, when there was a 5-day supply left.
-There was no documentation Resident #2's supply of Acetaminophen was low.
-Resident #2 could have experienced increased pain by missing 4 days of the Acetaminophen.
-She received no reports of Resident #2 complaining of increased pain.

Second interview with the RCC on 06/25/26 at 5:37pm revealed:
-She was not aware that 60 tablets of Resident #2's Acetaminophen were sent back to the facility's contracted pharmacy on 06/01/26.
-She did not know why Resident #2's

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Acetaminophen was sent back to the facility's contracted pharmacy.
-She was not notified that 60 tablets of Resident #2's Acetaminophen would be sent back to the facility's contracted pharmacy.
-MAs send medications back to the facility's contracted pharmacy and can do so without approval.
-Third shift staff usually sent medications back to the facility's contracted pharmacy.

Interview with the Administrator on 06/25/26 at 10:40am revealed:
-He was not aware Resident #2 was not administered Acetaminophen, and it was not in the facility from 06/12/26, 06/13/26, 06/14/26 and 06/15/26.
-He did not know why Resident #2's Acetaminophen was not in the facility from 06/12/26, 06/13/26, 06/14/26 and 06/15/26.
-When the medication was not available the MA was supposed to notify the RCC.
-The RCC would have the MA double check the overflow medications for the missing medication.
-If the medication was not in the overflow medications the MA was supposed to call the facility's contracted pharmacy to have the medication sent to the facility.
-The facility had Acetaminophen as a house stock medication so the MA should have contacted the primary care provider (PCP) for approval to administer Acetaminophen to Resident #2 out of the house stock medication.
-The MAs were aware they could have contacted the PCP for approval to administer house stock Acetaminophen to Resident #2.
-Resident #2 could have experienced increased pain due to missing 4 days of Acetaminophen.

Second interview with the Administrator on

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D 358	Continued From page 55 06/25/26 at 4:43pm revealed: -He did not know that 60 tablets of Resident #2's Acetaminophen were sent back to the facility's contract pharmacy on 06/01/26. -Any medications that needed to be returned to the facility's contracted pharmacy had to go through the RCC. Interview with a pharmacy technician at the facility's contracted pharmacy on 06/25/26 at 4:08pm and 4:54pm revealed: -Resident #2 had an order for Acetaminophen 500mg, take two tablets to equal 1000mg twice daily. -On 05/27/26, 120 tablets of Acetaminophen 500mg were dispensed and delivered to the facility on 05/28/26 at 3:10am. -On 06/01/26, 60 tablets of Acetaminophen 500mg were returned to the pharmacy with a return slip stating the medication was overstock. -If the Acetaminophen was administered to Resident #2 starting 5/28/26, twice a day at 4 tablets a day, the facility would have run out of the Acetaminophen on 6/12/26 due to the return of the 60 tablets. -She was unsure why Resident #2's Acetaminophen was returned to the pharmacy other than the explanation that was given on the return slip of "overstock". Interview with a pharmacist with the facility's contracted pharmacy on 06/25/26 at 4:38pm revealed: -Acetaminophen was usually prescribed for pain. -She was unsure why 60 tablets of Resident #2 Acetaminophen were sent back to the pharmacy on 06/01/26. -Resident #1 could have experienced increased pain due to not receiving the medication for 4 days.	D 358		

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D 358	Continued From page 56 Attempted telephone interview with Resident #2's primary care provider (PCP) on 06/25/26 at 10:50am and 12:18pm was unsuccessful.	D 358		
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 1 of 5 sampled residents (#1) for a controlled	D 367	SCUC audited all MARs to ensure they are accurate per physicians orders. SCUC will audit all MARs monthly to ensure they are accurate per physicians orders. Administrator/Compliance Director will audit MARs randomly thereafter to ensure they are accurate as per physicians orders.	8/9/2026

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substance used to treat moderate to severe pain and a controlled substance used for anxiety and agitation.

