STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF ROCKWELL RETIREMENT	612 HIGHWAY 152 EAST ROCKWELL, NC 28138

(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 and a complaint investigation from 08/25/26 through 08/27/26.	D 000		
D 072	10A NCAC 13F .0305 (m) Physical Environment 10A NCAC 13F .0305 Physical Environment (m) The requirements for outside premises are: (1) the outside grounds of new and existing facilities shall be maintained in a clean and safe condition. For the purpose of this Rule, "clean and safe condition" means free from debris, trash, uneven surfaces, and similar conditions as not to attract rodents and vermin and provide for safe movement throughout facility grounds. Creeks, ravines, ponds, pools, and other similar areas shall have safety protection. For the purpose of this Rule, "safety protection" means preventive measures, such as barriers, to block access to such areas; (2) if the facility has a fence around the premises, the fence shall not prevent residents from exiting or entering freely or have sharp edges, rusting posts, or other similar conditions that may cause injury; and (3) outdoor walkways and drives shall be illuminated by no less than five foot-candles of light at ground level. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to allow the assisted living (AL) residents to freely exit or enter the fence around the premises with a restriction on the top of a gate. The findings are:	D 072		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 072	Continued From page 1 Review of the facility's license revealed the license was effective from 01/01/26 through 12/31/26 for a capacity of 86 AL residents. Review of the facility's census on 08/25/26 revealed a census of 62 AL residents. Observation of the outside of the facility on 08/25/26 at 12:20pm and on 08/26/26 at 8:30am revealed: -There was a gated fence partially enclosing the assisted living courtyard. -There was a gate located at the far rear side of the fence that was restricted from opening by a wired coat hanger at the top post of the gate. -The wired coat hanger was hard twisted four times at the end and was at least 6 feet high from the bottom of the gate. -The rest of the courtyard was enclosed by the outside walls of the facility with access to the facility by 2 doors and there were no other exits to the courtyard. -There were residents in the courtyard who were ambulatory and some who were semi-ambulatory with wheelchairs who required staff assistance. Interview with a resident on 08/26/26 at 8:26am revealed: -The staff assisted him when he wanted to enter or exit the courtyard gate because he required physical assistance and he used a wheelchair. -He would not be able to remove the wired coat hanger at the top of the courtyard gate because it was too high to reach from his wheelchair. Interview with a second resident on 08/27/26 at 10:25am revealed: -The wired coat hanger had been on the top of the fence gate since he could recall.	D 072		

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	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 072	Continued From page 2	D 072		

-He was tall enough to lift the coat hanger over the gate post and exit the courtyard but someone who was not tall or sitting in a wheelchair would have a difficult time getting in and out of the gate.

Interview with a personal care aide (PCA) on 08/27/26 at 10:28am revealed:
-She was not aware of the wire coat hanger over the gate post in the courtyard.
-There were residents who required physical assistance and residents who were in wheelchairs that required additional assistance to get beyond the gate with a wire coat hanger at the top of the gate post.

Interview with a medication aide (MA) on 08/27/26 at 10:32am revealed:
-She was aware of the wire coat hanger over the gate post in the courtyard and it had been there for the last 3 years.
-There were residents who required staff assistance to get out of the gate but no residents had complained about the wire coat hanger on the top of the gate post.

Interview with a housekeeper on 08/27/26 at 1:37pm revealed:
-She was the maintenance assistant when the Regional Maintenance Manager was not present at the facility.
-She was aware of the wire coat hanger on the top of the gate post but it was there since she started in January 2026.
-She was aware there were residents who required physical assistance to go beyond the courtyard gate.

Interview with the Regional Maintenance Manager on 08/27/26 at 1:42pm revealed:
-He was not aware of the wire coat hanger over

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF ROCKWELL RETIREMENT	612 HIGHWAY 152 EAST ROCKWELL, NC 28138

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D 072	Continued From page 3 the gate post in the courtyard. -He was not aware the wire coat hanger over the gate post in the courtyard was considered a restriction of access. Interview with the Resident Care Coordinator (RCC) on 08/27/26 at 3:47pm revealed: -She was aware of the gate located at the far rear side of the fence that was restricted from opening by a wire coat hanger at the top post of the gate. -The gate had been that way since she started working at the facility four years ago. -She was not aware of the rule stating residents should be able to freely exit or enter the facility. -She was not sure why the wire coat hanger at the top post of the gate was in place. Interview with the Assistant Administrator on 08/27/26 at 4:16pm revealed: -He was not aware of the gate that was restricted from opening by a wire coat hanger at the top post of the gate. -He was aware of the rule stating residents should be able to freely exit or enter the facility. -He was not sure why the wired coat hanger at the top post of the gate was in place. Interview with the Administrator on 08/27/26 at 4:35pm revealed: -She was not aware of the wire coat hanger over the gate post in the courtyard. -She expected the courtyard gate and fence to be free of resident restrictions for entry and exiting within the facility courtyard.	D 072		
D 075	10A NCAC 13F .0306 (a)(2) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And	D 075		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF ROCKWELL RETIREMENT	612 HIGHWAY 152 EAST ROCKWELL, NC 28138

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D 075	Continued From page 4 Furnishings (a) Adult care homes shall: (2) have no persistent and recurring odors that are considered by the residents to be unpleasant; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain an environment free from unpleasant odors. The findings are: Observation of a resident's room 133 on 08/25/26 at 9:30am revealed when the door to the resident's room was opened, there was a strong urine odor. Observation of a resident's room 138 on 08/25/26 at 9:35am revealed when the door to the resident's room was opened, there was a strong urine odor. Observation of the facility on 08/26/26 at 8:00am revealed a strong urine odor was detected upon entering the facility from the front entrance. Interview with a resident on 08/25/26 at 9:00am	D 075		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF ROCKWELL RETIREMENT	612 HIGHWAY 152 EAST ROCKWELL, NC 28138

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D 075	Continued From page 5	D 075		

revealed:
-He had smelled a bad smell in the hallways of the facility sometimes.
-He would not want to smell that odor all the time.

Interview with a second resident on 08/25/26 at 10:00am revealed:
-She smelled urine often.
-She felt it was due to other residents being left in their urine for prolonged periods of time.
-She did not want to smell that odor.

Interview with a third resident on 08/26/26 at 10:25am revealed:
-She smelled unpleasant odors in the hallways sometimes.
-The unpleasant odors smelled like urine and feces.
-She did inform staff members at the facility.
-Staff would spray air freshener to help with the unpleasant odor.

Interview with a fourth resident on 08/26/26 at 10:30am revealed:
-He smelled unpleasant odors in his room and the hallways of the facility every day.
-His roommate soiled his bed linen often and was left to sleep or sit in it daily.
-If his roommate urinated on himself during the night, staff would not clean him up until the next morning.

Interview with a fifth resident on 08/27/26 at 10:11am revealed:
-There were sometimes unpleasant odors in the hallways of the facility.
-The unpleasant odor mostly came from room 133.
-Other residents used the bathroom in their wheelchair or recliners, and the facility did not do

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	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF ROCKWELL RETIREMENT	612 HIGHWAY 152 EAST ROCKWELL, NC 28138

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D 075	Continued From page 6	D 075		

a good job of cleaning them.
-Sometimes he saw staff members spraying air freshener to help with the unpleasant odors.

Interview with a personal care aide (PCA) on 08/26/26 at 10:33am revealed when she arrived at the facility for her morning shift, she smelled unpleasant odors.

Interview with a medication aide (MA) on 08/26/26 at 10:36am revealed:
-She was aware of the unpleasant odors in the hallways and resident rooms at the facility.
-Some of the smells were due to wounds.

Interview with a housekeeper on 08/27/26 at 1:58pm revealed:
-Someday's there was an unpleasant odor in the hallways and resident rooms at the facility.
-She witnessed some residents sitting in their urine and feces for several hours before being changed.
-She witnessed some residents with wounds not have their bandages changed which she felt affected the unpleasant odors.
-PCAs threw soiled resident briefs in trashcans with no trash bag inside of it.
-Housekeepers were only to sanitize, not clean up resident bodily fluids/waste.

Interview with the Resident Care Coordinator (RCC) on 08/27/26 at 3:49pm revealed:
-She was aware of the unpleasant odors in the hallways and resident rooms at the facility.
-Staff at the facility were in the process of trying to figure out where the unpleasant odors were coming from.
-She expected the facility to maintain an environment free from unpleasant odors.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF ROCKWELL RETIREMENT	612 HIGHWAY 152 EAST ROCKWELL, NC 28138

(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 075	Continued From page 7 Interview with the Administrator on 08/27/26 at 5:20pm revealed: -She was aware of the unpleasant odors in the hallways and resident rooms at the facility. -The unpleasant odors were coming from multiple sources. -No staff members or residents reported concerns about the unpleasant odors to her. -The housekeeping team completed weekly deep cleanings. -She expected the facility to maintain an environment free from unpleasant odors.	D 075		
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.	D 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF ROCKWELL RETIREMENT	612 HIGHWAY 152 EAST ROCKWELL, NC 28138

(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 253	Continued From page 8 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/divisional/health-benefits-nc-medicaid/forms/dma-3050r-adult-care-home-personal-care-physician/@@display-file/form_file/dma-3050R.pdf at no cost.	D 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF ROCKWELL RETIREMENT	612 HIGHWAY 152 EAST ROCKWELL, NC 28138

(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 253	Continued From page 9	D 253		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure that 5 of 7 sampled residents (#1, #3, #4, #6 and #7) were assessed and had a care plan developed within 30 days of admission and annually.

The findings are:

1. Review of Resident #1's FL2 dated 06/04/26 revealed:
-Diagnoses included essential hypertension, unspecified acute ischemic heart disease, prediabetes, and recurrent major depressive disorder.
-The resident required assistance with bathing and dressing.

Review of Resident #1's Resident Register revealed an admission of 08/09/24.

Review of Resident #1's record on 08/25/26 revealed:
-There was an assessment and care plan developed and signed on 07/17/25.
-Resident #1 required limited assistance from staff with eating, bathing, dressing, toileting, and grooming.
-There was no subsequent assessment and care plan available for review.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF ROCKWELL RETIREMENT	612 HIGHWAY 152 EAST ROCKWELL, NC 28138

(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 253	Continued From page 10 Interview with a medication aide (MA) supervisor on 07/28/26 at 3:30pm revealed: -The Administrator was responsible for ensuring assessments and care plans were developed, completed and singed annually. -She did not assist with the residents' assessments. Interview with the Resident Care Coordinator (RCC) on 08/27/26 at 3:20pm revealed she was not aware Resident #1 did not have an updated care plan. Interview with the Assistant Administrator on 08/27/26 at 4:00pm revealed he was not aware Resident #1 did not have an updated care plan. Interview with the Administrator on 08/27/26 at 4:35pm revealed she was not aware Resident #1 did not have an updated care plan. Refer to the interview with RCC on 08/27/26 at 3:20pm. Refer to the interview with the Assistant Administrator on 08/27/26 at 4:00pm. Refer to the interview with the Administrator on 08/27/26 at 4:35pm. 2. Review of Resident #4's current FL2 dated 06/18/26 revealed: -Diagnoses included diabetes mellitus type 2 without complication, unspecified bipolar disorder, unspecified disorder of thyroid, unspecified non-psychotic mental disorder, and unspecified schizoaffective disorder. -The resident required assistance with bathing and dressing.	D 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF ROCKWELL RETIREMENT	612 HIGHWAY 152 EAST ROCKWELL, NC 28138

(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 253	Continued From page 11	D 253		

Review of Resident #4's Resident Register revealed:
-An admission date of 06/09/26.
-Resident #4 required assistance with bathing and dressing.

