Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034100	A. BUILDING: _____ B. WING _____	R 08/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT AT UNIVERSITY PLACE	1635 EAST 5TH STREET WINSTON SALEM, NC 27101

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D 000	Initial Comments The Adult Care Licensure Section a follow-up survey from August 18, 2026 to August 20, 2026	D 000		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure physician's orders were implemented for 2 of 5 sampled residents (#1, #4) related to an order for a mental health provider (MHP) evaluation (#1) and for an A1C laboratory blood test (a blood test that measures blood glucose levels over the past 2-3 months) (#4). The findings are: 1. Review of Resident #1's current FL2 dated 06/10/26 revealed diagnoses included frontotemporal dementia, and diabetes mellitus type 2 with other specified complications. Review of Resident #1's Resident Register revealed an admission date of 04/07/26. Review of Resident #1's Physician Progress Notes dated 06/17/26 revealed there was an order for a MHP evaluation.	D 276	Responses to cited deficiencies do not constitute an admission or agreement by the facility of truth of facts alleged or conclusions set forth in the Statement of Deficiencies or the Corrective Action Report. The Plan of Correction is prepared solely as a matter of compliance with state laws. 10A NCAC 13F .0902 (c)(3-4) Health Care Special Care Coordinator will complete audit on resident record to ensure follow up and completion of required provider visits and ordered labs. Will notify appropriate provider of any incomplete orders or evaluations. Regional Clinical Support, RN conducted medication staff training to review order processing system and implementation.	08/31/26 08/28/26

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marilyn Shackelford — TITLE: Executive Director — (X6) DATE: 10/1/26

STATE FORM 6899 V3JK11 If continuation sheet 1 of 22

Reviewed and Acknowledged
10/05/26

BB

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D 276	Continued From page 1 Review of Resident #1's record revealed there were no MHP notes available for review after 06/17/26. Interview with Resident #1's responsible party on 08/20/26 at 9:45am revealed: -Resident #1 had not seen a MHP since being admitted in April 2026. -She was not aware of the Resident #1's physician order for a MHP referral from 06/17/26. -The facility staff had contacted her yesterday (08/19/26) for permission on Resident #1's MHP evaluation scheduled for next week. Interview with Resident #1's physician on 08/19/26 at 11:10am revealed: -She had ordered a MHP evaluation as a standard protocol for Resident #1's dementia diagnosis. -She was not aware until today (08/19/26) Resident #1 was not seen by a MHP. -She expected facility staff to follow her orders for any health care specialist evaluation. Interview with the Special Care Coordinator (SCC) on 08/20/26 at 9:55am revealed: -She was responsible for reviewing incoming paperwork to ensure orders and referrals were carried out and followed up on. -She was not aware of any MHP evaluation orders for Resident #1 from 06/17/26. -She overlooked the order for Resident #1's MHP evaluation referral from 06/17/26 and it was a "clerical oversight." Interview with the Regional Director of Operations (RDO) on 08/20/26 at 10:20am revealed she was not aware of any orders for Resident #1's MHP evaluation referral from 06/17/26.	D 276	Special Care Coordinator has implemented order processing system to ensure steps have been carried out for required resident needs. ED, Care Coordinator and/or other designee will review progress notes no less than 2 times weekly to ensure documentation of services to resident are completed. ED and Care Coordinator will review twice weekly requested orders and follow up for no less than 30 days and then weekly there after. Care Coordinator and/or ED will hold bi weekly meetings with medication staff to review resident needs according to rule .0902 (c) (3-4) for 30 days and then monthly thereafter.	08/28/26 10/01/26 10/01/26 10/02/26

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D 276	Continued From page 2 Refer to the interview with the SCC on 08/20/26 at 9:55am. Refer to the interview with the RDO on 08/20/26 at 10:20am. . Attempted interview with the Administrator on 08/20/26 at 10:28am was unsuccessful. Based upon observations, record reviews, and interviews it was determined that Resident #1 was not interviewable. 2. Review of Resident #3's current FL2 dated 06/03/26 revealed diagnoses included dementia type 2 diabetes, and hypertension. Review of Resident #3's Resident Register revealed an admission date of 09/02/25. Review of Resident #3's Physician Progress Notes dated 07/08/26 revealed there was an order for an A1C laboratory blood test (a blood test that measures blood glucose levels over the past 2-3 months). Review of Resident #3's record revealed there was no A1C laboratory blood test available for review after 07/08/26. Interview with Resident #3's physician on 08/19/26 at 11:00am revealed: -She intended for the facility to obtain Resident #3's A1C laboratory test. -She was not aware until today (08/19/26) Resident #3 did not have an A1C laboratory test completed. -She expected facility staff to follow her orders for any ordered laboratory blood test.	D 276		