The findings are:

Review of Resident #1's current FL-2 dated 01/17/26 revealed diagnoses included vascular dementia, glaucoma, hyperlipidemia, restless leg syndrome, calculus of kidney, type 2 diabetes mellitus, schizoaffective disorder, and calculus of gallbladder.

a. Review of Resident #1's current FL-2 dated 01/17/26 revealed an order for Oxycodone/Acetaminophen (APAP) 7.5/325mg 1 tablet every 4 hours as needed (prn) for pain. (Oxycodone/APAP is a controlled substance used for moderate to severe pain.)

Review of Resident #1's April 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for Oxycodone/APAP 7.5/325mg 1 tablet every 4 hours prn for pain control.
-Oxycodone/APAP was documented as administered on 21 occasions from 04/01/26 - 04/30/26.

Review of Resident #1's April 2026 controlled substance record (CSR) for Oxycodone/APAP 7.5/325mg revealed:
-There were 51 doses of Oxycodone/APAP 7.5/325mg documented as administered in April 2026.
-Oxycodone/APAP prn was documented as administered on 30 occasions when it was not documented as administered on the eMARs including doses administered on 04/01/26 (2

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doses), 04/02/26, 04/06/26 (3 doses), 04/07/26, 04/09/26 (2 doses), 04/11/26, 04/13/26, 04/14/26, 04/16/26, 04/17/26 (2 doses), 04/20/26 (3 doses), 04/22/26 (3 doses), 04/24/26, 04/25/26 (2 doses), 04/26/26, 04/27/26, 04/28/26 (2 doses), 04/29/26, and 04/30/26.

Review of Resident #1's April 2026 eMAR and April 2026 CSR for Oxycodone/APAP revealed:
-Oxycodone/APAP prn was documented as administered 51 times on the CSR but only 21 times on the eMAR.
-The time of administration and the effectiveness of the prn medication was not documented on the eMAR on 30 occasions.
-Documentation on the April 2026 eMAR was not accurate and did not include documentation of 30 doses of prn Oxycodone/APAP that was administered and deducted from the April 2026 CSR.

Review of Resident #1's May 2026 eMAR revealed:
-There was an entry for Oxycodone/APAP 7.5/325mg 1 tablet every 4 hours prn for pain control.
-Oxycodone/APAP was documented as administered on 19 occasions from 05/01/26 - 05/31/26.

Review of Resident #1's May 2026 CSR for Oxycodone/APAP 7.5/325mg revealed:
-There were 43 doses of Oxycodone/APAP 7.5/325mg documented as administered in May 2026.
-Oxycodone/APAP prn was documented as administered on 24 occasions when it was not documented as administered on the eMARs including doses administered on 05/01/26, 05/04/26, 05/05/26 (3 doses), 05/06/26 (2 doses),

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05/10/26 (2 doses), 05/14/26 (2 doses), 05/15/26, 05/16/26 (2 doses), 05/18/26, 05/19/26, 05/20/26, 05/21/26, 05/23/26, 05/24/26 (2 doses), 05/26/26, 05/27/26, and 05/28/26.

Review of Resident #1's May 2026 eMAR and May 2026 CSR for Oxycodone/APAP revealed:
-Oxycodone/APAP prn was documented as administered 43 times on the CSR but only 19 times on the eMAR.
-The time of administration and the effectiveness of the prn medication was not documented on the eMAR on 24 occasions.
-Documentation on the May 2026 eMAR was not accurate and did not include documentation of 24 doses of prn Oxycodone/APAP that was administered and deducted from the May 2026 CSR.

Review of Resident #1's June 2026 eMAR dated 06/01/26 - 06/23/26 revealed:
-There was an entry for Oxycodone/APAP 7.5/325mg 1 tablet every 4 hours prn for pain control.
-Oxycodone/APAP was documented as administered on 7 occasions from 06/01/26 - 06/23/26.

