STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060175	A. BUILDING: _____ B. WING _____	R 08/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 a follow-up survey on August 5, 2026 through August 6, 2026.	D 000		
D 253	10A NCAC 13F .0801 (a) (b) Resident Assessment 10A NCAC 13F .0801 Resident Assessment (a) The facility shall complete an assessment of each resident within 30 days following admission and annually thereafter. (b) The facility shall use the assessment instrument and instructional manual established by the Department or an instrument developed by the facility that contains at least the same information as required on the instrument established by the Department. The assessment shall be completed by an individual who has met the requirements of Rule .0508 of this Subchapter. If the facility develops its own assessment instrument, the facility shall ensure that the individual responsible for completing the resident assessment has completed training on how to conduct the assessment using the facility's assessment instrument. The assessment shall be a functional assessment to determine the resident's level of functioning to include psychosocial well-being, cognitive status, and physical functioning in activities of daily living. The assessment instrument established by the Department shall include the following: (1) resident identification and demographic information; (2) current diagnoses; (3) current medications; (4) the resident's ability to self-administer medications; (5) the resident's ability to perform activities of	D 253		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shannon Slagans — TITLE: Executive Director — (X6) DATE: 9/10/2026

Reviewed and acknowledged by Melissa J. Jones, 9/14/26.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 253	Continued From page 1 daily living, including bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting, and eating; (6) mental health history; (7) social history, to include family structure, previous employment and education, lifestyle habits and activities, interests related to community involvement, hobbies, religious practices, and cultural background; (8) mood and behaviors; (9) nutritional status, including specialized diet or dietary needs; (10) skin integrity; (11) memory, orientation and cognition; (12) vision and hearing; (13) speech and communication; (14) assistive devices needed; and (15) a list of and contact information for health care providers or services used by the resident. The assessment instrument established by the Department is available on the Division of Health Service Regulation website at https://policies.ncdhhs.gov/divisional/health-benefits-nc-medicaid/forms/dma-3050r-adult-care-home-personal-care-physician/@@display-file/form_file/dma-3050R.pdf at no cost. This Rule is not met as evidenced by:	D 253		

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D 253	Continued From page 2 Based on record reviews and interviews, the facility failed to ensure 2 of 5 sampled residents (#3, and #5) had a care plan completed within 30 days of admission. The findings are: Review of Resident #3's current FL2 dated 05/26/26 revealed: -Diagnoses included urinary tract infection, dysphagia, oropharyngeal phase, sepsis, hypothyroidism, subacute thyroiditis, unspecified severe protein calorie malnutrition, hypo-osmolality and hyponatremia, and polyneuropathy. -She was ambulatory. Review of Resident #3's Resident Register revealed: -There was no admission date. -Resident #3 required assistance with getting dressed, bathing, ambulation, getting in and out of the bed, toileting, and grooming. -Resident #3 required reminders for appointments and mouth care. -Resident #3 was forgetful and needed reminders. Review of Resident #3's Admission Record revealed an admission date of 05/08/26. Review of Resident #3's undated care plan revealed: -She required supervision with eating, limited staff assistance with toileting, ambulation, dressing, grooming, and transferring, and extensive staff assistance with bathing. -The assessor signed the care plan on 06/25/26. -There was no physician signature or date on the care plan.	D 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 253	Continued From page 3 Interview with a personal care assistant (PCA) on 08/06/26 at 9:40am revealed: -Resident #3 required one-person staff assistance. -Resident #3 did most of her activities of daily living (ADL's) on her own. -PCAs helped Resident #3 with showers and getting dressed. Interview with the Resident Care Coordinator (RCC) on 08/06/26 at 11:45am revealed: -She did not know Resident #3's care plan was late. -She did not know why Resident #3's care plan was not dated and signed by the PCP on time. Interview with the Administrator on 08/06/26 at 12:32pm revealed she did not know Resident #3's care plan was late. Refer to the interview with a PCA on 08/06/26 at 9:40am. Refer to the interview with a second PCA on 08/06/26 at 10:03am. Refer to the interview with a medication aide (MA) on 08/06/26 at 11:09am. Refer to the interview with the RCC on 08/06/26 at 11:45am. Refer to the interview with the Administrator on 08/06/26 at 12:32pm. 2. Review of Resident #5's current FL2 dated 05/21/26 revealed: -Diagnoses included cellulitis, recurrent falls, generalized anxiety disorder, atrial fibrillation, and	D 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 253	Continued From page 4 hypertension. -She was intermittent with orientation. -She was ambulatory. Resident #5's Resident Register revealed an admission date of 05/22/26. Review of Resident #5's Care Plan dated 07/22/26 revealed: -She was independent with eating, and required supervision with toileting, ambulation, bathing, dressing, grooming, and transferring. -The Primary Care Provider (PCP) signed the care plan after the initial 30 days on 07/22/26. Interview with a personal care aide (PCA) on 08/06/26 at 10:03am revealed: -Resident #5 required one-person staff assistance. -Resident #5 required assistance getting dressed and toileting. -Resident #5 was able to tell staff what she needed. Interview with the RCC on 08/06/26 at 11:45am revealed: -She knew Resident #5's care plan was late because when she started in the position, she helped complete her care plan. -She was not employed in her position when Resident #5 was admitted. Interview with the Administrator on 08/06/26 at 12:32pm revealed she knew of Resident #5's care plan being late. Refer to the interview with a PCA on 08/06/26 at 9:40am. Refer to the interview with a second PCA on	D 253		