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D 276	Continued From page 3 Interview with the Special Care Coordinator (SCC) on 08/20/26 at 9:58am revealed: -She was responsible for reviewing incoming paperwork to ensure orders were carried out and followed up on. -She was not aware of any A1C laboratory test for Resident #3 from 07/08/26. -Typically providers sent requested laboratory tests directly to the facilities contracted laboratory, so it was possible she would not have seen the A1C laboratory test order until she received a progress note which could have taken several days. -She overlooked the order for Resident #3's A1C laboratory test from 07/08/26 and it was a "clerical oversight." Interview with the Administrator on 08/20/26 at 10:26am revealed: -She was not aware of Resident #3's A1C laboratory blood test order from 07/08/26. -She only was at the facility twice a month. -Her expectation was that all laboratory tests were completed in a timely manner. Based upon observations, record reviews, and interviews it was determined that Resident #3 was not interviewable. Refer to the interview with the SCC on 08/20/26 at 9:55am. Refer to the interview with the RDO on 08/20/26 at 10:20am. _____ Interview with the Special Care Coordinator (SCC) on 08/20/26 at 9:55am revealed she was responsible for reviewing incoming paperwork to ensure orders and referrals were carried out and followed up on.	D 276		

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D 276	Continued From page 4 Interview with the Regional Director of Operations (RDO) on 08/20/26 at 10:20am -The SCC and the Administrator were responsible for reviewing physician progress notes for new orders, physician orders, and hospital discharge summaries to ensure orders were carried out and followed up on. -She expected the SCC to review physician orders and ensure orders were carried out within 24-48 hours of receiving the paperwork.	D 276	10A NCAC 13F .1004 (a) Medication Administration Facility will comply with rule 10A NCAC 13F .1004	10/02/26
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 3 residents (#8, #7) observed during the morning medication pass including errors with a nasal spray, a medication used to treat and prevent iron deficiency, a medication used to relieve dry and irritated eyes, and a cream to relieve dry and itchy skin (#8) and a medication used to treat chronic constipation (#7); and 2 of 5 sampled residents (#3, #4) for record review including errors with a	D 358	Regional Clinical Support will provide medication staff training on rule 10A NCAC 13F .1004 Special Care Coordinator will ensure physician orders to eMAR audit to cart audit will be completed on no less than 5 residents weekly for 30 days. Appropriate provider will be notified of any unmet needs.	08/28/26 10/02/26

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D 358	Continued From page 5 medication used to treat mental health conditions and a medication used to help prevent and treat minor skin irritations (#4); and a medication used to lower blood pressure (#3). The findings are: Review of the facility's undated Quality Assurance of Medication Administration policy revealed: -There was weekly monitoring of compliance levels of Medication Administration Record documentation by Care Coordinator, Administrator, and/or designee. -There would be bi-weekly visits by the registered nurse (RN) to observe medication administration by medication aides in addition to quarterly visits by the pharmacy consultant. -The RN, Administrator, Care Coordinator or designee audit carts or medication storage areas weekly and monthly for compliance. 1. The medication error rate was 19% as evidenced by the observation of 5 errors out of 26 opportunities during the 8:00am medication pass on 08/19/26. a. Review of Resident #8's current FL2 dated 08/13/26 revealed diagnoses included dementia, acute kidney injury, anxiety, and hypertension. 1. Review of Resident #8's FL2 dated 08/13/26 revealed there was an order for azelastine nasal spray 0.1% (used to relieve nasal allergy symptoms) 2 sprays into both nostrils daily. Observation of the morning medication pass on 08/19/26 at 8:18am revealed: -The medication aide (MA) removed Resident #8's medication bottles from the medication cart. -The MA did not administer azelastine nasal	D 358	ED and Care Coordinators will complete no less than 3 random med pass observations weekly for 30 days, monthly thereafter, including treatments being provided to ensure adherence to rule 10A NCAC 13F .1004. Care Coordinator will review no less than 5 resident eMARs weekly for 30 days to ensure medications are available and properly being administered as prescribed. Will review quarterly thereafter to ensure compliance. Medication staff will participate in weekly trainings for 30 days to continue compliance with rule .1004. Meetings will be conducted monthly thereafter for the next 90 days. Care Coordinator will complete resident records audit, including eMARs to ensure compliance and meeting residents needs.	10/02/26 10/02/26 10/02/26 10/02/26