Review of Resident #1's June 2026 CSR for Oxycodone/APAP 7.5/325mg revealed:
-There were 39 doses of Oxycodone/APAP 7.5/325mg documented as administered in June 2026.
-Oxycodone/APAP prn was documented as administered on 32 occasions when it was not documented as administered on the eMARs including doses administered on 06/01/26 (3 doses), 06/02/26 (2 doses), 06/03/26 (3 doses), 06/04/26, 06/05/26, 06/07/26, 06/09/26, 06/10/26 (2 doses), 06/11/26 (3 doses), 06/12/26, 06/15/26

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(3 doses), 06/16/26 (3 doses), 06/17/26, 06/18/26, 06/19/26 (3 doses), and 06/21/26 (3 doses).

Review of Resident #1's June 2026 eMAR and June 2026 CSR for Oxycodone/APAP revealed:
-Oxycodone/APAP prn was documented as administered 39 times on the CSR but only 7 times on the eMAR.
-The time of administration and the effectiveness of the prn medication was not documented on the eMAR on 32 occasions.
-Documentation on the June 2026 eMAR was not accurate and did not include documentation of 32 doses of prn Oxycodone/APAP that was administered and deducted from the June 2026 CSR.

Observation of Resident #1's medications on hand on 06/25/26 at 9:40am revealed:
-There was a supply of Oxycodone/APAP 7/5/325mg dispensed on 06/09/26 with instructions to take 1 tablet every 4 hours prn pain control.
-There were 25 of 30 tablets remaining.

Refer to interview with a medication aide (MA) on 06/25/26 at 11:40am.

Refer to interview with a second MA on 06/25/26 at 12:22pm.

Refer to interview with the Resident Care Coordinator (RCC) on 06/25/26 at 12:45pm.

Refer to interview with the Administrator on 06/25/26 at 6:34pm.

b. Review of Resident #1's current FL-2 dated 01/17/26 revealed an order for Lorazepam 0.5mg

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D 367	Continued From page 61 ½ tablet every 12 hours as needed for anxiety and agitation. (Lorazepam is a controlled substance used for agitation and anxiety.) Review of Resident #1's April 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Lorazepam 0.5mg take ½ tablets (0.25mg) every 12 hours prn for anxiety/agitation. -The prn Lorazepam was documented as administered on 8 occasions in April 2026. -Lorazepam was documented as administered on 04/02/26, 04/07/26, 04/23/26, 04/24/26, 04/27/26, 04/28/26, 04/29/26, and 04/30/26. Review of Resident #1's April 2026 controlled substance record (CSR) for Lorazepam 0.5mg revealed: -There were 11 doses of Lorazepam 0.5mg (1/2 tablet) documented as administered in April 2026. -The time of administration and the effectiveness of the prn medication was not documented on the eMAR on 3 occasions. -Lorazepam prn was documented as administered on 3 occasions when it was not documented as administered on the eMARs including 04/03/26 at 8:00am, 04/17/26 at 9:00am, and 04/25/26 at 9:00am. Review of Resident #1's April 2026 eMAR and April 2026 CSR for Lorazepam revealed: -Lorazepam prn was documented as administered 11 times on the CSR but only 8 times on the eMAR. -Documentation on the April 2026 eMAR was not accurate and did not include documentation of 3 doses of prn Lorazepam that was administered and deducted from the April 2026 CSR.	D 367		

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Review of Resident #1's May 2026 eMAR revealed:
-There was an entry for Lorazepam 0.5mg take ½ tablets (0.25mg) every 12 hours prn for anxiety/agitation.
-The prn Lorazepam was documented as administered on 7 occasions in May 2026.
-Lorazepam was documented as administered on 05/04/26, 05/11/26, 05/15/26, 05/18/26, 05/19/26, 05/20/26, and 05/29/26.

Review of Resident #1's May 2026 controlled substance record (CSR) for Lorazepam 0.5mg revealed:
-There were 12 doses of Lorazepam 0.5mg (1/2 tablet) documented as administered in May 2026.
-Lorazepam prn was documented as administered on 5 occasions when it was not documented as administered on the eMARs including 05/14/26 at 8:00am, 05/16/26 at 7:00am, 05/23/26 at 8:00am, 05/24/26 at 8:00am, and 05/26/26 at 8:00am.