Review of Resident #4's record on 08/26/26 revealed:
-There was no current assessment and signed care plan until 08/26/26.
-Resident #4 required supervision assistance from staff with bathing, dressing, and grooming.
-There was no subsequent assessment and care plan available for review within 30 days of Resident #4's admission date.

Interview with the Resident Care Coordinator (RCC) on 08/27/26 at 3:20pm revealed she was not aware Resident #4 did not have an updated care plan.

Interview with the Assistant Administrator on 08/27/26 at 4:00pm revealed he was aware Resident #4 did not have an updated care plan and it must have been overlooked.

Interview with the Administrator on 08/27/26 at 4:35pm revealed she was not aware Resident #4 did not have an updated care plan.

Refer to the interview with RCC on 08/27/26 at 3:20pm.

Refer to the interview with the Assistant Administrator on 08/27/26 at 4:00pm.

Refer to the interview with the Administrator on 08/27/26 at 4:35pm.

3. Review of Resident #6's FL2 dated 03/25/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF ROCKWELL RETIREMENT	612 HIGHWAY 152 EAST ROCKWELL, NC 28138

(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 253	Continued From page 12	D 253		

revealed:
-Diagnoses included hypertension, gastroesophageal reflux disease (GERD), hyperlipidemia, insomnia, dementia, and anxiety
-The resident was intermittently disoriented and incontinent of bowel.
-The resident required assistance with bathing and dressing.

Review of Resident #6's Resident Register revealed:
-An admission date of 04/30/26.
-Resident #6 required assistance with bathing and toileting with an indication for incontinence of both bowel and bladder.

Review of Resident #6's record on 08/26/26 revealed:
-There was no assessment and signed care plan developed for Resident #6.
-There was no subsequent assessment and care plan available for review within 30 days of Resident #6's admission date.

Interview with the Resident Care Coordinator (RCC) on 08/27/26 at 3:20pm revealed she was not aware Resident #6 did not have an updated care plan.

Interview with the Assistant Administrator on 08/27/26 at 4:00pm revealed he was not aware Resident #6 did not have an updated care plan because he had not started in the previous RCC position until 06/03/26.

Interview with the Administrator on 08/27/26 at 4:35pm revealed she was not aware Resident #6 did not have an updated care plan.

Refer to the interview with RCC on 08/27/26 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF ROCKWELL RETIREMENT	612 HIGHWAY 152 EAST ROCKWELL, NC 28138

(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 253	Continued From page 13 3:20pm. Refer to the interview with the Assistant Administrator on 08/27/26 at 4:00pm. Refer to the interview with the Administrator on 08/27/26 at 4:35pm. 4. Review of Resident #3's FL2 dated 01/20/26 revealed: -Diagnoses included essential hypertension, atrial fibrillation, type 2 diabetes, chronic kidney disorder, and depression. -The resident required assistance with bathing and dressing. Review of Resident #3's Resident Register revealed an admission of 03/01/24. Review of Resident #3's record on 08/25/26 revealed: -There was an assessment and care plan developed and signed on 02/24/25. -Resident #3 required limited assistance from staff with eating, toileting, ambulation, bathing, dressing, grooming and transferring. -There was no subsequent assessment and care plan available for review. Interview with the Resident Care Coordinator (RCC) on 08/27/26 at 3:21pm revealed she was not aware Resident #3 did not have an updated care plan. Interview with the Assistant Administrator on 08/27/26 at 4:04pm revealed he was not aware Resident #3 did not have an updated care plan. Interview with the Administrator on 08/27/26 at 4:49pm revealed she was not aware Resident #3 did not have an updated care plan.	D 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF ROCKWELL RETIREMENT	612 HIGHWAY 152 EAST ROCKWELL, NC 28138

(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 253	Continued From page 14 Refer to the interview with RCC on 08/27/26 at 3:20pm. Refer to the interview with the Assistant Administrator on 08/27/26 at 4:00pm. Refer to the interview with the Administrator on 08/27/26 at 4:35pm. 5. Review of Resident #7's FL2 dated 04/30/26 revealed: -Diagnoses included type 2 diabetes, post-traumatic stress disorder, and chronic obstructive pulmonary disease. -The resident required assistance with bathing and dressing. Review of Resident #7's Resident Register revealed an admission of 04/23/26. Review of Resident #7's record on 08/25/26 revealed: -There was an assessment and care plan developed and signed on 08/25/26. -There was no previous assessment and care plan available for review. Interview with the Resident Care Coordinator (RCC) on 08/27/26 at 3:21pm revealed she was not aware Resident #7 did not have a care plan developed within 30 days of admission. Interview with the Assistant Administrator on 08/27/26 at 4:04pm revealed he was not aware Resident #7 did not have a care plan developed within 30 days of admission. Interview with the Administrator on 08/27/26 at 4:49pm revealed she was not aware Resident #7	D 253		

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D 253	Continued From page 15 did not have a care plan developed within 30 days of admission. Refer to the interview with RCC on 08/27/26 at 3:20pm. Refer to the interview with the Assistant Administrator on 08/27/26 at 4:00pm. Refer to the interview with the Administrator on 08/27/26 at 4:35pm. _____ Interview with RCC on 08/27/26 at 3:20pm revealed: -She was aware residents were to be assessed, and a care plan be developed within 30 days of admission and annually. -She was responsible for making sure residents were assessed and had a care plan developed within 30 days of admission and annually. -She was responsible for monthly chart audits. -Chart audits consisted of picking a sample of residents and reviewing their charts for any missing or missed items. -She was not sure how the out-of-date care plans were missed. Interview with the Assistant Administrator on 08/27/26 at 4:00pm revealed he was not responsible for making sure residents were assessed and had a care plan developed within 30 days of admission and annually. Interview with the Administrator on 08/27/26 at 4:35pm revealed she expected residents to be assessed and a care plan be developed within 30 days of admission and annually.	D 253		

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D 352	Continued From page 16	D 352		
D 352	10A NCAC 13F .1003(a) Medication Labels 10A NCAC 13F .1003 Medication Labels (a) Prescription legend medications shall have a legible label with the following information: (1) the name of the resident for whom the medication is prescribed; (2) the most recent date of issuance; (3) the name of the prescriber; (4) the name and concentration of the medication, quantity dispensed, and prescription serial number; (5) directions for use stated and not abbreviated; (6) a statement of generic equivalency shall be indicated if a brand other than the brand prescribed is dispensed; (7) the expiration date, unless dispensed in a single unit or unit dose package that already has an expiration date; (8) auxiliary statements as required of the medication; (9) the name, address, telephone number of the dispensing pharmacy; and (10) the name or initials of the dispensing pharmacist. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure all prescription medications were labeled for 1 of 7 sampled resident (#3) related to an insulin product not being labeled with the name of the resident, the date of issuance, the name of the prescriber, the name and concentration of the medication, quantity dispensed, prescription serial number, directions for use, the expiration date, the name and address of the dispensing pharmacy, and the name or initials of the dispensing pharmacist.	D 352		

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D 352	Continued From page 17 The findings are: Review of Resident #3's FL2 dated 01/20/26 revealed diagnoses included essential hypertension, atrial fibrillation, type 2 diabetes, chronic kidney disorder, and depression. Review of Resident #3's physician orders signed 08/17/26 revealed: -There was an order for insulin glargine (a medication used to lower blood sugar) insulin pen inject 17 units daily. Review of Resident #3's June 2026 electronic medication administration record (eMAR) revealed: -There was an entry for insulin glargine pen inject 17 units once a day every morning at 9:00am. -Lantus insulin was documented as administered daily at 9:00am. Review of Resident #3's July 2026 eMAR revealed: -There was an entry for insulin glargine pen inject 17 units once a day every morning at 9:00am. -Lantus insulin was documented as administered daily at 9:00am. Review of Resident #3's August 2026 eMAR from 08/01/26 to 08/25/26 revealed: -There was an entry for insulin glargine pen inject 17 units once a day every morning at 9:00am. -Lantus insulin was documented as administered daily at 9:00am from 08/01/26 to 08/25/26. Observation of Resident #3's medications on hand on 08/26/26 at 10:30am revealed: -There was a plastic storage bag in the medication cart with the resident's name handwritten on the front of the bag.	D 352		

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D 352	Continued From page 18 -The plastic storage bag contained a small black bag with a glucometer, glucometer test strips, disposable lancets, and one insulin glargine pen. -There was no prescription label on the Lantus insulin pen in the medication cart. -There was a handwritten open date of 08/14/26 on the lid of the Lantus insulin pen. -There was no label for the insulin glargine pen to indicate the name of the resident, the date of issuance, the name of the prescriber, the name and concentration of the medication, quantity dispensed, prescription serial number, directions for use, the expiration date, the name and address of the dispensing pharmacy, and the name or initials of the dispensing pharmacist. Interview with a medication aide (MA) on 08/27/26 at 10:30am revealed: -Because there was no medication label on the insulin, she used the instructions on the eMAR to see what type of insulin and how much insulin to administer to Resident #3. -She was not aware a prescription label was required for insulin glargine . -She knew which insulin belonged to Resident #3 because it was located in the plastic storage bag with her name handwritten on it. Interview with the Resident Care Coordinator (RCC) on 08/27/26 at 4:45pm revealed: -She was not aware Resident #3's insulin glargine pen was not properly labeled. -She was aware insulin products required a label with the name of the resident, the date of issuance, the name of the prescriber, the name and concentration of the medication, quantity dispensed, prescription serial number, directions for use, the expiration date, the name and address of the dispensing pharmacy, and the name or initials of the dispensing pharmacist.	D 352		