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D 253	Continued From page 5 08/06/26 at 10:03am. Refer to the interview with a MA on 08/06/26 at 11:09am. Refer to the interview with the RCC on 08/06/26 at 11:45am. Refer to the interview with the Administrator on 08/06/26 at 12:32pm. _____ Interview with a PCA on 08/06/26 at 9:40am revealed: -She had been employed at the facility since December 2025. -She had never seen a resident care plan before. -The RCC and the special care coordinator (SCC) would tell them what each resident's care needs were. -She thought care plans may be in resident charts and online, but she was not sure. -She had never been told to refer to a care plan. -She had four days of training on the floor and was told by staff what each resident's needs were. Interview with a second PCA on 08/06/26 at 10:03am revealed: -She had been employed at the facility since November 2025. -She had never seen a resident care plan before. -She figured out the needs of residents on her own or from other PCAs and MAs. -She thought care plans may be in the resident charts or online, but she did not have access to anything online. -She had never been told to refer to a resident care plan by anyone. Interview with a MA on 08/06/26 at 11:09am	D 253		

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D 253	Continued From page 6 revealed: -She had been employed at the facility for a little over a year. -She had never seen a care plan. -She had never been told to refer to a care plan. -She figured out resident needs on her own. -If residents were to go out to the hospital and return with a different level of care, she would not be told by anyone, she would have to figure it out on her own. Interview with the RCC on 08/06/26 at 11:45am revealed: -She knew care plans had to be completed within 30 days. -She tried to have PCP's sign care plans within 15 days. -She did not know why some care plans were late. -She was auditing care plans weekly. -She did not know why she did not catch care plans being late in the audits other than she was looking at over 40 residents and missed some. Interview with the Administrator on 08/06/26 at 12:32pm revealed: -She did not know care plans needed to be signed by the PCP and completed within 30 days of admission. -It was the RCC's responsibility to complete care plans. -After she approved the care plans, the RCC printed them and had PCP sign them. -She knew some care plans were late, but not all of them. -They had sheets at each nursing station for all staff to refer to with information about level of care on each resident. -She audited care plans monthly. -She thought care plans were late due to previous	D 253		

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D 253	Continued From page 7 RCC not completing them on time.	D 253		
D 259	10A NCAC 13F .0802 (a) (c) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (a) The facility shall develop and implement a care plan for each resident based on the resident's assessment completed in accordance with Rule .0801 of this Section. The care plan shall be resident-centered and include the resident's preferences related to the provision of care and services. A copy of each resident's current care plan shall be maintained in a location in the facility where it can be accessed by facility staff who are responsible for the implementation of the care plan. (c) The care plan shall include the following: (1) a description of services, supervision, tasks, and level of assistance to be provided to address the resident's needs identified in the resident's assessment in Rule .0801 of this Section; (2) frequency of the services or tasks to be performed; (3) revisions of tasks and frequency based on reassessments in accordance with Rule .0801 of this Section; (4) licensed health professional tasks required according to Rule .0903 of this Subchapter; (5) a dated signature of the assessor upon completion; and (6) a dated signature of the resident's physician or physician extender as defined in Rule .0102 of this Subchapter within 15 days of completion of the care plan certifying the resident is under this physician's care and has a medical diagnosis with associated physical or mental limitations warranting the provision of the personal care services in the above care plan in accordance	D 259		

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D 259	Continued From page 8 with G.S. 131D-2.15. This shall not apply to residents assessed through the Medicaid State Plan Personal Care Services Assessment for the portion of the assessment covering tasks needed for each activity of daily living of this Rule for which care planning and signing are directed by Medicaid. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 5 of 5 sampled residents had a care plan that could be accessed in a location by facility staff who were responsible for the implementation of the care plan (Resident #1, #2, #3, #4, and #5) and signed by a physician or physician extender within 15 days of completion (#3, and #5). The findings are: 1. Review of Resident #1's current FL2 dated 08/06/25 revealed diagnoses included diabetes mellitus, intellectual disabilities and hypertension. Review of Resident #1's Resident Register revealed an admission date of 07/03/17. Review of Resident #1's care plan dated 10/17/25 revealed Resident #1 was independent with eating, toileting, ambulation, bathing dressing, grooming and transfers.	D 259		

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D 259	Continued From page 9 Refer to the interview with a PCA on 08/06/26 at 9:40am. Refer to the interview with a second PCA on 08/06/26 at 10:03am. Refer to the interview with a medication aide (MA) on 08/06/26 at 11:09am. Refer to the interview with the RCC on 08/06/26 at 11:45am. Refer to the interview with the Administrator on 08/06/26 at 12:32pm. 2. Review of Resident #2's current FL2 dated 08/06/25 revealed diagnoses included type 2 diabetes with diabetic amyotrophy and hypertension. Review of Resident #2's Resident Register revealed an admission date of 07/19/17. Review of Resident #2's care plan dated 10/29/25 revealed: -He required supervision with eating. -He required limited staff assistance with ambulation. -He required total assistance with toileting, ambulation, dressing, grooming, and transferring. Refer to the interview with a PCA on 08/06/26 at 9:40am. Refer to the interview with a second PCA on 08/06/26 at 10:03am. Refer to the interview with a medication aide (MA) on 08/06/26 at 11:09am.	D 259		