Review of Resident #1's May 2026 eMAR and May 2026 CSR for Lorazepam revealed:
-Lorazepam prn was documented as administered 12 times on the CSR but only 7 times on the eMAR.
-The time of administration and the effectiveness of the prn medication was not documented on the eMAR on 5 occasions.
-Documentation on the May 2026 eMAR was not accurate and did not include documentation of 5 doses of prn Lorazepam that was administered and deducted from the May 2026 CSR.

Review of Resident #1's June 2026 eMAR dated 06/01/26 - 06/24/26 revealed:
-There was an entry for Lorazepam 0.5mg take ½ tablets (0.25mg) every 12 hours prn for

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	HAL054068	A. BUILDING: _____ B. WING _____	R 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(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 367	Continued From page 63	D 367		

anxiety/agitation.
-The prn Lorazepam was documented as administered on 6 occasions from 06/01/26 - 06/24/26.
-Lorazepam was documented as administered on 06/05/26, 06/06/26, 06/14/26, 06/18/26, 06/20/26, and 06/23/26.

Review of Resident #1's June 2026 CSR for Lorazepam 0.5mg revealed:
-There were 13 doses of Lorazepam 0.5mg (1/2 tablet) documented as administered in June 2026.
-Lorazepam prn was documented as administered on 7 occasions when it was not documented as administered on the eMARs including 06/01/26 at 8:00am, 06/03/26 at 8:00am, 06/07/26 at 11:00am, 06/11/26 at 8:00am, 06/16/26 at 8:00am, 06/19/26 at 8:00am, and 06/21/26 at 7:00am.

Review of Resident #1's June 2026 eMAR and June 2026 CSR for Lorazepam revealed:
-Lorazepam prn was documented as administered 13 times on the CSR but only 6 times on the eMAR.
-The time of administration and the effectiveness of the prn medication was not documented on the eMAR on 7 occasions.
-Documentation on the June 2026 eMAR was not accurate and did not include documentation of 7 doses of prn Lorazepam that was administered and deducted from the June 2026 CSR.

Observation of Resident #1's medications on hand on 06/25/26 at 9:40am revealed:
-There was a supply of Lorazepam 0.5mg tablets (1/2 tablet in each bubble) dispensed on 06/16/26 with instructions to take ½ tablet (0.25mg) every 12 hours as needed for anxiety/agitation.

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D 367	Continued From page 64 -There were 27 doses (1/2 tablets) out of 30 (half tablets) remaining. Refer to interview with a medication aide (MA) on 06/25/26 at 11:40am. Refer to interview with a second MA on 06/25/26 at 12:22pm. Refer to interview with the Resident Care Coordinator (RCC) on 06/25/26 at 12:45pm. Refer to interview with the Administrator on 06/25/26 at 6:34pm. _____ Interview with a medication aide (MA) on 06/25/26 at 11:40am revealed: -The MAs were supposed to document the administration of controlled substances on the electronic medication administration records (eMARs) and the controlled substance records (CSRs) as soon as the medication was administered. -The MAs did not always document the administration of as needed (prn) controlled substances on the eMAR because prn medications did not automatically "pop up" on the eMAR to be administered. -There had been no discrepancies with the controlled substance counts during shift change. -It was a documentation issue. Interview with a second MA on 06/25/26 at 12:22pm revealed: -The MAs were supposed to document controlled substances on the eMAR and the CSR when the medication was administered. -The date, time, and effectiveness of prn medications should be documented on the eMARs.	D 367		

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D 367	Continued From page 65 -If a controlled substance was documented as administered on the CSR but not on the eMAR, it was because the MAs forgot to document the eMAR. Interview with the Resident Care Coordinator (RCC) on 06/25/26 at 12:45pm revealed: -The MAs were supposed to document the administration of all controlled substances including prn controlled substances on the eMAR and the CSR. -Documentation for prn medications on the eMAR should be complete and include the effectiveness of the medication. -There was no system to compare the administration of controlled substances documented on the eMAR with the CSR. Interview with the Administrator on 06/25/26 at 6:34pm revealed: -The MAs should document the administration of controlled substances on the eMAR and the CSR when the medication was administered. -He and the RCC were responsible for doing chart audits, including reviewing the eMARs and CSRs. -He had identified a couple of times in the past when the MAs had forgotten to click on the computer to document the administration of controlled substances. -He was not aware of current issues with eMAR documentation not being accurate.	D 367		
D 466	10A NCAC 13F .1308(b) Special Care Unit Staffing 10A NCAC 13F .1308 Special Care Unit Staffing (b) There shall be a care coordinator on duty in the unit at least eight hours a day, five days a	D 466		