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D 358	Continued From page 6 spray, 2 sprays into both nostrils, to Resident #8. Review of Resident #8's August 2026 electronic medication administration record (eMAR) for 08/19/26 revealed: -There was an entry for azelastine nasal spray 0.1%, 2 sprays into both nostrils daily, scheduled for administration at 8:00am. -There was documentation azelastine nasal spray 0.1% was administered at 8:00am on 08/19/26. Interview with the MA observed during the medication pass on 08/19/26 at 12:58pm revealed: -She was aware of Resident #8's azelastine nasal spray order scheduled for administration at 8:00am. -She went back later at 9:30am to administer Resident #8's azelastine nasal spray. -She had to retrieve Resident #8's azelastine nasal spray from the medication stock room which is why she administered the medication late. Interview with the Special Care Coordinator (SCC) on 08/20/26 at 10:14am revealed: -She was aware of Resident #8's azelastine nasal spray order scheduled for administration at 8:00am. -She was not aware the MA documented Resident #8's azelastine nasal spray as administered before administering the medication. -She expected MAs to administer medications before documenting the administration. 2. Review of Resident #8's FL2 dated 08/13/26 revealed there was an order for ferrous sulfate (a medication used to treat and prevent iron deficiency) 325mg 1 tablet daily.	D 358	Care Coordinator, ED and Regional Clinical support in-serviced medication staff on medication administration and accurate documentation. Nursing Support in-serviced care and medication staff on treatment application and vital recording. Care coordinator and ED worked with providers and pharmacy on adjusting times of administration for treatments to ensure accuracy and administration as prescribed. ED will review weekly with Care Coordinator on medication administration, to include medication availability. ED and Care Coordinator will communicate medication availability issues with appropriate providers to ensure residents needs are met according to rule .1004.	08/28/26 09/14/26 08/28/26 10/02/22

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D 358	Continued From page 7 Observation of the morning medication pass on 08/19/26 at 8:18am revealed: -The MA removed Resident #8's medication bottles from the medication cart. -The MA did not administer ferrous sulfate 325mg to Resident #8. Review of Resident #8's August 2026 eMAR for 08/19/26 revealed: -There was an entry for ferrous sulfate 325mg, take 1 tablet daily, scheduled for administration at 8:00am. -There was documentation ferrous sulfate 325mg was administered at 8:00am on 08/19/26. Interview with the MA observed during the medication pass on 08/19/26 at 12:58pm revealed: -She was aware of Resident #8's ferrous sulfate order scheduled for administration at 8:00am. -She went back later at 9:30am to administer Resident #8's ferrous sulfate. -She had to retrieve another medication for Resident #8 from the medication stock room which was why she administered Resident #8's ferrous sulfate late. Interview with the Special Care Coordinator (SCC) on 08/20/26 at 10:14am revealed: -She was aware of Resident #8's ferrous sulfate order scheduled for administration at 8:00am. -She was not aware the MA documented Resident #8's ferrous sulfate as administered before administering the medication. -She expected MAs to administer medications before documenting the administration. 3. Review of Resident #8's FL2 dated 08/13/26 revealed there was an order for propylene glyco	D 358		