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D 259	Continued From page 10 Refer to the interview with the RCC on 08/06/26 at 11:45am. Refer to the interview with the Administrator on 08/06/26 at 12:32pm. 3. Review of Resident #3's current FL2 dated 05/26/26 revealed: -Diagnoses included urinary tract infection, dysphagia, oropharyngeal phase, sepsis, hypothyroidism, subacute thyroiditis, unspecified severe protein calorie malnutrition, hypo-osmolality and hyponatremia, and polyneuropathy. -She was ambulatory. Review of Resident #3's Resident Register revealed: -There was no admission date. -Resident #3 required assistance with getting dressed, bathing, ambulation, getting in and out of the bed, toileting, and grooming. -Resident #3 required reminders for appointments and mouth care. -Resident #3 was forgetful and needed reminders. Review of Resident #3's Admission Record revealed an admission date of 05/08/26. Review of Resident #3's undated care plan revealed: -She required supervision with eating, limited staff assistance with toileting, ambulation, dressing, grooming, and transferring, and extensive staff assistance with bathing. -The assessor signed the care plan on 06/25/26. -There was no physician signature or date on the care plan.	D 259		

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D 259	Continued From page 11 Refer to the interview with a PCA on 08/06/26 at 9:40am. Refer to the interview with a second PCA on 08/06/26 at 10:03am. Refer to the interview with a medication aide (MA) on 08/06/26 at 11:09am. Refer to the interview with the RCC on 08/06/26 at 11:45am. Refer to the interview with the Administrator on 08/06/26 at 12:32pm. 4. Review of Resident #4's current FL2 dated 04/22/26 revealed diagnoses included Parkinson's, hypertension and tremor. Review of Resident #4's Resident Register revealed an admission date of 04/20/26. Review of Resident #4's care plan dated 05/11/26 revealed: -He required extensive assistance with eating, bathing, and transferring. -He required total assistance with toileting, ambulation, dressing, and grooming. Refer to the interview with a PCA on 08/06/26 at 9:40am. Refer to the interview with a second PCA on 08/06/26 at 10:03am. Refer to the interview with a medication aide (MA) on 08/06/26 at 11:09am. Refer to the interview with the RCC on 08/06/26	D 259		

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D 259	Continued From page 12 at 11:45am. Refer to the interview with the Administrator on 08/06/26 at 12:32pm. 5. Review of Resident #5's current FL2 dated 05/21/26 revealed: -Diagnoses included cellulitis, recurrent falls, generalized anxiety disorder, atrial fibrillation, and hypertension. -She was intermittent with orientation. -She was ambulatory. Resident #5's Resident Register revealed an admission date of 05/22/26. Review of Resident #5's Care Plan dated 07/22/26 revealed: -She was independent with eating, and required supervision with toileting, ambulation, bathing, dressing, grooming, and transferring. -The Primary Care Provider (PCP) signed the care plan after the initial 15 days on 07/22/26. Refer to the interview with a PCA on 08/06/26 at 9:40am. Refer to the interview with a second PCA on 08/06/26 at 10:03am. Refer to the interview with a MA on 08/06/26 at 11:09am. Refer to the interview with the RCC on 08/06/26 at 11:45am. Refer to the interview with the Administrator on 08/06/26 at 12:32pm. Interview with a PCA on 08/06/26 at 9:40am	D 259		

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D 259	Continued From page 13 revealed: -She had been employed at the facility since December 2025. -She had never seen a resident care plan before. -The RCC and the special care coordinator (SCC) would tell them what each resident's care needs were. -She thought care plans may be in resident charts and online, but she was not sure. -She had never been told to refer to a care plan. -She had four days of training on the floor and was told by staff what each resident's needs were. Interview with a second PCA on 08/06/26 at 10:03am revealed: -She had been employed at the facility since November 2025. -She had never seen a resident care plan before. -She figured out the needs of residents on her own or from other PCAs and MAs. -She thought care plans may be in the resident charts or online, but she did not have access to anything online. -She had never been told to refer to a resident care plan by anyone. Interview with a MA on 08/06/26 at 11:09am revealed: -She had been employed at the facility for a little over a year. -She had never seen a care plan. -She had never been told to refer to a care plan. -She figured out resident needs on her own. -If residents were to go out to the hospital and return with a different level of care, she would not be told by anyone, she would have to figure it out on her own. Interview with the RCC on 08/06/26 at 11:45am	D 259		

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D 259	Continued From page 14 revealed: -She knew care plans had to be completed within 30 days. -She tried to have PCP's sign care plans within 15 days. -She did not know why some care plans were late. -She was auditing care plans weekly. -She did not know why she did not catch care plans being late in the audits other than she was looking at over 40 residents and missed some. Interview with the Administrator on 08/06/26 at 12:32pm revealed: -She did not know care plans needed to be signed by the PCP or extender within 15 days. -It was the RCC's responsibility to complete care plans. -After she approved the care plans, the RCC printed them and had PCP sign them. -She knew some care plans were late, but not all of them. -They had sheets at each nursing station for all staff to refer to with information about level of care on each resident. -She audited care plans monthly. -She thought care plans were late due to previous RCC not completing them on time.	D 259		
{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	{D 358}		