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D 352	Continued From page 19 -She was not sure why Resident #3's insulin glargine was not labeled properly. -No MAs reported to her that Resident #3's insulin glargine was not labeled properly. Interview with the Administrator on 08/27/26 at 5:17pm revealed: -Prescription medications, including insulin, should have prescription labels. -The MAs should contact the pharmacy if a medication did not have a prescription label. -The MAs should let her or the RCC know if a prescription medication did not have a label and they were unable to resolve the issue with the pharmacy. -She was not aware Resident #3's insulin glargine pen was not properly labeled. -Her expectation was that insulin products would have a label with the name of the resident, the date of issuance, the name of the prescriber, the name and concentration of the medication, quantity dispensed, prescription serial number, directions for use, the expiration date, the name and address of the dispensing pharmacy, and the name or initials of the dispensing pharmacist.	D 352		
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 20 This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Non-compliance continues with increased severity resulting in residents placed at substantial risk that death or serious physical harm, abuse, neglect or exploitation will occur. THIS IS A TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 5 of 7 sampled residents (#1, #3, #4, #5, and #7) related to medications used to treat elevated blood sugars (#4, #5), migraine frequency and nasal allergy symptoms (#1), anxiety and mental health disorders (#7), and cough, congestion, constipation, and yeast infections(#3). The findings are: Review of the facility's medication administration policy revealed: -The facility would ensure medications were administered in a safe, consistent, and compliant manner. -The facility would complete monthly audits of medication records. 1. Review of Resident #4's current FL2 dated 06/18/26 revealed diagnoses included diabetes mellitus type 2 without complication. Review of Resident #4's laboratory values dated 07/28/26 revealed: -A hemoglobin A1C (HBA1c) value of 13.9. (The hemoglobin A1C measures the average level of blood sugar over the previous 3 months. The normal A1C level is below 5.7%).	D 358		

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D 358	Continued From page 21 -A glucose value of 690 (The glucose value within a comprehensive metabolic panel (CMP) measures the amount of blood sugar present in the blood at the time the sample is drawn. The normal level is below 100.) Review of Resident #4's signed physician order dated 07/30/26 revealed: -There was an order for FSBS checks three times daily with meals. -There was an order for insulin aspart flex pen (Novolog) 100unit/ml inject 5 units (a fast-acting insulin used to lower blood sugar) three times daily with meals, hold for FSBS readings less than 140. Review of Resident #4's physician orders dated 08/06/26 revealed there was an order for insulin aspart flex pen 100unit/ml inject 10 units three times daily with meals, hold for FSBS less than 140. Review of Resident #4's physician orders dated 08/13/26 revealed there was an order insulin aspart flex pen 100unit/ml inject 20 units three times daily with meals, hold for FSBS less than 140. Review of Resident #4's physician orders dated 08/20/26 revealed there was an order insulin aspart flex pen 100unit/ml inject 30 units three times daily with meals, hold for FSBS less than 140. Review of Resident #4's August 2026 electronic medication administration record (eMAR) from 08/01/26 through 08/24/26 revealed: -There was an entry for FSBS checks three times daily with meals with a scheduled time of 6:30am, 11:00am, and 5:00pm.	D 358		

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D 358	Continued From page 22 -There was an entry for insulin aspart flex pen 100 unit/ml inject 5 units three times daily with meals to be administered at 8:00am, 12:00pm, and 5:00pm hold for FSBS less than 140 from 08/01/26 to 08/06/26. -There was a second entry for insulin aspart flex pen 100 unit/ml inject 10 units three times daily with meals to be administered at 7:30am, 11:30am, and 4:30pm hold for FSBS less than 140 from 08/07/26 to 08/14/26. -There was a third entry for insulin aspart flex pen 100 unit/ml inject 20 units three times daily with meals to be administered at 8:00am, 12:00pm, and 5:00pm hold for FSBS less than 140 from 08/14/26 to 08/20/26. -There was a fourth entry for insulin aspart flex pen 100 unit/ml inject 30 units three times daily with meals to be administered at 7:00am, 11:00am, and 5:00pm hold for FSBS less than 140 from 08/21/26 to 08/24/26. -There was documentation FSBS was checked 48 of 72 opportunities ranging from 217 to 600 from 08/01/26 to 08/24/26 with 20 opportunities where the FSBS values ranged from 500 to 600. -There was no documentation for Resident #4's FSBS values to indicate insulin aspart was held or administered on 24 occasions with examples as follows: -On 08/01/26 Resident #4's FSBS value was not documented at 6:30am and 5:00pm -On 08/02/26 Resident #4's FSBS value was not documented at 6:30am, 12:00pm, and 5:00pm. -On 08/03/26 Resident #4's FSBS value was not documented at 12:00pm. -On 08/04/26 Resident #4's FSBS value was not documented at 6:30am and 12:00pm. -On 08/06/26 Resident #4's FSBS value was not documented at 12:00pm. -On 08/07/26 Resident #4's FSBS value was not documented at 7:30am and 4:30pm.	D 358		

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D 358	Continued From page 23 -On 08/08/26 Resident #4's FSBS value was not documented at 11:30am and 4:30pm. -On 08/09/26 Resident #4's FSBS value was not documented at 7:30am. -On 08/12/26 Resident #4's FSBS value was not documented at 11:30am. -On 08/15/26 Resident #4's FSBS value was not documented at 12:00pm and 5:00pm. -On 08/16/26 Resident #4's FSBS value was not documented at 12:00pm. -On 08/17/26 Resident #4's FSBS value was not documented at 12:00pm. -On 08/19/26 Resident #4's FSBS value was not documented at 12:00pm. -On 08/20/26 Resident #4's FSBS value was not documented at 12:00pm. -On 08/21/26 Resident #4's FSBS value was not documented at 11:00am. -On 08/24/26 Resident #4's FSBS value was not documented at 7:00am and 11:00am. Observation of Resident #4's medication on hand on 08/27/26 at 11:24am revealed: -There was a insulin aspart 100units/ml flex pen on the medication cart available for administration with a dispense date of 08/12/26. -There was a insulin aspart 100 units/ml flex pen in the medication room with a dispense date of 08/20/26, unopened. Telephone interview with a representative from the facility's contracted pharmacy on 08/27/26 at 12:25pm revealed: -Resident #4 had an order for FSBS checks three times daily with meals. -Resident #4 had a current order for insulin aspart flex pen 100units/ml inject 30 units with three times daily with meals, hold for FSBS less than 140 and was last dispensed on 08/20/26. -Resident #4 had a previous order for insulin	D 358		

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D 358	Continued From page 24 aspart flex pen 100units/ml inject 5 units with three times daily with meals, hold for FSBS less than 140 and was last dispensed on 07/30/26. -Resident #4 had a second previous order for insulin aspart flex pen 100units/ml inject 10 units with three times daily with meals, hold for FSBS less than 140 and was last dispensed on 08/12/26. -Resident #4 had another previous order for insulin aspart flex pen 100 units/ml inject 20 units with three times daily with meals, hold for FSBS less than 140 which was dispensed date 08/12/26 from the order for insulin aspart 100units/ml inject 10 units. Interview with Resident #4's PCP on 08/27/26 at 10:46am revealed: -She ordered the insulin aspart to control Resident #4's high blood sugar. -She was not aware of the missing FSBS values from August 2026 for Resident #4. -She expected the medication aides (MA) to document Resident #4's FSBS and administer her insulin as ordered or Resident #4's insulin control would not be managed effectively. -Resident #4's elevated blood sugar levels were a concern and could increase, which could cause blurry vision, increased urination, weariness and fatigue, as well as increased confusion if FSBS were not documented accurately and her insulin was not administered as ordered. Interview with a medication aide (MA) on 08/27/26 at 11:45am revealed: -She administered medications to Resident #4 and she followed the medication orders in the eMAR system when administering medications to residents. -She knew there was a parameter to hold Resident #4's insulin if his FSBS was lower than	D 358		

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D 358	Continued From page 25 "some" number but she was not sure of the exact parameter number. -She was not aware the eMAR was missing FSBS values for Resident #4's insulin aspart administration in August 2026. -The Resident Care Coordinator (RCC) was responsible for eMAR audits but she had not been informed of any medication errors. Interview with the RCC on 08/27/26 at 3:20pm revealed: -She was not aware Resident #4's eMAR had missing FSBS values related to her insulin administration from August 2026. -She was not aware of who was responsible for auditing the residents' eMARs for accuracy or how often the eMARs were audited. -She expected the MAs to administer medications and record ordered parameters correctly. Interview with the Assistant Administrator on 08/27/26 at 4:00pm revealed he was not aware Resident #4's eMAR had missing FSBS values related to her insulin administration from August 2026 because he was the former RCC up until 08/03/26. Interview with the Administrator on 08/27/26 at 4:35pm revealed she was not aware Resident #4's eMAR had missing FSBS values related to her insulin administration from August 2026. Refer to the interview with RCC on 08/27/26 at 3:20pm. Refer to the interview with the Assistant Administrator on 08/27/26 at 4:00pm. Refer to the interview with the Administrator on 08/27/26 at 4:35pm.	D 358		

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D 358	Continued From page 26 2. Review of Resident #5's FL2 dated 07/17/26 revealed diagnoses included diabetes mellitus type 2. a. Review of Resident #5's FL2 dated 07/17/26 revealed an order for insulin aspart (a fast-acting insulin used to lower blood sugar) 100units/ml flex pen check FSBS and inject three times daily with meals per SSI parameters: 0-150=0u, 151-200=1u, 201-250=2u, 251-300=3u, 301-350=4u, 351-399=5u, greater than 400=6u and call provider. Review of Resident #5's laboratory values dated 07/27/26 revealed a hemoglobin A1C (HBA1c) value of 9.5. (The hemoglobin A1C measures the average level of blood sugar over the previous 3 months. The normal A1C level is below 5.7%). Review of Resident #5's July 2026 electronic medication administration record (eMAR) from 07/18/26 through 07/31/25 revealed: -There was an entry for insulin lispro 100units/ml flex pen check FSBS and inject three times daily with meals per SSI parameters: 0-150=0u, 151-200=1u, 201-250=2u, 251-300=3u, 301-350=4u, 351-399=5u, greater than 400=6u and call provider. scheduled for administration at 6:30am, 11:30am, 4:30pm, and 8:00pm with a stop date of 07/23/26. -The eMAR had a space for staff to initial after obtaining the FSBS and to document the FSBS values; but the eMAR had was no space to document the site of administration and to document the amount of insulin aspart administered from 07/18/26 to 07/23/26. -There was no documentation for the amount of insulin aspart administered for 17 of 17 opportunities from 07/18/26 to 07/23/26.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF ROCKWELL RETIREMENT	612 HIGHWAY 152 EAST ROCKWELL, NC 28138