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D 358	Continued From page 8 eyedrops (a medication used to relieve dry, irritated eyes) 0.6% instill 1 drop, in both eyes, four times daily. Observation of the morning medication pass on 08/19/26 at 8:18am revealed: -The MA removed Resident #8's medication bottles from the medication cart. -The MA did not administer propylene glycol eyedrops to Resident #8. Review of Resident #8's August 2026 eMAR for 08/19/26 revealed: -There was an entry for propylene glycol eyedrops 0.6%, instill one drop in both eyes four times a day, scheduled for administration at 8:00am. -There was documentation propylene glycol eyedrops was administered at 8:00am on 08/19/26. Interview with the MA observed during the medication pass on 08/19/26 at 12:58pm revealed: -She was aware of Resident #8's propylene glycol eyedrops order scheduled for administration at 8:00am. -She went back later at 9:30am to administer Resident #8's propylene glycol eyedrops. -She had to retrieve another medication for Resident #8 from the medication stock room which was why she administered Resident #8's propylene glycol eyedrops late. Interview with the Special Care Coordinator (SCC) on 08/20/26 at 10:14am revealed: -She was aware of Resident #8's propylene glycol eyedrops order scheduled for administration at 8:00am. -She was not aware the MA documented	D 358		

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D 358	Continued From page 9 Resident #8's propylene glycol eyedrops as administered before administering the medication. -She expected MAs to administer medications before documenting the administration. 4. Review of Resident #8's FL2 dated 08/13/26 revealed there was an order for eucerin (a medication used to moisturize, protect, and repair dry, sensitive, or irritated skin) apply to affected areas daily. Observation of the morning medication pass on 08/19/26 at 8:18am revealed: -The MA removed Resident #8's medication bottles from the medication cart. -The MA did not administer eucerin to Resident #8. Review of Resident #8's August 2026 eMAR for 08/19/26 revealed: -There was an entry for eucerin, apply to affected areas daily, scheduled for administration at 8:00am. -There was documentation eucerin was applied at 8:00am on 08/19/26. Interview with the MA observed during the medication pass on 08/19/26 at 12:58pm revealed: -She was aware of Resident #8's eucerin order scheduled for administration at 8:00am. -She went back later at 9:30am to administer Resident #8's eucerin. -She had to retrieve another medication for Resident #8 from the medication stock room which is why she administered Resident #8's eucerin late. Interview with the Special Care Coordinator	D 358		

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D 358	Continued From page 10 (SCC) on 08/20/26 at 10:14am revealed: -She was aware of Resident #8's eucerin order scheduled for administration at 8:00am. -She was not aware the MA documented Resident #8's eucerin as administered before administering the medication. -She expected MAs to administer medications before documenting the administration. Interview with the MA observed during the medication pass on 08/19/26 at 12:58pm revealed: -When she administered medications, she administered the medication before documenting the administration. -She knew that she should not have documented any medication as administered before administering the medication. -She knew she was supposed to administer Resident #8's medications as early as 7:00am or as late as 9:00am. Based on observations, interviews and record reviews, it was determined that Resident #8 was not interviewable. Attempted telephone interview with a representative from Resident #8's pharmacy on 08/19/26 at 11:35am was successful. Refer to the interview with the Administrator on 08/20/26 at 10:41am. b. Review of Resident #7's current FL2 dated 06/10/26 revealed: -Diagnoses included leukemia and atherosclerotic heart disease. -There was an order for lactulose (a medication used to treat chronic constipation) 15mL daily.	D 358		

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D 358	Continued From page 11 Observation of the morning medication pass on 08/19/26 at 8:18am revealed: -The medication aide (MA) removed Resident #7's multi-dose medication card from the medication cart. -The MA administered four oral medications to Resident #7. -The MA did not administer lactulose 15mL to Resident #7. Review of Resident #7's August 2026 electronic medication administration record (eMAR) for 08/19/26 revealed: -There was an entry for lactulose, give 15mL daily, scheduled for administration at 8:00am. -There was documentation lactulose 15mL was administered at 8:00am on 08/19/26. Interview with the MA observed during the medication pass on 08/19/26 at 12:52pm revealed: -She was aware of Resident #7's lactulose daily order, scheduled for administration at 8:00am. -Resident #7 refused his lactulose frequently which was why she did not administer it to him. -She went back into the eMAR and changed the documentation to refused instead of given. -She knew her eMAR documentation was to reflect refused if a resident refused a medication. Interview with the Special Care Coordinator (SCC) on 08/20/26 at 10:14am revealed: -She was aware of Resident #7's lactulose daily order, scheduled for administration at 8:00am. -She was not aware the MA documented Resident #7's lactulose as administered instead of refused. -She was not aware Resident #7 refused his lactulose frequently. -She expected MAs eMAR documentation to	D 358		