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	HAL060175	A. BUILDING: _____ B. WING _____	R 08/06/2026

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{D 358}	Continued From page 15 (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 5 sampled residents (# 1 and #2) related to a medication used to treat diabetes. The findings are: 1. Review of Resident #1's current FL2 dated 08/06/25 revealed diagnoses included diabetes mellitus. Review of Resident #1's signed Nurse Practitioner's (NP) order dated 03/27/26 revealed there was an order for novolog insulin 100 units (u)/ml inject 5 units before meals and hold if finger stick blood sugar (FSBS) was less than 150. Interview with Resident #1 on 08/06/26 at 10:00am revealed: -The medication aides (MA) checked his FSBS before meals and administered his insulin. -Depending on his FSBS, sometimes his insulin was not administered. -He was not sure what his FSBS needed to be to hold the insulin but the MAs had the order on their computer screen. -He could "feel" when his FSBS was low and he had snacks and crackers in his room to eat to raise his blood sugar. -He could not remember a time he felt his blood sugar was too low or he would have told the MAs. Review of Resident #1's June 2026 electronic medication administration record (eMAR)	{D 358}		

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{D 358}	Continued From page 16 revealed: -There was an entry for novolog insulin 100u/ml, inject 5 units before meals scheduled at 8:00am, 11:30am and 4:30pm and to hold for FSBS less than 150. -There were 18 of 90 opportunities novolog insulin 5 units was documented administered to Resident #1 when his FSBS was less than 150. -For example, on 06/16/26 at 11:30am novolog insulin 5 units was documented administered to Resident #1 when his FSBS was 105. Review of Resident #1's July 2026 eMAR revealed: -There was an entry for novolog insulin 100u/ml, inject 5 units before meals scheduled at 8:00am, 11:30am and 4:30pm and to hold for FSBS less than 150. -There were 12 of 93 opportunities novolog insulin 5 units was documented administered to Resident #1 when his FSBS was less than 150. -For example, on 07/20/26 at 4:30pm and on 07/22/26 at 11:30am novolog insulin 5 units was documented administered to Resident #1 when his FSBS was 77. Observation of medications available for administration for Resident #1 on 08/05/26 at 4:33pm revealed there was a novolog insulin kwikpen available for administration. Telephone interview with Resident #1's Nurse Practitioner (NP) on 08/06/26 at 8:41am revealed: -She expected the MAs to administer medications as ordered. -If Resident #1 was administered novolog insulin 5 units when his FSBS was less than 150 he could experience low blood sugar symptoms including light-headedness.	{D 358}		

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{D 358}	Continued From page 17 Interview with a MA on 08/05/26 at 4:33pm revealed: -She did not administer Resident #1's novolog insulin when his FSBS was less than 150 as the eMAR indicated. -She was told today (08/05/26) that she was missing a step when documenting insulin administration to Resident #1. -After documenting Resident #1's FSBS reading in the eMAR system, there was another "explanation" box that she was not completing so it appeared as though she administered the novolog when she did not. -She was trained on how to document insulin administration upon hire by another MA that no longer worked at the facility. -She was not instructed step by step how to document Resident #1's novolog insulin administration and thought she was doing it correctly. -She thought management reviewed the eMARs for accuracy, but she had not been informed she was documenting Resident #1's novolog insulin when it should be held. Interview with a second MA on 08/06/26 at 11:09am revealed: -She thought she accidentally documented she had administered Resident #1's novolog insulin when his FSBS was less than 150 because she knew his insulin was to be held. -She always paid attention when checking Resident #1's FSBS and administering his insulin because the resident always asked what his FSBS reading was. -She was taught how to document on the eMAR when she was hired by another MA and the corporate nurse. -She did not know if any eMAR audits were completed.	{D 358}		

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{D 358}	Continued From page 18 Refer to the interview with the Resident Care Coordinator (RCD) on 08/06/26 at 11:38am. Interview with the Administrator on 08/06/26 at 12:32pm revealed: -The MAs were responsible to read the orders in the eMAR system and administer resident medications as ordered. -She thought the MA was properly trained how to document Resident #1's insulin administration on the eMAR but may have forgotten. -The Special Care Coordinator (SCC) was responsible for reviewing medication exceptions report, missed medications report and alert charting notes daily. -She did not know if the SCC reviewed FSBS readings and insulin administration. 2. Review of Resident #2's current FL2 dated 08/06/25 revealed diagnoses included type 2 diabetes with diabetic amyotrophy and hypertension. Review of Resident #2's Resident Register revealed an admission date of 07/19/17. Review of Resident #2's signed Nurse Practitioner (NP) orders dated 06/03/26 revealed an order for Lantus (a medication to lower blood sugar levels) 28 units daily, check blood sugar before giving and notify provider if finger stick blood sugar (FSBS) is less than 70 or greater than 450. Interview with Resident #2 on 08/06/26 at 8:30am revealed: -He thought he received his insulin every morning. -He did not know what his FSBS parameters	{D 358}		