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 27 -FSBS ranged from 134 to 599. -There were no additional notes docuemented in the eMAR to explain why the amount of insulin aspart was not documented as administered from 07/18/26 to 07/23/26. Observation of medications on hand for Resident #5 on 08/27/26 at 9:20am revealed Lispro flex pen insulin was available for administration and labeled with a dispense date of 07/17/26 with instruction to inject per SSI parameters: 0-150=0 units, 151-200=1 unit, 201-250=2 units, 251-300=3 units, 301-350=4 units, 351-399=5 units, greater than 400=6 units dispensed 07/17/26. Telephone interview with a representative from the facility's contracted pharmacy on 08/27/26 at 12:25pm revealed: -Resident #5 had a previous order dated 07/17/26 for Lispro flex pen check FSBS three times a day with meals and inject per SSI parameters: 0-150=0u, 151-200=1u, 201-250=2u, 251-300=3u, 301-350=4u, 351-399=5u, greater than 400=6u and call provider and was dispensed on 07/17/26. -Resident #5's order had not been discontinued on 07/23/26. Interview with Resident #5's primary care provider (PCP) on 08/27/26 at 10:45am revealed: -She expected the facility staff to administer Resident #5's insulin lispro per the sliding scale and document how many units of insulin were administered. -She would not be able to tell if Resident #5 received the correct amount of insulin if it was not documented. Interview with a medication aide (MA) on	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

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D 358	Continued From page 28 08/27/26 at 12:45pm revealed: -She was aware of Resident #5's previous insulin parameters with FSBS of 3 times a day with meals. -She was aware the eMAR system did not have a space on the order entry to document the amount of insulin administered but she documented information how the eMAR system allowed her. -She had not brought it to the attention of the Special Care Coordinator (SCC) because she thought it was part of the new eMAR system process. -She was not aware of any additional methods to document the amount of insulin units administered to Resident #5. -She had administered Resident #5's lispro insulin through the middle of July 2026. -The SCC was responsible for auditing the eMARS for accuracy and for updating orders in the Special Care Unit (SCU). Interview with the Administrator on 08/27/26 at 4:35pm revealed she was not aware Resident #5's eMAR had missing insulin administration amounts from July 2026. Refer to the interview with the Administrator on 08/27/26 at 4:35pm. Attempted interview with SCC on 08/27/26 at 3:09pm was unsuccessful. Attempted telephone interview with Resident #5's responsible party on 08/27/26 at 1:48pm was unsuccessful. Based upon observations, interviews, and record reviews it was determined Resident #5 was not interviewable.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 29 b. Review of Resident #5's signed physician order dated 07/24/26 revealed: -There was an order for FSBS checks three times daily with meals. -There was an order for insulin lispro Kwik pen (Humalog) 100unit/ml inject 2 units (a fast-acting insulin used to lower blood sugar) three times daily with meals, hold for FSBS readings less than 140. Review of Resident #5's signed physician order dated 08/17/26 revealed: -There was an order for FSBS checks three times daily with meals. -There was an order for insulin lispro flex pen (Novolog) 100unit/ml inject 2 units (a fast-acting insulin used to lower blood sugar) three times daily with meals, hold for FSBS readings less than 140. Review of Resident #5's July 2026 electronic medication administration record (eMAR) from 07/01/26 through 07/31/26 revealed: -There was an entry for insulin lispro (Humalog) Kwik pen 100 unit/ml inject 2 units three times daily with meals to be administered at 7:00am, 11:00am, and 5:00pm hold for FSBS less than 140 from 07/23/26 to 07/31/26. -There was documentation FSBS was checked 25 of 25 opportunities ranging from 217 to 600 from 07/23/26 to 07/3126 with 2 opportunities where the FSBS values ranged from 119-132. -There was no documentation to indicate insulin lispro was held or administered for two times when Resident #5's FSBS were less than 140 with examples as follows: -On 08/26/26 Resident #5's FSBS value was not documented at 5:00pm. -On 08/30/26 Resident #5's FSBS value was not documented at 5:00pm.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 30 Review of Resident #5's August 2026 electronic medication administration record (eMAR) from 08/01/26 through 08/24/26 revealed: -There was an entry for insulin lispro (Humalog) Kwik pen 100 unit/ml inject 2 three times daily with meals to be administered at 7:00am, 11:00am, and 5:00pm hold for FSBS less than 140 from 08/01/26 to 08/18/26. -There was a second entry for insulin aspart (Novolog) flex pen 100 unit/ml inject 2 units three times daily with meals to be administered at 7:00am, 11:00am, and 5:00pm hold for FSBS less than 140 from 08/19/26 to 08/24/26. -There was documentation FSBS was checked 72 of 72 opportunities ranging from 81 to 397 from 08/01/26 to 08/24/26 with 14 opportunities where the FSBS values ranged from 81 to 139. -There was no documentation for Resident #4's FSBS values to indicate insulin was held or administered fourteen times with examples as follows: -On 08/03/26 Resident #5's FSBS value was documented as 102 at 7:00am. -On 08/16/26 Resident #5's FSBS value was documented as 106 at 7:00pm. -On 08/16/26 Resident #5's FSBS value was documented as 97 at 11:00am -On 08/16/26 Resident #5's FSBS value was documented as 114 at 5:00pm. -On 08/17/26 Resident #5's FSBS value was documented as 81 at 7:00am. -On 08/17/26 Resident #5's FSBS value was documented as 126 at 11:00am. -On 08/19/26 Resident #5's FSBS value was documented as 121 at 7:00am. -On 08/19/26 Resident #5's FSBS value was documented as 131 at 5:00pm. -On 08/20/26 Resident #5's FSBS value was documented as 138 at 7:00am.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 31 -On 08/23/26 Resident #5's FSBS value was documented as 139 at 7:30am. -On 08/23/26 Resident #5's FSBS value was documented as 130 at 5:00pm. -On 08/24/26 Resident #5's FSBS value was documented as 119 at 7:00am. -On 08/24/26 Resident #5's FSBS value was documented as 119 at 11:00am. -On 08/24/26 Resident #5's FSBS value was documented as 133 at 7:00pm. Observation of Resident #5's medication on hand on 08/27/26 at 9:20am revealed: -There was a insulin aspart (Novolog) 100units/ml flex pen on the medication cart available for administration that was dispensed on 08/18/26. -An insulin lispro (Humalog) 100 units/ml Kwik pen was not on the medication cart. Telephone interview with a representative from the facility's contracted pharmacy on 08/27/26 at 12:25pm revealed: -Resident #5 had a current order for insulin aspart (Novolog) 100units/ml inject 2 units with three times daily with meals, hold for FSBS less than 140 and was last dispensed on 08/18/26. -Resident #5 had a previous order for insulin lispro (Humalog) 100units/ml inject 2 units with three times daily with meals, hold for FSBS less than 140 and was last dispensed on 08/15/26 and 7/25/26. Interview with Resident #5's primary care provider (PCP) on 08/27/26 at 10:45am revealed: -She ordered the insulin aspart to control Resident #5's blood sugar levels. -She expected the medication aides (MA) to document Resident #5's FSBS and administer her insulin as ordered or Resident #5's insulin control would not be managed effectively.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 32	D 358		

-Resident #5's low blood sugar levels were a concern and could increase, which could cause shakiness, dizziness, headaches, and increased anxiety if FSBS were not documented accurately and her insulin was not administered as ordered.

Interview with a MA on 08/27/26 at 9:20am revealed:
-She administered medications to Resident #5 and she followed the medication orders in the eMAR system when administering medications to residents.
-She knew there was a parameter to hold Resident #5's insulin if his FSBS was lower than "some" number but she was not sure of the exact parameter number.
-She was not aware of the eMAR occurrences where it was not documented whether Resident #5's insulin was administered or held from July 2026 and August 2026.
-The SCC was responsible for eMAR audits but she had not been informed of any medication errors.

Interview with the Administrator on 08/27/26 at 4:35pm revealed she was not aware of the eMAR occurrences where it was not documented whether Resident #5's insulin was administered or held from July 2026 and August 2026.

Refer to the interview with the Administrator on 08/27/26 at 4:35pm.

Attempted interview with SCC on 08/27/26 at 3:09pm was unsuccessful.

Attempted telephone interview with Resident #5's responsible party on 08/27/26 at 1:48pm was unsuccessful.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 33 Based upon observations, interviews, and record reviews it was determined Resident #5 was not interviewable. 3. Review of Resident #1's FL2 dated 06/04/26 revealed diagnoses included essential hypertension, unspecified acute ischemic heart disease, prediabetes, and recurrent major depressive disorder. a. Review of Resident #1's signed physician's orders dated 06/04/26 revealed there was an order for amitriptyline (used for migraine prevention) 25mg take 1 tablet at bedtime for migraines. Review of Resident #1's June 2026 electronic medication administration record (eMAR) revealed: -There was an entry for amitriptyline 25mg take 1 tablet at bedtime for migraines scheduled for administration at 8:00pm from 06/01/26 to 06/30/26. -There was documentation amitriptyline was administered from 06/01/26 to 06/30/26. Review of Resident #1's July 2026 eMAR revealed: -There was an entry for amitriptyline 25mg take 1 tablet at bedtime for migraines scheduled for administration at 8:00pm from 07/01/26 to 07/31/26. -There was documentation amitriptyline was administered from 07/01/26 to 07/31/26. Review of Resident #1's August 2026 eMAR from 08/1/26 to 08/24/26 revealed: -There was an entry for amitriptyline 25mg take 1 tablet at bedtime for migraines scheduled for administration at 8:00pm.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

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D 358	Continued From page 34 -There was documentation amitriptyline was administered from 08/01/26 to 08/24/26. Observation of Resident #1's medications on hand on 08/27/26 at 11:10am revealed there was no amitriptyline 25mg available for administration. Interview with Resident #1 on 08/27/26 at 2:10pm revealed: -He relied on the medication aides (MA) to give him his medication and was not sure if he had received all of his medications recently. -He had not experienced any recent migraines or any pain. Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/27/26 at 12:25pm revealed: -Resident #1 had a current order on file for amitriptyline 25mg take 1 tablet at bedtime for migraines -Resident #1's amitriptyline 25mg was last dispensed on 08/14/26 for a quantity of 2 tablets for a two-day supply due Resident #1's refill orders ran out and needed a new prescription. -The pharmacy had not received a refill request or a new order from the facility staff. Telephone interview with Resident #1's PCP on 08/27/26 at 2:25pm revealed: -She had ordered Resident #1 amitriptyline due to his history of migraines. -She was not aware the facility did not have the amitriptyline available for administration for Resident #1. -She expected the facility to have the amitriptyline available for administration for Resident #1 and she expected the facility to communicate with her for order refills. -She expected MAs to administer medications as	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