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D 358	Continued From page 12 reflect what actually happened during medication passes. Based on observations, interviews and record reviews, it was determined that Resident #7 was not interviewable. Refer to the interview with the Administrator on 08/20/26 at 10:41am. 2. Review of Resident #4's current FL2 dated 06/25/26 revealed diagnosis included dementia. a. Review of Resident #4's physician orders signed 07/27/26 revealed there was an order to start sertraline (a medication used to treat depression) 25mg, take 1 tablet daily. Review of Resident #4's July 2026 electronic medication administration record (eMAR) revealed: -There was an entry for sertraline 25mg, take one tablet daily for depression, scheduled for administration at 8:00am. -There was documentation sertraline 25mg was administered from 07/29/26 to 07/31/26 at 8:00am. Review of Resident #4's August 2026 eMAR from 08/01/26 to 08/18/26 revealed: -There was an entry for sertraline 25mg, take one tablet daily for depression, scheduled for administration at 8:00am. -There was documentation sertraline 25mg was administered from 08/01/26 to 08/18/26 at 8:00am. Observation of the medications on hand for Resident #4 on 08/18/26 at 3:58pm revealed there was no sertraline 25mg available for	D 358		

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	HAL034100	A. BUILDING: _____ B. WING _____	R 08/20/2026

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D 358	Continued From page 13 administration. Review of a hospice visit note report for Resident #4 revealed: -On 07/21/26 Resident #4 had been more tearful and crying about her family member. -On 07/24/26 Resident #4 was having crying outbursts which was normal at that time. -On 07/25/26 revealed Resident #4 was agitated and tearful. -On 07/26/26 Resident #4 was tearful. -On 07/28/26 Resident #4 appeared more anxious that day, and experienced crying spells off and on. Interview with Resident #4's Primary Care Provider (PCP) on 08/19/26 at 11:00am revealed: -Resident #4 was on hospice. -She was not aware Resident #4 did not have any sertraline 25mg available for administration on the medication cart. -Resident #4 was prescribed sertraline 25mg for depression. -She expected the facility to administer Resident #4's sertraline 25mg as ordered. Interview with Resident #4's responsible party on 08/19/26 at 12:06am revealed: -She visited the facility at least once a week. -The week of 08/09/26, she visited Resident #4 at the facility and Resident #4 was very agitated and aggravated, with reports from staff that Resident #4 had been that way for a few days. -The Activity Director reported to her that Resident #4 cried all the time and staff just let her sit and cry. Interview with a medication aide (MA) on 08/19/26 at 1:01pm revealed: -Resident #4's sertraline was not available on the	D 358		

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D 358	Continued From page 14 medication cart. -She was not sure why Resident #4's sertraline was not available on the medication cart. -She was not sure how long Resident #4's sertraline had not been available on the medication cart. -She was not sure why Resident #4's sertraline was being documented as given even though it was not available on the cart. -If a medication was not available to be administered, documentation for that medication should reflect unavailability. -Medication cart audits were done weekly by third shift MAs. -Medication cart audits included comparing the eMAR to what was available on the medication cart. Interview with a second MA on 08/20/26 at 9:30am revealed: -Resident #4 cried and was agitated "most of the time" and was it not a new behavior. -She reported Resident #4's crying and agitation to the Special Care Coordinator (SCC) and the hospice representative. Interview with the SCC on 08/20/26 at 10:00am revealed: -She was aware of Resident #4's sertraline order. -Resident #4's needed a new order through hospice for her sertraline which was why the pharmacy had not filled the order. -She was not sure how long Resident #4 had gone without her sertraline. -Weekly medication cart and eMAR audits were completed by MAs. -She expected Resident #4's sertraline to be available for administration. b. Review of Resident #4's FL2 dated 06/25/26	D 358		