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{D 358}	Continued From page 19 were. Review or Resident #2's June 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Lantus 28 units daily, check blood sugar before giving and notify provider if FSBS is less than 70 or greater than 450 at 8:00am. -There was an entry for FSBS. -Lantus 28 units was documented as did not give (DNG) on 06/03/26 with a FSBS of 148. -Lantus 28 units was documented as DNG on 06/08/26 with a FSBS of 145. -Lantus 28 units was documented as DNG on 06/11/26 with a FSBS of 95. -Lantus 28 units was documented as DNG on 06/12/26 with a FSBS of 124. -Lantus 28 units was documented as DNG on 06/24/26 with a FSBS of 105. -Lantus 28 units was documented as not administered 5 times when Resident #2 should have received insulin. Review of Resident #2's June 2026 order administration tracking form revealed: -There was an entry for Lantus 28 units daily, check blood sugar before giving and notify provider if FSBS is less than 70 or greater than 450 at 8:00am. -On 06/03/26 and on 06/24/26 at 8:00am, Lantus was documented as DNG per vitals. -On 06/08/26 and 06/12/26 at 8:00am, Lantus was documented as DNG, no pass per vitals. -On 06/11/26 at 8:00am, Lantus was documented as DNG, hold FSBS was 95. Review or Resident #2's July 2026 eMAR revealed: -There was an entry for Lantus 28 units daily,	{D 358}		

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{D 358}	Continued From page 20 check blood sugar before giving and notify provider if FSBS is less than 70 or greater than 450 at 8:00am. -There was an entry for FSBS. -Lantus 28 units was documented as DNG on 07/02/26 with a FSBS of 79. -Lantus 28 units was documented as DNG on 07/06/26 with a FSBS of 120. -Lantus 28 units was documented as DNG on 07/07/26 with a FSBS of 98. -Lantus 28 units was documented as DNG on 07/08/26 with a FSBS of 105. -Lantus 28 units was documented as DNG on 07/11/26 and 07/12/26 with a FSBS of 95. -Lantus 28 units was documented as DNG on 07/13/26 with a FSBS of 83. -Lantus 28 units was documented as DNG on 07/27/26 with a FSBS of 70. -Lantus 28 units was documented as not administered 7 times when Resident #2 should have received insulin. Review of Resident #2's July 2026 order administration tracking form revealed: -There was an entry for Lantus 28 units daily, check blood sugar before giving and notify provider if FSBS is less than 70 or greater than 450 at 8:00am. -On 07/02/26, 07/06/26, 07/07/26, 07/08/26, 07/13/26 and 07/27/26 at 8:00am, Lantus was documented as DNG per vitals. -On 07/11/26 and 07/12/26 at 8:00am, Lantus was documented as DNG, hold. Interview with Resident #2's Nurse Practitioner (NP) on 08/05/26 at 8:41am revealed: -She did not know Resident #2 had not received his insulin as ordered. -She expected the facility to follow all orders. -Resident #2 could experience high blood sugar,	{D 358}		

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{D 358}	Continued From page 21 diabetic ketoacidosis (a serious and life-threatening medical emergency that happens when the body does not have enough insulin) and other issues if he did not receive his insulin as ordered. Interview with a Medication Aide (MA) on 08/06/26 at 11:08am revealed: -MAs were responsible for following all Physician orders. -She did not give Resident #2 his Lantus when his FSBS was 95 because she made a, "judgement call" and thought his FSBS was too low. -Resident #2's parameters were on the eMAR. -She did not know what Resident #2's parameters were. -She did not notify anyone that she had not given Resident #2 his insulin when within parameters. Interview with the Resident Care Director (RCD) on 08/06/26 at 11:38am revealed she did not know Resident #2 had not been receiving his insulin as ordered until yesterday (08/5/26). Interview with the Administrator on 08/06/26 at 12:32pm revealed: -She did not know Resident #2 had not received his insulin as ordered until yesterday (08/5/26). -A MA had told her she had held Resident #2's insulin because she had thought his FSBS/parameters were for less than 150. -MAs failed to read Resident #2's orders. -If MAs did not understand orders/parameters, they should have asked the lead MA or the RCD. -She did not know if there were audits in place to monitor/audit parameters.	{D 358}		

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{D 367}	Continued From page 22	{D 367}		
{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 medication administration records were accurate for 2 of 5 sampled residents (#1 & #5) related to finger stick blood sugars (FSBS) (#1) and a medication to treat pain (#5). The findings are: 1. Review of Resident #1's current FL2 dated 08/06/25 revealed diagnoses included diabetes mellitus.	{D 367}		

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{D 367}	Continued From page 23 Review of Resident #1's Resident Register revealed an admission date of 07/03/17. Review of Resident #1's signed Nurse Practitioner's (NP) order dated 03/27/26 revealed there was an order for novolog insulin 100 units (u)/ml inject 5 units before meals and hold if finger stick blood sugar (FSBS) was less than 150. Review of Resident #1's June 2026 electronic medication administration record (eMAR) revealed: -There was an entry for FSBS three times daily at 8:00am, 11:30am and 4:30pm. -There was no documentation Resident #1's FSBS was checked at 4:30pm from 06/02/26 to 06/05/26, 06/08/26 to 06/11/26, on 06/14/26, 06/15/26, 06/17/26 and 06/18/26. -There were 12 of 90 opportunities Resident #1's FSBS was not documented. Review of Resident #1's July 2026 eMAR revealed: -There was an entry for FSBS three times daily at 8:00am, 11:30am and 4:30pm. -There was no documentation Resident #1's FSBS was checked at 4:30pm on 07/02/26 and 07/07/26. -There were 2 of 93 opportunities Resident #1's FSBS was not documented. Review of Resident #1's glucometer on 08/06/26 at 10:10am revealed: -Resident #1's glucometer history revealed FSBS readings back to February 2026. -Resident #1's FSBS readings were completed at 4:30pm from 06/02/26 to 06/05/26, 06/08/26 to 06/11/26, on 06/14/26, 06/15/26, 06/17/26, 06/18/26, 07/02/26 and 07/07/26.	{D 367}		