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D 358	Continued From page 35 ordered for the resident's. Interview with a MA on 08/27/26 at 10:36am revealed: -She administered Resident #1's medications according to the eMAR entries. -She was not aware there was no amitriptyline available for administration for Resident #1 until today 08/27/26. -She was not sure why documentation reflected that amitriptyline was administered to Resident #1 despite no amitriptyline being available on the medication cart. -The Resident Care Coordinator (RCC) was responsible for medication cart audits to ensure medications were available for residents. Interview with the RCC on 08/27/26 at 3:20pm revealed she was not aware Resident #1's amitriptyline was not available on the medication cart for administration. Interview with the Administrator on 08/13/25 at 4:35pm revealed she was not aware Resident #1's amitriptyline was not available on the medication cart for administration. Refer to the interview with RCC on 08/27/26 at 3:20pm. Refer to the interview with the Assistant Administrator on 08/27/26 at 4:00pm. Refer to the interview with the Administrator on 08/27/26 at 4:35pm. b. Review of Resident #1's signed physician's orders dated 06/04/26 revealed there was an order for fluticasone nasal spray (used to manage nasal and allergy symptoms) 50mcg instill 1 spray	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 36 in each nostril twice daily. Review of Resident #1's June 2026 electronic medication administration record (eMAR) revealed: -There was an entry for fluticasone spray 50mcg instill 1 spray in each nostril twice daily scheduled for administration at 9:00am and 9:00pm from 06/01/26 to 06/30/26. -There was documentation fluticasone was administered from 06/01/26 to 06/30/26. Review of Resident #1's July 2026 eMAR revealed: -There was an entry for fluticasone spray 50mcg instill 1 spray in each nostril twice daily scheduled for administration at 9:00am and 9:00pm from 07/01/26 to 07/31/26. -There was documentation fluticasone was administered from 07/01/26 to 07/31/26. Review of Resident #1's August 2026 eMAR from 08/1/26 to 08/24/26 revealed: -There was an entry for fluticasone spray 50mcg instill 1 spray in each nostril twice daily scheduled for administration at 9:00am and 9:00pm scheduled for administration at 9:00am and 9:00pm. -There was documentation fluticasone was administered from 08/01/26 to 08/24/26. Observation of Resident #1's medications on hand on 08/27/26 at 11:10am revealed there was no fluticasone spray 50mcg available for administration. Interview with Resident #1 on 08/27/26 at 2:10pm revealed: -He relied on the MAs to give him his medication was not sure if he had received all of his	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 37	D 358		

medications recently.
-He had not experienced any nasal or sinus issues recently.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/27/26 at 12:25pm revealed:
-Resident #1 had a current order on file for fluticasone spray 50mcg instill 1 spray in each nostril twice daily.
-Resident #1's fluticasone was last dispensed on 07/03/26 for a 30-day supply.
-The pharmacy had not received a refill request from the facility staff.

Telephone interview with Resident #1's PCP on 08/27/26 at 2:25pm revealed:
-She had ordered Resident #1 fluticasone spray due to his history of sinus issues and headaches.
-She was not aware the facility did not have the fluticasone available for administration for Resident #1.
-She expected the facility to have the fluticasone available for administration for Resident #1 and she expected the facility to communicate with her for order refills.
-She expected MAs to administer medications as ordered for the resident's.

Interview with a MA on 08/27/26 at 10:36am revealed:
-She administered Resident #1's medications according to the eMAR entries.
-She was not aware there was no fluticasone available for administration for Resident #1 until today 08/27/26.
-She was not sure why documentation reflected that fluticasone was administered to Resident #1 despite no fluticasone being available on the medication cart.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF ROCKWELL RETIREMENT	612 HIGHWAY 152 EAST ROCKWELL, NC 28138

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D 358	Continued From page 38 -The RCC was responsible for medication cart audits to ensure medications were available for residents. Interview with the RCC on 08/27/26 at 3:20pm revealed she was not aware Resident #1's fluticasone was not available on the medication cart for administration. Interview with the Administrator on 08/13/25 at 4:35pm revealed she was not aware Resident #1's fluticasone was not available on the medication cart for administration. Refer to the interview with RCC on 08/27/26 at 3:20pm. Refer to the interview with the Assistant Administrator on 08/27/26 at 4:00pm. Refer to the interview with the Administrator on 08/27/26 at 4:35pm. 4. Review of Resident #7's current FL2 dated 04/30/26 revealed diagnoses included post-traumatic stress disorder, type 2 diabetes mellitus and chronic obstructive pulmonary disease. a. Review of Resident #7's physician orders signed 06/13/26 revealed: -There was an order to stop clonazepam (a medication used to help manage anxiety) 0.5mg, one tablet daily. -There was an order to start clonazepam 0.5mg, half a tablet daily. Review of Resident #7's June 2026 electronic medication administration record (eMAR) from	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF ROCKWELL RETIREMENT	612 HIGHWAY 152 EAST ROCKWELL, NC 28138

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 39 06/13/26 to 06/30/26 revealed: -There was an entry for clonazepam 0.5mg, one tablet daily, scheduled for administration at 8:00am. -There was documentation clonazepam 0.5mg, one tablet was administered daily at 8:00am from 06/13/26 to 06/30/26. -There was no entry or documentation for clonazepam 0.5mg, half a tablet from 06/13/26 to 06/30/26. Review of Resident #7's July 2026 eMAR revealed: -There was an entry for clonazepam 0.5mg, one tablet daily, scheduled for administration at 8:00am. -There was documentation clonazepam 0.5mg, one tablet was administered daily at 8:00am. -There was no entry or documentation for clonazepam 0.5mg, half a tablet. Review of Resident #7's August 2026 eMAR from 08/01/26 to 08/25/26 revealed: -There was an entry for clonazepam 0.5mg, one tablet daily, scheduled for administration at 8:00am. -There was documentation clonazepam 0.5mg, one tablet was administered daily at 8:00am. -There was no entry or documentation for clonazepam 0.5mg, half a tablet from 08/01/26 to 08/25/26. Observation of the medications on hand for Resident #7 on 08/26/26 at 10:21am revealed there was no medication cards labeled for clonazepam 0.5mg, half tablet daily. Telephone interview with a representative from the facilities contracted pharmacy on 08/27/26 at 12:30pm revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF ROCKWELL RETIREMENT	612 HIGHWAY 152 EAST ROCKWELL, NC 28138

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D 358	Continued From page 40 -There was an active order for clonazepam 0.5mg, take one tablet daily for Resident #7. -There was not an order in their system for clonazepam 0.5mg, take half tablet daily for Resident #7. -They last dispensed Resident #7's clonazepam 0.5mg, take one tablet daily, on 07/30/26 for a 30 day supply. Interview with Resident #3's psychiatric provider on 08/27/26 at 1:00pm revealed: -She intended for the facility to implement Resident #7's clonazepam 0.5mg take half a tablet daily order. -She decreased Resident #7's clonazepam 0.5mg to decrease his daytime fatigue. -She visited the facility every 2 weeks. -Last time she visited the facility, she received reports from staff that Resident #7 had increased sedation. -She sent new medication orders electronically directly to the facilities contracted pharmacy. -She had confirmation of the electronic prescription for Resident #7's clonazepam 0.5 take half a tablet daily, that she sent to the pharmacy on 06/13/26. Interview with a medication aide (MA) on 08/27/26 at 4:48pm revealed: -She administered medications to Resident #7 sometimes. -She was not aware of Resident #7's clonazepam 0.5mg take half a tablet daily order. -If the order change was not on the eMAR she would not have known about it. -MAs did not receive new orders from providers. Interview with the Resident Care Coordinator (RCC) on 08/27/26 at 3:40pm revealed: -She was not aware of Resident #7's clonazepam	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF ROCKWELL RETIREMENT	612 HIGHWAY 152 EAST ROCKWELL, NC 28138

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 41	D 358		

0.5mg take half a tablet daily order.
-The psychiatric provider typically sent electronic prescriptions straight to the pharmacy when she added or changed a medication order.
-She started as the RCC on 08/03/26.

Interview with the Administrator on 08/27/26 at 5:35pm revealed:
-She was not aware of Resident #7's clonazepam 0.5mg take half a tablet daily order.
-It may have been a clerical oversight on why Resident #7's clonazepam 0.5mg take half a tablet daily order was missed.
-She expected all order changes to be implemented within a timely manner.

Refer to the interview with RCC on 08/27/26 at 3:20pm.

Refer to the interview with the Assistant Administrator on 08/27/26 at 4:00pm.

Refer to the interview with the Administrator on 08/27/26 at 4:35pm.

b. Review of Resident #7's physician orders signed 06/13/26 revealed:
-There was an order to stop olanzapine (a medication used to manage mental health) 20mg, one tablet at bedtime.
-There was an order to start olanzapine 15mg, one tablet at bedtime.

Review of Resident #7's June 2026 electronic medication administration record (eMAR) from 06/13/26 to 06/30/26 revealed:
-There was an entry for olanzapine 20mg, one tablet at bedtime, scheduled for administration at 8:00pm.
-There was documentation olanzapine 20mg, one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF ROCKWELL RETIREMENT	612 HIGHWAY 152 EAST ROCKWELL, NC 28138

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 42	D 358		

tablet was administered at 8:00pm.
-There was no entry or documentation for olanzapine 15mg, one tablet at bedtime.

Review of Resident #7's July 2026 eMAR revealed:
-There was an entry for olanzapine 20mg, one tablet at bedtime, scheduled for administration at 8:00pm.
-There was documentation olanzapine 20mg, one tablet was administered at 8:00pm
-There was no entry or documentation for olanzapine 15mg, one tablet at bedtime.

Review of Resident #7's August 2026 eMAR from 08/01/26 to 08/25/26 revealed:
-There was an entry for olanzapine 20mg, one tablet at bedtime, scheduled for administration at 8:00pm.
-There was documentation olanzapine 20mg, one tablet was administered at 8:00pm
-There was no entry or documentation for olanzapine 15mg, one tablet at bedtime.

Observation of the medications on hand for Resident #7 on 08/26/26 at 10:21am revealed there was a multidose medication packet which included olanzapine 20mg, one tablet at bedtime, printed 08/20/26.