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D 358	Continued From page 15 revealed there was an order for zinc oxide cream (a medication used to help prevent and treat minor skin irritations) 12% apply two times daily. Review of Resident #4's June 2026 eMAR revealed: -There was an entry for zinc oxide cream 12% apply two times daily, as needed. -There was no entry for zinc oxide cream 12% two times daily. Review of Resident #4's July 2026 eMAR revealed: -There was an entry for zinc oxide cream 12% apply two times daily, as needed. -There was no entry for zinc oxide cream 12% two times daily. Interview with Resident #4's PCP on 08/19/26 at 11:00am revealed: -Resident #4 was on hospice. -She intended for the facility to apply Resident #4's zinc oxide 12% twice a day. -Resident #4's zinc oxide 12% was prescribed to prevent the progression of a wound. Interview with Resident #4's responsible party on 08/19/26 at 12:06am revealed: -Resident #4 was her family member and she visited the facility at least once a week. -She had never witnessed staff apply Resident #4's zinc oxide 12%. Interview with a MA on 08/19/26 at 1:01pm revealed: -She administered Resident #4's medications and creams according to the eMAR. -She was only aware of Resident #4's as needed zinc oxide order. -She was not aware of Resident #4's order to	D 358		

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D 358	Continued From page 16 apply zinc oxide two times daily. -She never applied Resident #4's zinc oxide. -MAs were not responsible for chart reviews or physician order reviews. Interview with the SCC on 08/20/26 at 10:08am revealed: -She was not aware of Resident #4's zinc oxide apply two times daily order. -She was in charge of chart audits. -During chart audits, she referenced FL2's and any subsequent orders to ensure the eMAR was accurate. -She was not sure how she missed Resident #4's zinc oxide apply two times daily order. -She thought Resident #4 was only supposed to receive her zinc oxide as needed. _____ Based on observations, interviews and record reviews, it was determined that Resident #4 was not interviewable. Attempted telephone interview with a representative from Resident #4's pharmacy on 08/19/26 at 11:35am was unsuccessful. Refer to the interview with the Administrator on 08/20/26 at 10:41am. 3. Review of Resident #3's current FL2 dated 06/03/26 revealed diagnoses included dementia, type 2 diabetes, and hypertension. a. Review of Resident #3's current FL2 dated 06/03/26 revealed there was an order to administer clonidine (a medication used to lower blood pressure) 0.1mg, 1 tablet if systolic blood pressure was greater than 160.	D 358		

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D 358	Continued From page 17 Review of Resident #3's June 2026 electronic medication administration record (eMAR) revealed: -There was no entry for clonidine 0.1mg, 1 tablet if systolic blood pressure was greater than 160. -There were entries for daily blood pressures ranging from 115/78 to 162/77. Review of Resident #3's July 2026 eMAR revealed: -There was no entry for clonidine 0.1mg, 1 tablet if systolic blood pressure was greater than 160. -There were entries for daily blood pressures ranging from 94/74 to 145/70. Review of Resident #3's August 2026 eMAR from 08/01/26 to 08/18/26 revealed: -There was no entry for clonidine 0.1mg, 1 tablet if systolic blood pressure was greater than 160. -There were entries for daily blood pressures ranging from 100/50 to 142/91. Observation of the medications on hand for Resident #3 on 08/18/26 at 3:48pm revealed there was no clonidine 0.1mg available for administration on the medication cart. Interview with Resident #3's Primary Care Provider (PCP) on 08/19/26 at 11:00am revealed: -She intended for Resident #3's clonidine 0.1mg to be on the eMAR and available on the medication cart for administration if needed. -If Resident #3 did not have clonidine 0.1mg available for administration if needed, he was at risk for increased hypertension and a stroke. -She had not received any reports from staff of increased blood pressures for Resident #3. Interview with a medication aide (MA) on 08/19/26 at 1:06pm revealed:	D 358		