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{D 367}	Continued From page 24 Interview with a medication aide (MA) on 08/05/26 at 4:33pm revealed: -She was told today (08/05/26) that she was missing a step when documenting FSBS and insulin administration to Resident #1. -She was trained how to document on the eMAR upon hire by another MA that no longer worked at the facility. -She was not instructed step by step how to document Resident #1's FSBS and thought she was doing it correctly. -She thought management reviewed the eMARs for accuracy and holes. Interview with the Resident Care Director (RCD) on 08/06/26 at 11:38am revealed: -The MAs were trained upon hire by another MA how to document in the eMAR system. -The Special Care Coordinator (SCC) was responsible for reviewing the missed medications and exceptions report daily Monday through Friday. -She was not aware there were times Resident #1's FSBS was not documented on his eMAR. -The "holes" that were created when Resident #1's FSBS was not documented did not show up on the missed medications report or the exceptions report, just on the eMAR. -There were no routine audits for missing documentation on resident eMARs. Interview with the Administrator on 08/06/26 at 12:32pm revealed: -The Special Care Coordinator (SCC) was responsible for reviewing the medication exceptions report, missed medications report and alert charting notes daily. -She did not know if the SCC reviewed FSBS documentation.	{D 367}		

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{D 367}	Continued From page 25 -The "holes" in Resident #1 FSBS documentation did not show up on the medications exceptions report or the missed medications report. -She was not aware there were times Resident #1's FSBS was not documented on his eMAR. 2. Review of Resident #5's current FL2 dated 05/21/26 revealed diagnoses included cellulitis, recurrent falls, generalized anxiety disorder, paroxysmal atrial fibrillation, and hypertension. Review of Resident #5's Resident Register revealed an admission date of 05/22/26. Review of Resident #5's physician's order dated 07/21/26 revealed an order for oxycodone (used to treat pain) 5 mg one tablet every four hours as needed with a quantity of 20 tablets. Review of Resident #5's July 2026 electronic medication administration record (eMAR) compared to Resident #5's controlled substance count sheet (CSCS) for oxycodone 5mg one tablet every four hours as needed revealed: -There was an entry for oxycodone 5mg one tablet every four hours as needed on the July eMAR. -On 07/26/26 at 1:22am oxycodone was documented as administered on the CSCS and was not documented on the eMAR. -On 07/27/26 at 1:15am oxycodone was documented as administered on the CSCS and was not documented on the eMAR. Telephone interview with the facility's contracted pharmacy on 08/06/26 at 1:21pm revealed: -Resident #5's oxycodone 5mg was filled at another pharmacy. -Dispense quantity was 20 tablets. -She did not know the date it was dispensed due	{D 367}		

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{D 367}	Continued From page 26 to it being filled at another pharmacy. Interview with a medication aide (MA) on 08/06/26 at 11:09am revealed: -She counted controlled medications on every shift. -For as needed controlled medications, she would ask the resident their level of pain. -She would document on the CSCS; sign and date with the number left, and document on the eMAR once a controlled medication was given. Interview with the Resident Care Coordinator (RCC) on 08/06/26 at 11:45am revealed: -When controlled medications were administered, the MAs would ask the resident their pain level and the pain level was documented; the medication was checked off in the eMAR after the resident swallowed the medication; the MA would immediately write it on the CSCS with the number of tablets remaining; then they would follow-up 30 minutes later and click on the eMAR if the medication was effective or non-effective. -The MAs also would document on the 24-hour report when controlled medications were administered. -Controlled medications were counted at each shift, oncoming and off going. -They did not have a system in place to audit and compare the CSCS with the eMAR. -She was not sure why the MA did not document on the eMAR when they gave oxycodone two times. Interview with the Administrator on 08/06/26 at 12:32pm revealed: -The MAs were responsible for giving controlled medications. -The MAs were to document the medication on the eMAR after it was administered and on the	{D 367}		

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SPRING ARBOR OF STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(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 27 CSCS with their signature, date, and time and the number remaining. -The MAs were also responsible for counting controlled medications on each shift. -Controlled sheets got audited daily by the SCC, but no system was in place to compare the eMAR with the CSCS. -She did not know why the MAs would not document on both the eMAR and the CSCS when a controlled medication was administered. Attempted telephone interview with a second MA on 08/06/26 at 11:29am was unsuccessful. Attempted telephone interview with a local pharmacy on 08/06/26 at 3:06pm was unsuccessful.	{D 367}		

PLAN OF CORRECTION for Annual Survey August 6, 2026

Spring Arbor of Steele Creek

HAL-060-175

Mecklenburg County

It is Spring Arbor of Steele Creek's policy and standard practice to comply with all North Carolina Adult Care rules and state regulations.

10A NCAC 13 F .0801 (a) (b) Resident Assessment

a) The facility shall complete an assessment of each resident within 30 days following admission and annually thereafter.