Telephone interview with a representative from the facility's contracted pharmacy on 08/27/26 at 12:30pm revealed:
-There was an active order for olanzapine 20mg, one tablet at bedtime, for Resident #7.
-There was not an order in their system for olanzapine 15mg, one tablet at bedtime, for Resident #7.
-They last dispensed Resident #7's olanzapine 20mg, one tablet at bedtime, on 08/21/26 for a 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF ROCKWELL RETIREMENT	612 HIGHWAY 152 EAST ROCKWELL, NC 28138

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 43 day supply. Interview with Resident #3's psychiatric provider on 08/27/26 at 1:00pm revealed: -She intended for the facility to implement Resident #7's olanzapine 15mg, one tablet at bedtime order. -She decreased Resident #7's olanzapine to decrease his daytime fatigue. -She visited the facility every 2 weeks. -Last time she visited the facility, she received reports from staff that Resident #7 had increased sedation. -She sent new medication orders electronically directly to the facilities contracted pharmacy. -She had confirmation of the electronic prescription for Resident #7's olanzapine 15mg, one tablet at bedtime, that she sent to the pharmacy on 06/13/26. Interview with a medication aide (MA) on 08/27/26 at 4:48pm revealed: -She administered medications to Resident #7 sometimes. -She was not aware Resident #7's olanzapine 15mg one tablet at bedtime order. -If the order change was not on the eMAR she would not have known about it. -MAs did not receive new medication orders from providers. Interview with the Resident Care Coordinator (RCC) on 08/27/26 at 3:40pm revealed: -She was not aware of Resident #7's olanzapine 15mg one tablet at bedtime order. -The psychiatric provider typically sent electronic prescriptions straight to the pharmacy when she added or changed a medication order. -She started as the RCC on 08/03/26.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF ROCKWELL RETIREMENT	612 HIGHWAY 152 EAST ROCKWELL, NC 28138

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D 358	Continued From page 44 Interview with the Administrator on 08/27/26 at 5:35pm revealed: -She was not aware of Resident #7's olanzapine 15mg one tablet at bedtime order. -It may have been a clerical oversight on why Resident #7's c olanzapine 15mg one tablet at bedtime order was missed. -She expected all order changes to be implemented within a timely manner. Refer to the interview with RCC on 08/27/26 at 3:20pm. Refer to the interview with the Assistant Administrator on 08/27/26 at 4:00pm. Refer to the interview with the Administrator on 08/27/26 at 4:35pm. 5. Review of Resident #3's current FL2 dated 01/20/26 revealed diagnoses included seasonal allergies, depression, type 2 diabetes and hypertension. a. Review of Resident #3's physician orders signed 08/17/26 revealed there was an order for diabetic tussin (a medication used to treat cough and chest congestion) 20-400mg, take 30mL every 4 hours as needed for cough. Review of Resident #3's June 2026 electronic medication administration record (eMAR) revealed: -There was an entry for diabetic tussin 20-400mg, take 30mL every 4 hours as needed, scheduled for administration as needed. -There was documentation diabetic tussin 20-400mg was administered one time on 06/15/26.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF ROCKWELL RETIREMENT	612 HIGHWAY 152 EAST ROCKWELL, NC 28138

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 45 Review of Resident #3's July 2026 eMAR revealed: -There was an entry for diabetic tussin 20-400mg, take 30mL every 4 hours as needed, scheduled for administration as needed. -There was no documentation for diabetic tussin 20-400mg. Review of Resident #3's August 2026 eMAR from 08/01/26 to 08/25/26 revealed: -There was an entry for diabetic tussin 20-400mg, take 30mL every 4 hours as needed, scheduled for administration as needed. -There was no documentation for diabetic tussin 20-400mg. Observation of the medications on hand for Resident #3 on 08/26/26 at 10:30am revealed there was no diabetic tussin 20-400mg available for administration. Telephone interview with a representative from the facilities contracted pharmacy on 08/27/26 at 12:30pm revealed: -There was an active order for diabetic tussin 20-400mg for Resident #3. -Diabetic tussin 20-400mg was an over-the-counter (OTC) medication. -There was a note on Resident #3's profile that stated, "family supplied OTC medications". -They had never dispensed diabetic tussin 20-400mg for Resident #3 because it was an OTC medication. Interview with Resident #3's Primary Care Provider (PCP) on 08/27/26 at 1:00pm revealed: -Resident #3's family supplied OTC medications. -No staff reported to her that Resident #3 did not have diabetic tussin 20-400mg available for administration.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 46	D 358		

-She expected the facility to have diabetic tussin 20-400mg available for Resident #3 in case she needed it.
-She expected the facility to reach out the Resident #3's family if diabetic tussin 20-400mg was not available for administration.
-If Resident #3 did not have diabetic tussin 20-400mg available for administration, she was at risk for cough and chest congestion.

Interview with Resident #3's responsible party on 08/27/26 at 1:21pm revealed:
-She supplied the facility with a new bottle of diabetic tussin 20-400mg for Resident #3 several months ago when Resident #3 had a cold.
-Because it was a new bottle of diabetic tussin 20-400mg so it should not have expired.
-She was not aware Resident #3 did not have diabetic tussin 20-400mg available for administration.
-No one from the facility let her know Resident #3 did not have diabetic tussin 20-400mg available for administration.

Interview with Resident #3 on 08/27/26 at 1:30pm revealed she was not aware she did not have diabetic tussin 20-400mg available for administration.

Interview with a medication aide (MA) on 08/27/26 at 1:01pm revealed:
-She administered medications to Resident #3 sometimes.
-She was not aware Resident #3 did not have diabetic tussin 20-400mg available for administration.
-She was not sure why Resident #3 did not have diabetic tussin 20-400mg available for administration.
-Resident #3 never requested diabetic tussin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF ROCKWELL RETIREMENT	612 HIGHWAY 152 EAST ROCKWELL, NC 28138

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D 358	Continued From page 47 20-400mg on her shift. Interview with the Resident Care Coordinator (RCC) on 08/27/26 at 3:33pm revealed: -She was not aware Resident #3 did not have diabetic tussin 20-400mg available for administration. -There was no reason that Resident #3 did not have diabetic tussin 20-400mg available for administration. -No staff reported to her that Resident #3 did not have diabetic tussin 20-400mg available for administration. Interview with the Administrator on 08/27/26 at 5:35pm revealed: -She was not aware Resident #3 did not have diabetic tussin 20-400mg available for administration. -She expected Resident #3 to have diabetic tussin 20-400mg available for administration. Refer to the interview with RCC on 08/27/26 at 3:20pm. Refer to the interview with the Assistant Administrator on 08/27/26 at 4:00pm. Refer to the interview with the Administrator on 08/27/26 at 4:35pm. b. Review of Resident #3's physician orders signed 08/17/26 revealed there was an order for guaifenesin (a medication used to relieve chest congestion) 200mg, take 1 tablet every 6 hours as needed for cough or congestion. Review of Resident #3's June 2026 electronic medication administration record (eMAR) revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF ROCKWELL RETIREMENT	612 HIGHWAY 152 EAST ROCKWELL, NC 28138

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 48 -There was an entry for guaifenesin 200mg, take 1 tablet every 6 hours as needed, scheduled for administration as needed. -There was no documentation that guaifenesin 200mg was administered. Review of Resident #3's July 2026 eMAR revealed: -There was an entry or for guaifenesin 200mg, take 1 tablet every 6 hours as needed, scheduled for administration as needed. -There was no documentation that guaifenesin 200mg was administered. Review of Resident #3's August 2026 eMAR from 08/01/26 to 08/25/26 revealed: -There was an entry for guaifenesin 200mg, take 1 tablet every 6 hours as needed, scheduled for administration as needed. -There was no documentation that guaifenesin 200mg was administered. Observation of the medications on hand for Resident #3 on 08/26/26 at 10:30am revealed there was no guaifenesin 200mg available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 08/27/26 at 12:30pm revealed: -There was an active order for guaifenesin 200mg for Resident #3. - guaifenesin 200mg was an over-the-counter (OTC) medication. -There was a note on Resident #3's profile that stated, "family supplied OTC medications". -They had never dispensed guaifenesin 200mg for Resident #3 because it was an OTC medication.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 49 Interview with Resident #3's Primary Care Provider (PCP) on 08/27/26 at 1:00pm revealed: -Resident #3's family supplied OTC medications. -No staff reported to her that Resident #3 did not have guaifenesin 200mg available for administration. -She expected the facility to have guaifenesin 200mg available for Resident #3 in case she needed it. -She expected the facility to reach out to the family of Resident #3 if guaifenesin 200mg was not available for administration. -If Resident #3 did not have guaifenesin 200mg available for administration, she was at risk for cough and chest congestion. Interview with Resident #3's responsible party on 08/27/26 at 1:21pm revealed: -She supplied the facility with guaifenesin 200mg for Resident #3 several months ago when Resident #3 had a cold. -The guaifenesin 200mg should not have expired. -She was not aware Resident #3 did not have guaifenesin 200mg available for administration. -No one from the facility let her know Resident #3 did not have guaifenesin 200mg available for administration. Interview with Resident #3 on 08/27/26 at 1:30pm revealed she was not aware she did not have guaifenesin 200mg available for administration. Interview with a medication aide (MA) on 08/27/26 at 1:01pm revealed: -She administered medications to Resident #3 sometimes. -She was not aware Resident #3 did not have guaifenesin 200mg available for administration. -She was not sure why Resident #3 did not have guaifenesin 200mg available for administration.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF ROCKWELL RETIREMENT	612 HIGHWAY 152 EAST ROCKWELL, NC 28138

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 50 -Resident #3 never requested guaifenesin 200mg on her shift. Interview with the Resident Care Coordinator (RCC) on 08/27/26 at 3:33pm revealed: -She was not aware Resident #3 did not have guaifenesin 200mg available for administration. -There was no reason that Resident #3 did not have guaifenesin 200mg available for administration. -No staff reported to her that Resident #3 did not have guaifenesin 200mg available for administration. Interview with the Administrator on 08/27/26 at 5:35pm revealed: -She was not aware Resident #3 did not have guaifenesin 200mg available for administration. -She expected Resident #3 to have guaifenesin 200mg available for administration. Refer to the interview with RCC on 08/27/26 at 3:20pm. Refer to the interview with the Assistant Administrator on 08/27/26 at 4:00pm. Refer to the interview with the Administrator on 08/27/26 at 4:35pm. c. Review of Resident #3's physician orders signed 08/17/26 revealed there was an order for docusate sodium (a medication used to relieve constipation) 250mg, take 1 tablet daily as needed for constipation. Review of Resident #3's June 2026 electronic medication administration record (eMAR) revealed: -There was an entry for docusate sodium 250mg,	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF ROCKWELL RETIREMENT	612 HIGHWAY 152 EAST ROCKWELL, NC 28138

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 51	D 358		

take 1 tablet daily as needed, scheduled for administration as needed.
-There was no documentation that docusate sodium 250mg was administered.

Review of Resident #3's July 2026 eMAR revealed:
-There was an entry for docusate sodium 250mg, take 1 tablet daily as needed, scheduled for administration as needed.
-There was no documentation that docusate sodium 250mg was administered.

Review of Resident #3's August 2026 eMAR from 08/01/26 to 08/25/26 revealed:
-There was an entry for docusate sodium 250mg, take 1 tablet daily as needed, scheduled for administration as needed.
-There was no documentation that docusate sodium 250mg was administered.

Observation of the medications on hand for Resident #3 on 08/26/26 at 10:30am revealed there was no docusate sodium 250mg available for administration on the medication cart.

Telephone interview with a representative from the facilities contracted pharmacy on 08/27/26 at 12:30pm revealed:
-There was an active order for docusate sodium 250mg for Resident #3.
-Docusate sodium 250mg was an over-the-counter (OTC) medication.
-There was a note on Resident #3's profile that stated, "family supplied OTC medications".
-They had never dispensed docusate sodium 250mg for Resident #3 because it was an OTC medication.