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D 358	Continued From page 18 -She administered Resident #3's morning medications. -She was aware of Resident #3's clonidine order. -Resident #3 never needed his clonidine on her shift. -Medication cart audits were done on third shift when new medications arrived at the facility. -She was not aware and did not know why Resident #3's clonidine was not on the eMAR and was not available on the medication cart. Interview with the Special Care Coordinator (SCC) on 08/20/26 at 10:04am revealed: -She was aware of Resident #3's clonidine 0.1mg order but was confused by the order. -She intended to clarify Resident #3's clonidine order with his PCP. -She was not aware Resident #3's clonidine was not available on the medication cart. -She was not sure why Resident #3's clonidine was not available on the medication cart. -Her expectation was that as needed medications were available on the medication cart for administration. b. Review of Resident #3's current FL2 dated 06/03/26 revealed there was an order to administer clonidine (a medication used to lower blood pressure) 0.2 mg, 2 tablets if the systolic blood pressure was greater than 180 or the diastolic blood pressure was greater than 110. Review of Resident #3's June 2026 eMAR revealed: -There was an entry for clonidine 0.2 mg, 2 tablets if the systolic blood pressure was greater than 180 or the diastolic blood pressure was greater than 110, as needed daily. -There was no documentation that clonidine 0.2 mg, 2 tablets if the systolic blood pressure was	D 358		

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D 358	Continued From page 19 greater than 180 or the diastolic blood pressure was greater than 110, was administered. -There were entries for daily blood pressures ranging from 115/78 to 162/77. Review of Resident #3's July 2026 eMAR revealed: -There was an entry for clonidine 0.2 mg, 2 tablets if the systolic blood pressure was greate than 180 or the diastolic blood pressure was greater than 110, as needed daily. -There was no documentation that clonidine 0.2 mg, 2 tablets if the systolic blood pressure was greater than 180 or the diastolic blood pressure was greater than 110, was administered. -There were entries for daily blood pressures ranging from 94/74 to 145/70. Review of Resident #3's August 2026 eMAR fro m 08/01/26 to 08/18/26 revealed: -There was an entry for clonidine 0.2 mg, 2 tablets if the systolic blood pressure was greate than 180 or the diastolic blood pressure was greater than 110, as needed daily. -There was no documentation that clonidine 0.2 mg, 2 tablets if the systolic blood pressure was greater than 180 or the diastolic blood pressure was greater than 110, was administered from 08/01/26 to 08/18/26. -There were entries for daily blood pressures ranging from 100/50 to 142/91. Observation of the medications on hand for Resident #3 on 08/18/26 at 3:48pm revealed there was no clonidine 0.2mg available for administration on the medication cart. Interview with Resident #3's PCP on 08/19/26 a 11:00am revealed: -She intended for Resident #3's clonidine 0.2mg	D 358		

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D 358	Continued From page 20 to be on the eMAR and available on the medication cart for administration if needed. -If Resident #3 did not have clonidine 0.2mg available for administration if needed, he was at risk for increased hypertension and a stroke. -She had not received any reports from staff of increased blood pressures for Resident #3. Interview with a MA on 08/19/26 at 1:06pm revealed: -She administered Resident #3's morning medications. -She was aware of Resident #3's clonidine order -Resident #3 never needed his clonidine on her shift. -Medication cart audits were done on third shift when new medications arrived at the facility. -She was not aware and did not know why Resident #3's clonidine was not available on the medication cart. Interview with the SCC on 08/20/26 at 10:04am revealed: -She was aware of Resident #3's clonidine order -She was not aware and was not sure why Resident #3's clonidine was not available on the medication cart. -Her expectation is that as needed medications were available on the medication cart for administration. _____ Based on observations, interviews and record reviews, it was determined that Resident #3 was not interviewable. Attempted telephone interview with a representative from Resident #3's pharmacy on 08/19/26 at 11:35am was successful. Refer to the interview with the Administrator on	D 358		

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D 358	Continued From page 21 08/20/26 at 10:41am. Interview with the Administrator on 08/20/26 at 10:41am revealed: -She expected the SCC to complete record, medication cart, and eMAR audits weekly. -She expected any necessary orders to be discontinued or clarified with the PCP. -She expected MAs to document administration of a medication after the medication was administered. -She expected medications to be administered according to eMAR entries. -She expected all medications to be available for administration. The facility failed to administer a medication used to treat depression (sertraline) to Resident #4. The resident had increased crying, agitation, and anxiousness, and there was no sertraline on hand. This failure was detrimental to the health, safety, and welfare of the residents, which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on August 19, 2026 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 4, 2026.	D 358		