(b) The facility shall use the assessment instrument and instructional manual established by the Department or an instrument developed by the facility that contains at least the same information as required on the instrument established by the Department. The assessment shall be completed by an individual who has met the requirements of Rule .0508 of this Subchapter. If the facility develops its own assessment instrument, the facility shall ensure that the individual responsible for completing the resident assessment has completed training on how to conduct the assessment using the facility's assessment instrument. The assessment shall be a functional assessment to determine the resident's level of functioning to include psychosocial well-being, cognitive status, and physical functioning in activities of daily living. The assessment instrument established by the Department shall include the following:

(1) resident identification and demographic information;

(2) current diagnoses;

(3) current medications;

(4) the resident's ability to self-administer medications;

(5) the resident's ability to perform activities of daily living, including bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting, and eating;

(6) mental health history;

(7) social history, to include family structure, previous employment and education, lifestyle habits and activities, interests related to community involvement, hobbies, religious practices, and cultural background;

(8) mood and behaviors;

(9) nutritional status, including specialized diet or dietary needs;

(10) skin integrity;

(11) memory, orientation and cognition;

(12) vision and hearing;

(13) speech and communication;

(14) assistive devices needed; and

(15) a list of and contact information for health care providers or services used by the resident.

The assessment instrument established by the Department is available on the Division of Health Service Regulation website at https://policies.ncdhhs.gov/wp-content/uploads/DMA-3050R.pdf at no cost.

Plan of Correction:

Immediately after the findings of this survey, the clinical team conducted a comprehensive review of resident assessment and care-plan records to identify any required assessments and resident reviews that were incomplete or overdue. Identified deficiency were corrected by August 31, 2026. The RCD/CCC and ED were re-educated on 10A NCAC 13F .0801 and the Spring Arbor Resident Care Operational Guide requirements for timely resident assessment and follow-up care planning.

Prevention of Re-occurrence:

The RCD/CCC will maintain an admission and assessment tracking process identifying each resident's admission date and required assessment/care-planning due dates. New admissions and upcoming assessment requirements will be reviewed during daily stand-up for 30 days and then weekly for three months to verify completion within required regulatory timeframes.

Monitoring Responsibility & Frequency:

The RCD/CCC will maintain the tracking process, and the ED or designee will review assessment status daily for 30 days and weekly for three months. Any overdue or incomplete item identified through monitoring will be addressed promptly, with additional education or corrective action as indicated. The Regional Director of Wellness, Quality & Education Nurse, will continue to be available as a resource and educator to the Team regarding assessments and care-plan compliance.

Applicable Spring Arbor Resident Care Operational Guide References:

Chapter 2 - Resident Admission Criteria and Functional Assessment/Level of Care: Overview of Resident Assessments

Chapter 3 - Resident Admissions: Follow-Up Admission Procedures

Correction Completion Date: 8/31/2026

10A NCAC 13F .0802 RESIDENT CARE PLAN

(a) The facility shall develop and implement a care plan for each resident based on the resident's assessment completed in accordance with Rule .0801 of this Section. The care plan shall be resident-centered and include the resident's preferences related to the provision of care and services. A copy of each resident's current care plan shall be maintained in a location in the facility where it can be accessed by facility staff who are responsible for the implementation of the care plan.

(c) The care plan shall include the following:

(1) a description of services, supervision, tasks, and level of assistance to be provided to address the residents' needs identified in the resident's assessment in Rule .0801 of this Section;

(2) frequency of the services or tasks to be performed;

(3) revisions of tasks and frequency based on reassessments in accordance with Rule .0801 of this Section;

(4) licensed health professional tasks required according to Rule .0903 of this Subchapter;

(5) a dated signature of the assessor upon completion; and

(6) a dated signature of the resident's physician or physician extender as defined in Rule .0102 of this Subchapter within 15 days of completion of the care plan certifying the resident is under this physician's care and has a medical diagnosis with associated physical or mental limitations warranting the provision of the personal care services in the above care plan in accordance with G.S. 131D-2.15. This shall not apply to residents assessed through the Medicaid State Plan Personal Care Services Assessment for the portion of the assessment covering tasks needed for each activity of daily living of this Rule for which care planning and signing are directed by Medicaid.

Plan of Correction:

The RCD/CCC and ED will complete a 100% thorough review of all current resident care plans to verify that each resident has a current care plan based on the resident assessment; the plan identifies required services, supervision, tasks, level of assistance and frequency of services; the assessor has dated and signed the plan; and the physician and/or provider signature is obtained within the timeframe required by 10A NCAC 13F .0802. Any identified deficiency will be corrected by the correction completion date. The community will also verify that a current copy of each resident's care plan is maintained in a location accessible to staff responsible for implementing resident care. Medication-administration staff will be re-educated on where current care plans are located, how to access them, and the expectation to review and follow the care plan when providing services.

Prevention of Re-occurrence:

The RCD/CCC will track care-plan completion and physician/provider signature due dates as part of the admission and assessment tracking process. Current care plans will remain accessible to staff responsible for implementation. Changes in resident condition, level of assistance, hospital/rehab return, or other significant changes will be communicated to direct-care staff, and the care plan will be reviewed and revised as indicated.