Interview with Resident #3's Primary Care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 52 Provider (PCP) on 08/27/26 at 1:00pm revealed: -Resident #3's family supplied OTC medications. -No staff reported to her that Resident #3 did not have docusate sodium 250mg available for administration. -She expected the facility to have docusate sodium 250mg available for Resident #3 in case she needed it. -She expected the facility to reach out to the family of Resident #3 if docusate sodium 250mg was not available for administration. -If Resident #3 did not have docusate sodium 250mg available for administration, she was at risk for constipation. Interview with Resident #3's responsible party on 08/27/26 at 1:21pm revealed: -She supplied the facility with docusate sodium 250mg for Resident #3 several months ago. -The docusate sodium 250mg should not have expired. -She was not aware Resident #3 did not have docusate sodium 250mg available for administration. -No one from the facility let her know Resident #3 did not have docusate sodium 250mg available for administration. Interview with Resident #3 on 08/27/26 at 1:30pm revealed she was not aware she did not have docusate sodium 250mg available for administration. Interview with a medication aide (MA) on 08/27/26 at 1:01pm revealed: -She administered medications to Resident #3 sometimes. -She was not aware Resident #3 did not have docusate sodium 250mg available for administration.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

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D 358	Continued From page 53 -She was not sure why Resident #3 did not have docusate sodium 250mg available for administration. -Resident #3 never requested docusate sodium 250mg on her shift. Interview with the Resident Care Coordinator (RCC) on 08/27/26 at 3:33pm revealed: -She was not aware Resident #3 did not have docusate sodium 250mg available for administration. -There was no reason that Resident #3 did not have docusate sodium 250mg available for administration. -No staff reported to her that Resident #3 did not have docusate sodium 250mg available for administration. Interview with the Administrator on 08/27/26 at 5:35pm revealed: -She was not aware Resident #3 did not have docusate sodium 250mg available for administration. -She expected Resident #3 to have docusate sodium 250mg available for administration. Refer to the interview with RCC on 08/27/26 at 3:20pm. Refer to the interview with the Assistant Administrator on 08/27/26 at 4:00pm. Refer to the interview with the Administrator on 08/27/26 at 4:35pm. d. Review of Resident #3's physician orders signed 08/17/26 revealed there was an order for lactulose (a medication used to relieve constipation) 10gm/15mL, give 30mL daily as needed for constipation.	D 358		

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	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

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D 358	Continued From page 54 Review of Resident #3's June 2026 electronic medication administration record (eMAR) revealed: -There was an entry for lactulose 10gm/15mL, give 30mL daily as needed for constipation, scheduled for administration as needed. -There was no documentation that lactulose 10gm/15mL was administered. Review of Resident #3's July 2026 eMAR revealed: -There was an entry for lactulose 10gm/15mL, give 30mL daily as needed for constipation, scheduled for administration as needed. -There was no documentation that lactulose 10gm/15mL was administered. Review of Resident #3's August 2026 eMAR from 08/01/26 to 08/25/26 revealed: -There was an entry for lactulose 10gm/15mL, give 30mL daily as needed for constipation, scheduled for administration as needed. -There was no documentation that lactulose 10gm/15mL was administered. Observation of the medications on hand for Resident #3 on 08/26/26 at 10:30am revealed there was no lactulose 10gm/15mL available for administration. Telephone interview with a representative from the facilities contracted pharmacy on 08/27/26 at 12:30pm revealed: -There was an active order for lactulose 10gm/15mL for Resident #3. -Lactulose 10gm/15mL was last dispensed on 07/13/26 for a 15 day supply for Resident #3. Interview with Resident #3's Primary Care	D 358		

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D 358	Continued From page 55	D 358		

Provider (PCP) on 08/27/26 at 1:00pm revealed:
-No staff reported to her that Resident #3 did not have lactulose 10gm/15mL available for administration.
-She expected the facility to have lactulose 10gm/15mL available for Resident #3 in case she needed it.
-She expected the facility to reach out to the pharmacy if lactulose 10gm/15mL was not available for administration.
-If Resident #3 did not have lactulose 10gm/15mL available for administration, she was at risk for constipation.

Interview with Resident #3's responsible party on 08/27/26 at 1:21pm revealed she was not aware Resident #3 did not have lactulose 10gm/15mL available for administration.

Interview with Resident #3 on 08/27/26 at 1:30pm revealed she was not aware she did not have lactulose 10gm/15mL available for administration.

Interview with a medication aide (MA) on 08/27/26 at 1:01pm revealed:
-She administered medications to Resident #3 sometimes.
-She was not aware Resident #3 did not have lactulose 10gm/15mL available for administration.
-She was not sure why Resident #3 did not have lactulose 10gm/15mL available for administration.
-Resident #3 never requested lactulose 10gm/15mL on her shift.

Interview with the Resident Care Coordinator (RCC) on 08/27/26 at 3:33pm revealed:
-She was not aware Resident #3 did not have lactulose 10gm/15mL available for administration.
-There was no reason that Resident #3 did not have lactulose 10gm/15mL available for

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D 358	Continued From page 56	D 358		

administration.
-No staff reported to her that Resident #3 did not have lactulose 10gm/15mL available for administration.

Interview with the Administrator on 08/27/26 at 5:35pm revealed:
-She was not aware Resident #3 did not have lactulose 10gm/15mL available for administration.
-She expected Resident #3 to have lactulose 10gm/15mL available for administration.

Refer to the interview with RCC on 08/27/26 at 3:20pm.

Refer to the interview with the Assistant Administrator on 08/27/26 at 4:00pm.

Refer to the interview with the Administrator on 08/27/26 at 4:35pm.

e. Review of Resident #3's physician orders signed 08/17/26 revealed there was an order for lidocaine patch (a medication used to relieve localized pain) 4%, apply one patch to back at bedtime, remove in the morning.

Review of Resident #3's August 2026 eMAR from 08/01/26 to 08/25/26 revealed:
-There was an entry for lidocaine patch 4%, apply one patch to back at bedtime, remove in the morning, scheduled for application at bedtime.
-There was documentation that lidocaine patch 4% was applied daily at bedtime and removed from 08/10/26 to 08/24/26.

Observation of the medications on hand for Resident #3 on 08/26/26 at 10:30am revealed there was no lidocaine patch 4% available for application.

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	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

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D 358	Continued From page 57 Telephone interview with a representative from the facilities contracted pharmacy on 08/27/26 at 12:30pm revealed: -There was an active order for lidocaine patch 4% for Resident #3. -Lidocaine patch 4% was an over-the-counter (OTC) medication. -There was a note on Resident #3's profile that stated, "family supplied OTC medications". -They had never dispensed lidocaine patch 4% for Resident #3 because it was an OTC medication. Interview with Resident #3's Primary Care Provider (PCP) on 08/27/26 at 1:00pm revealed: -Resident #3's family supplied OTC medications. -No staff reported to her that Resident #3 did not have lidocaine patch 4% available for application. -She expected the facility to have lidocaine patch 4% available for Resident #3. -She expected the facility to reach out the Resident #3's family if lidocaine patch 4% was not available for application. -If Resident #3 did not have lidocaine patch 4% available for application, she was at risk of pain. Interview with Resident #3's responsible party on 08/27/26 at 1:21pm revealed: -She had not supplied the facility with lidocaine patch 4% for Resident #3. -She was not aware she was supposed to supply the facility with lidocaine patch 4% for Resident #3. -She was not aware Resident #3 did not have lidocaine patch 4% available for application. -No one from the facility let her know Resident #3 did not have lidocaine patch 4% available for application.	D 358		

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	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

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D 358	Continued From page 58 Interview with Resident #3 on 08/27/26 at 1:30pm revealed no staff ever applied her lidocaine patch 4%. Interview with a medication aide (MA) on 08/27/26 at 1:01pm revealed: -She applied medications to Resident #3 sometimes. -She was not aware Resident #3 did not have lidocaine patch 4% available for application. -She was not sure why Resident #3 did not have lidocaine patch 4% available for application. -She was not sure why eMAR documentation reflected that Resident #3's lidocaine patch 4% had been applied from 08/10/26 to 08/25/26. -If a medication was not given, MAs had the ability to document not given on the eMAR. Interview with the Resident Care Coordinator (RCC) on 08/27/26 at 3:33pm revealed: -Resident #3's responsible party said lidocaine patch 4% was too expensive and because of this she assumed the medication was never put on the eMAR. -She was not sure why eMAR documentation reflected that Resident #3's lidocaine patch 4% had been administered from 08/10/26 to 08/25/26 -Because lidocaine patch 4% was on the eMAR for Resident #3, there was no reason that Resident #3 did not have lidocaine patch 4% available for administration. -No staff reported to her that Resident #3 did not have lidocaine patch 4% available for administration. Interview with the Administrator on 08/27/26 at 5:35pm revealed: -She was not aware Resident #3 did not have lidocaine patch 4% available for administration. -She expected Resident #3 to have lidocaine	D 358		

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	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

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D 358	Continued From page 59 patch 4% available for administration. Refer to the interview with RCC on 08/27/26 at 3:20pm. Refer to the interview with the Assistant Administrator on 08/27/26 at 4:00pm. Refer to the interview with the Administrator on 08/27/26 at 4:35pm. f. Review of Resident #3's physician orders signed 08/17/26 revealed there was an order for nystatin powder (a medication used to treat and prevent yeast infections) , apply two times daily. Review of Resident #3's June 2026 electronic medication administration record (eMAR) revealed: -There was an entry for nystatin, apply two times daily, scheduled for administration at 8:00am and 8:00pm. -There was documentation that nystatin was applied daily at 8:00am and 8:00pm. Review of Resident #3's July 2026 eMAR revealed: -There was an entry for nystatin, apply two times daily, scheduled for administration at 8:00am and 8:00pm. -There was documentation that nystatin was applied daily at 8:00am and 8:00pm. Review of Resident #3's August 2026 eMAR from 08/01/26 to 08/25/26 revealed: -There was an entry for nystatin, apply two times daily, scheduled for administration at 8:00am and 8:00pm. -There was documentation that nystatin was applied daily at 8:00am and 8:00pm from	D 358		

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D 358	Continued From page 60 08/01/26 to 08/25/26. Observation of the medications on hand for Resident #3 on 08/26/26 at 10:30am revealed there was no nystatin available for administration on the medication cart. Telephone interview with a representative from the facilities contracted pharmacy on 08/27/26 at 12:30pm revealed: -There was an active order for nystatin for Resident #3. -Nystatin was last dispensed on 07/01/26 for a 7 day supply for Resident #3. Interview with Resident #3's Primary Care Provider (PCP) on 08/27/26 at 1:00pm revealed: -No staff reported to her that Resident #3 did not have nystatin available for administration. -She expected the facility to have nystatin available for Resident #3. -She expected the facility to reach out to the pharmacy if nystatin was not available for administration. -If Resident #3 did not have nystatin available for administration, she was at risk for yeast production. -Resident #3 was at risk for yeast infections under her breast and under her abdominal folds. Interview with Resident #3's responsible party on 08/27/26 at 1:21pm revealed she was not aware Resident #3 did not have nystatin available for administration. Interview with Resident #3 on 08/27/26 at 1:30pm revealed: -She told the medication aide (MA) that she no longer needed her nystatin. -She could not remember the last time her	D 358		