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D 466	Continued From page 66 week. The care coordinator may be counted in the staffing required in Paragraph (a) of this Rule for units of 15 or fewer residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a care coordinator was on duty in the Special Care Unit (SCU) at least eight hours a day, five days a week to oversee resident care to ensure each resident received care and services appropriate to each resident's needs. The findings are: Review of the facility's current license effective 01/01/26 revealed the facility was licensed for a capacity of 94 beds including 62 beds for Assisted Living (AL) and 32 beds for the Special Care Unit (SCU). Review of the facility's resident census list provided on 06/24/26 revealed: -The facility had a census of 44 residents. -20 of the residents resided on the AL unit. -24 of the residents resided on the SCU. Interview with a medication aide (MA) on 06/24/26 at 3:41pm revealed the Resident Care Coordinator (RCC) was over the SCU and the AL unit. Interview with a second MA on 06/25/26 at 9:02am revealed; -The RCC managed the AL side of the facility and the SCU. -There was no designated Special Care Coordinator (SCC) that she was aware of since	D 466	Administrator will assure that there is a person assigned as the SCU Coordinator on the SCU 8 hours per day, five days a week. Administrator/Designee will monitor to ensure SCUC is on the unit at least 8 hours a day, 5 days per weeks. QI department/Compliance department/COO will conduct audits of facility at least quarterly or as needed basis to monitor rule areas and ensure compliance.	8/9/2026

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D 466	Continued From page 67 she had been employed at the facility. Interview with a third MA on 06/25/26 at 9:53am revealed: -The RCC worked on both sides of the facility, including the AL side and the SCU. -The RCC's office was in the back hall of the facility on the AL side. -The RCC came to the SCU to check orders and medications on hand. -The RCC also filled in and provided personal care and administered medications if needed in the SCU. -She was not sure how many hours per day the RCC was in the SCU because it varied from day to day. Observation of the RCC on 06/25/26 at 12:45pm revealed the RCC was doing paperwork at a desk in her office located on the back hall of the AL side of the facility. Interview with the RCC on 06/25/26 at 12:45pm revealed: -She was hired as the RCC at the facility in August 2025. -She usually worked Monday through Friday from 8:00am to 6:00pm. -She also worked about 4 hours on some Saturdays but not every Saturday. -She did not usually work on Sundays. -She usually worked on both sides of the facility, including the AL side and the SCU. Second interview with the RCC on 06/25/26 at 5:37pm revealed: -Her title was SCC. -She worked both the SCU and AL unit because the census was low. -Her office was located on the AL unit.	D 466		

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D 466	Continued From page 68 -She did not have an office on the SCU. -She was responsible for keeping care plans, diet orders, physician's orders, standing orders and FL-2s in compliance. -She was responsible for scheduling staff and interviewing personal care aides (PCAs) and medication aides (MAs). -When there was a shortage of PCAs and/or MAs, she stepped in to assist. -She administered medication when needed. -She was on the SCU daily, at least 5 hours per day. -She was available wherever she was needed in the facility. Interview with the Administrator on 06/25/26 at 4:43pm and 5:25pm revealed: -There was no one in the RCC role. -The staff member that was referred to by staff as the RCC was the SCC. -The SCC worked on the SCU a minimum of 8 hours per day. -The SCC's office was located on the AL unit and was used to complete paperwork and to store purged records. -The SCC duties included making sure medications were in the facility, ensuring orders were current and matched the electronic medication administration records (eMARs), ensuring documentation was done, communicating with the primary care providers (PCPs) and nurses, and making sure appointments were followed up on for the entire facility. -The SCC focused on the SCU and helped him with the same duties in the AL unit.	D 466		