Monitoring Responsibility & Frequency:

For one month, the RCD/CCC or designee will review care-plan status daily during stand-up, followed by weekly review for three months. The ED or designee will review the monitoring results. During the monitoring period, the RCD/CCC or ED will also validate that direct-care staff can identify where current care plans are located and demonstrate awareness of the care needs for residents assigned to them. Any concern identified will be corrected promptly and additional education or corrective action will be implemented as indicated.

Regional Director of Wellness, Quality & Education Nurse will continue to ensure adherence to this rule with routine community visits.

Applicable Spring Arbor Resident Care Operational Guide References:

Chapter 3 - Resident Admissions: Move-In Day Admission Procedures and Follow-Up Admission Procedures

Chapter 4 - Basic Resident Care: Daytime, Evening and Overnight Basic Care Routines

Correction Completion Date: 8/31/2026

10A NCAC 13 F.1004(a) Medication Administration

(a) An adult care home shall assure that the preparation and administration of medications, prescriptions and non-prescriptions, and treatments by staff are in accordance with
(1) Orders by a licensed prescribing practitioner which are maintained in the resident's record; and
(2) Rules in this section and the facility's policies and procedures

Plan of Correction:

Re-education and training of all Med Techs was conducted by the RCD on administration and documentation of blood glucose readings and insulin in the eMAR. Med Techs were re-educated on the requirement to follow the licensed prescribing practitioner's order and prescribed blood glucose parameters, including that a medication may not be independently held, changed, or administered outside of the order. Med Techs were also re-educated to obtain clarification from the RCD/CCC and/or prescribing practitioner when an order or parameter is unclear and to notify the provider as required. The RCD/CCC will review residents with blood glucose monitoring and/or insulin orders to verify that current physician orders, blood glucose parameters and eMAR instructions are accurate and consistent. Validation of Med Techs competency on the correct eMAR documentation process for blood glucose results, insulin administered, and insulin held in accordance with prescribed parameters. Our pharmacy is scheduled to return on 9/08/26 to conduct a Diabetes In-Service for Med Techs in addition to the on-going monthly in-services.

Prevention of Re-occurrence:

Prior to administering or withholding insulin, Med Techs will review and follow the resident's current physician order and prescribed parameters. Med Techs will not make independent clinical

decisions to alter or withhold medication outside of order. Questions or concerns regarding an order or blood glucose parameter will be escalated to the RCD/CCC and prescribing practitioner as appropriate and documented in the resident record.

Monitoring Responsibility & Frequency:

The RCD/CCC will audit MAR/eMAR documentation for residents receiving blood glucose monitoring and insulin daily for 30 days and then weekly for three months. Monitoring will compare blood glucose results, prescribed parameters, and insulin administration/omission documentation to verify that medications are administered as ordered and documentation is accurate. Any variance identified will be investigated and addressed promptly, including provider notification and medication-variance reporting when indicated. The ED or designee will review audit findings for trends and sustained compliance. The Regional Director of Wellness, Quality & Education Nurse will review randomly while onsite and remote for compliance with routine community visits.

Applicable Spring Arbor Resident Care Operational Guide References:

Chapter 5 - Medication Management: Administration of Medications

Chapter 5 - Medication Management: Safe Medication Administration

Chapter 5 - Medication Management: Blood Glucose and Blood Glucose Testing

Correction Completion Date: 8/27/2026

10A NCAC 13 F.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).

PLAN OF CORRECTION for Annual Survey August 6, 2026

Plan of Correction:

The RCD/CCC will complete a review of current medication administration records to identify missing or inaccurate documentation. For residents receiving blood glucose monitoring, available glucometer results will be compared with eMAR documentation to identify missing blood glucose entries. Controlled-substance administration records will be reconciled with corresponding eMAR documentation to identify discrepancies. Any identified documentation deficiency will be addressed by the correction completion date. Med Techs will be re-educated on Chapter 5 of the Spring Arbor Resident Care Operational Guide (RCOG) regarding timely and accurate documentation of medication administration, medication omissions, blood glucose results, controlled substances and PRN medications, including documentation of the reason for PRN administration and the resulting effect. A copy of the RCOG is readily available in each med room for Med Techs for reference and review now.

Prevention of Re-occurrence:

Medication administration will be documented in the eMAR at the time of administration. Blood glucose results will be documented in the eMAR following testing. Controlled-substance administration will be documented on both the controlled-substance record and the eMAR. Medication staff will report any documentation omission or discrepancy to the RCD/CCC for follow-up. Monitoring will include direct review of eMAR documentation and will not rely solely on medication exception or missed-medication reports.

Monitoring Responsibility & Frequency:

For 30 days, the RCD/CCC or designee will conduct daily reviews for eMAR omissions, including blood glucose documentation, and will reconcile controlled-substance administration records against the eMAR. Thereafter, these reviews will be completed weekly for three months. The RCD/CCC and ED or designee will review findings for trends and sustained compliance. Any discrepancy will be addressed promptly, with additional education, medication-variance reporting, provider notification, or corrective action implemented as indicated.

Applicable Spring Arbor Resident Care Operational Guide References:

Chapter 5 - Medication Management: Documentation Procedures for Medication Administration

Chapter 5 - Medication Management: Administration of Medications

Chapter 5 - Medication Management: Blood Glucose Testing

Correction Completion Date: 8/27/2026

Submitted by: Shannon Stagens Date: 9/10/26

Executive Director