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 358	Continued From page 61 nystatin was applied. Interview with a MA on 08/27/26 at 1:01pm revealed: -She administered medications to Resident #3 sometimes. -She was not aware Resident #3 did not have nystatin available for administration. -She never administered nystatin to Resident #3. -She was not sure why Resident #3 did not have nystatin available for administration. -If a medication was not given, MAs had the ability to document not given on the eMAR. -She was not sure why documentation reflected that nystatin was applied to Resident #3 although there was no nystatin available. Interview with the Resident Care Coordinator (RCC) on 08/27/26 at 3:33pm revealed: -She was not aware Resident #3 did not have nystatin available for administration. -There was no reason that Resident #3 did not have nystatin available for administration. -No staff reported to her that Resident #3 did not have nystatin available for administration. Interview with the Administrator on 08/27/26 at 5:35pm revealed: -She was not aware Resident #3 did not have nystatin available for administration. -She expected Resident #3 to have nystatin available for administration. -She expected eMAR documentation to reflect not given if a medication was not administered. Refer to the interview with RCC on 08/27/26 at 3:20pm. Refer to the interview with the Assistant Administrator on 08/27/26 at 4:00pm.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

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D 358	Continued From page 62 Refer to the interview with the Administrator on 08/27/26 at 4:35pm. _____ Interview with the Resident Care Coordinator (RCC) on 08/27/26 at 3:20pm revealed: -She was not aware of who was responsible for auditing the residents' eMARs for accuracy or how often the eMARs were audited. -She expected the MAs to administer medications and record ordered parameters correctly. -She expected MAs eMAR documentation to reflect if a medication was not given. -She expected MAs to let her know when medication was not available. -MAs completed medication cart audits weekly. -Because she was new to the RCC position, she was not sure how MAs completed medication cart audits. Interview with the Assistant Administrator on 08/27/26 at 4:00pm revealed: -The MAs were responsible to audit the medication carts weekly and the SCC and RCC were responsible to audit the medication carts monthly. -The SCC and RCC were responsible to audit eMARs daily. -He expected the MAs to administer medications as ordered by the provider and to record ordered parameters correctly. Interview with the Administrator on 08/27/26 at 4:35pm revealed: -She expected MAs to complete medication cart audits to ensure residents medication administered according to the order in the eMAR. -The RCC and SCC were responsible for ensuring eMAR audits were completed weekly and medication errors were addressed and	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

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D 358	Continued From page 63 corrected with MAs. -She expected eMAR documentation to reflect not given if a medication was not administered. -She expected the MAs to administer medications as ordered by the provider and to record ordered parameters correctly. _____ The facility failed to administer medications as ordered when staff continued to administer the same dosages of clonazepam and olanzapine to Resident #7 after the PCP decreased the dosages due to the resident experiencing daytime sedation and for two residents with orders for sliding scale insulin, related to not documenting the FSBS results for Resident #4 and documenting if insulin was administered or withheld for Resident #4 and for Resident #5. This failure resulted in substantial risk of serious physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/27/26. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED September 26, 2026.	D 358		
D 441	10A NCAC 13F .1208 Death Reporting Requirements 10A NCAC 13F .1208 Death Reporting Requirements (a) Upon learning of a resident death as described in Paragraphs (b) and (c) of this Rule, a facility shall file a report in accordance with this Rule. A facility shall be deemed to have learned	D 441		

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 441	Continued From page 64 of a resident death when any facility staff obtains information that the death occurred. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to complete a written report within 3 days following a death for 1 of 1 sampled resident (#6) who had choked and had a cardiac arrest within 24-48 hours of his death. The findings are: Review of Resident #6's FL2 dated 03/25/26 revealed: -Diagnoses included hypertension, gastroesophageal reflux disease (GERD), hyperlipidemia, insomnia, dementia, and anxiety -The resident was intermittently disoriented. Review of Resident #6's Resident Register revealed an admission date of 04/30/26.(did they put the D/C date on the RR?) Review of Resident #6's resident progress notes revealed: -On 08/25/26 there was a late note for 07/30/26 that Resident #6 had a choking episode and the Assistant Administrator and primary care physician (PCP) initiated the Heimlich maneuver (a first aid method used when someone is choking). -On 07/30/26 Resident #6 was sent out by the emergency medical services (EMS) to the local hospital for further evaluation and treatment. Review of Resident #6's facility incident reports revealed:	D 441		

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 441	Continued From page 65 -On 08/26/26, there was a late note for 07/30/26 that Resident #6 had a choking incident that was reported by the Assistant Administrator. -There was a note for 07/30/26 that the diagnosis was documented as choking, the location outcomes was documented as transferred to emergency room, and the care outcomes was documented as admitted to hospital/acute care for Resident #6. Review of Resident #6's EMS report dated 05/23/25 at 5:45am revealed: -EMS was dispatched to the facility for a choking incident. -Resident #6 lost all pulses and went into cardiac arrest while being transported to the local hospital. -Resident #6 was unconscious and his condition remained unchanged upon EMS arrival to the local hospital. Review of Resident #6's PCP notes dated 07/30/26 revealed: -Resident #6 experienced an acute event following lunch and became unresponsive and appeared to aspirate. -Facility staff responded and assisted Resident #6 before he was transported by EMS to the hospital for further evaluation and management. Interview with the Administrator on 08/26/26 at 4:13pm revealed: -She had not reported the death of Resident #6 because the death occurred while he was at the hospital. -She was not aware she was required to send a written report within 3 days following a resident's death due to accident. -It was her understanding the resident's guardian was responsible to report a resident's death to the	D 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080026	A. BUILDING: _____ B. WING _____	R-C 08/27/2026

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D 441	Continued From page 66 state agency. Interview with the Assistant Administrator on 08/27/26 at 8:35am revealed: -He learned of Resident #6's death on 08/03/26 from a medication aide (MA) who visited the hospital. -He was not aware a written report should have been sent within 3 days following a resident's death due to an accident. -He was not aware of who was responsible to send a written report within 3 days following a resident's death due to an accident. -He was not sure if a written report was sent regarding Resident #6's death. Interview with a MA on 08/27/26 at 10:32am revealed: -She had learned of Resident #6's death on 07/31/26 and told the Assistant Administrator the same day. -She was not sure if a written report was sent regarding Resident #6's death and she was sure of who was responsible to send a written death report. Interview with the Resident Care Coordinator (RCC) on 08/27/26 at 3:20pm revealed: -She was not sure if a written report was sent regarding Resident #6's death. -The Administrator was responsible to complete and send written death reports. Second interview with the Administrator on 08/27/26 at 4:35pm revealed: -She did not submit a written death report when Resident #6 died because he died at the hospital and not at the facility. -She was responsible to send written death reports to the state agency and the Resident	D 441		

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D 441	Continued From page 67 Care Coordinator (RCC), the Special Care Coordinator (SCC), and the Assistant Administrator were responsible in her absence. Attempted interview with SCC on 08/27/26 at 3:09pm was unsuccessful.	D 441		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to notify the local county Department of Social Services (DSS) of an incident/accident that required emergency medical treatment and evaluation following a choking incident and a cardiac arrest which led to a resident's death for 1 of 1 resident (#6). . The findings are: Review of the facility's policy for Guidelines for Incident Reporting dated 09/2021 revealed: -Incident reports should be completed for any incident involving a resident. -Incident reports must be sent to DSS within 48	D 451		

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D 451	Continued From page 68 hours if the resident received medical intervention greater than first aid. Review of Resident #6's FL2 dated 03/25/26 revealed: -Diagnoses included hypertension, gastroesophageal reflux disease (GERD), hyperlipidemia, insomnia, dementia, and anxiety -The resident was intermittently disoriented. Review of Resident #6's Resident Register revealed an admission date of 04/30/26. Review of Resident #6's progress notes revealed: -On 08/25/26 there was a late note for 07/30/26 that Resident #6 had a choking episode and the Assistant Administrator and primary care physician (PCP) initiated the Heimlich maneuver (a first aid method used when someone is choking). -On 07/30/26 Resident #6 was sent out by the emergency medical services (EMS) to the local hospital for further evaluation and treatment. Review of Resident #6's facility incident reports revealed: -On 08/26/26, there was a late note for 07/30/26 that Resident #6 had a choking incident that was reported by the Assistant Administrator. -There was a note for 07/30/26 that the diagnosis was documented as choking, the location outcomes was documented as transferred to emergency room, and the care outcomes was documented as admitted to hospital/acute care for Resident #6. Review of Resident #6's EMS report dated 05/23/25 at 5:45am revealed: -EMS was dispatched to the facility for a choking incident.	D 451		

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D 451	Continued From page 69	D 451		

-Resident #6 lost all pulses and went into cardiac arrest while being transported to the local hospital.
-Resident #6 was unconscious and condition remained unchanged upon EMS arrival to the local hospital.

Review of Resident #6's PCP notes dated 07/30/26 revealed:
-Resident #6 experienced an acute event following lunch and became unresponsive and appeared to aspirate.
-Facility staff responded and assisted Resident #6 before he was transported by EMS to the hospital for further evaluation and management.

Interview with the local DSS supervisor on 08/27/26 at 8:20am revealed:
-Someone from the facility had left her a voicemail about Resident #6's choking incident on 07/30/26.
-She was told Resident #6 had died on 07/31/26 by the hospital nurse.
-No incident report for Resident #6 had been sent to the local DSS office from the facility.

Interview with the Assistant Administrator on 08/27/26 at 8:35am revealed:
-He completed the facility incident report for Resident #6's choking incident from 07/30/26 on 08/25/26 because he overlooked completing it.
-He told the local DSS supervisor about Resident #6's choking incident on 07/30/26 by telephone conversation.
-He was not aware an incident report should have been sent to the local DSS for Resident #6's death related to the choking incident.
-He was not aware of who was responsible to an incident report to DSS for Resident #6's choking incident.

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D 451	Continued From page 70 -He was aware was an incident report was not sent to DSS regarding Resident #6's choking incident. Interview with a MA on 08/27/26 at 10:32am revealed: -The Assistant Administrator completed the incident report related to Resident #6's choking incident on 07/30/26. -She was not sure if an incident report was sent to the local DSS related to Resident #6's choking but she was not sure who would be responsible to send the incident report. Interview with the Resident Care Coordinator (RCC) on 08/27/26 at 3:20pm revealed: -She was no sure if an incident report was sent to the local DSS regarding Resident #6's choking incident. -The Administrator was responsible for completing and for sending incident reports. Another Interview with the Administrator on 08/27/26 at 4:35pm revealed: -She did not send an incident report when Resident #6's choking incident. -She was responsible for sending incident reports to the local DSS and the Resident Care Coordinator (RCC), the Special Care Coordinator (SCC), and the Assistant Administrator were responsible in her absence.	D 451		