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THE LANDINGS OF SWANSBORO	280 SWANSBORO LOOP ROAD SWANSBORO, NC 28584

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D 000	Initial Comments The Adult Care Licensure Section and the Onslow County Department of Social Services conducted a follow up survey and complaint investigation from 07/07/26 to 07/10/26 and 07/13/26 to 07/14/26 with an exit conference via telephone on 07/15/26. The complaint investigations were initiated by the Onslow County Department of Social Services on 05/05/26 and 05/27/26.	D 000		
D 176	10A NCAC 13F .0601 (a) Management of Facilities-General Administrato 10A NCAC 13F .0601 Management Of Facilities - General Administrator And Manager Responsibilities (a) Each adult care home shall have an administrator who is certified in accordance with Rule .1701 of this Subchapter. The administrator shall be responsible for the total operation and management of the facility to assure that all care and services are provided to maintain the health, safety, and welfare of the residents in accordance with all applicable local, state, and federal regulations and codes. The administrator shall also be responsible to the Division of Health Service Regulation and the county department of social services for complying with the rules of this Subchapter. The co administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term "administrator" also refers to co administrator where it is used in this Subchapter. This Rule is not met as evidenced by: TYPE A2 VIOLATION	D 176		

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D 176	Continued From page 1 Based on observations, interviews, and record reviews, the Administrator failed to ensure the overall management of the facility to meet and maintain rules related to controlled substances, medication administration, health care, infection prevention and control policies and procedures, fire safety and emergency preparedness plans, accounting for resident's personal funds, settlement of cost of care, resident rights, special care unit staffing, resident contract, and pharmaceutical services. The findings are: Review of the facility's license revealed the facility's license was effective 01/01/26 through 12/31/26 for a capacity up to 80 residents. Review of the facility's census on 07/07/26 revealed there were 60 residents residing in the facility, 39 on assisted living (AL) and 21 on the special care unit (SCU). Interview with a resident on 07/07/26 at 1:30pm revealed: -For several months the facility did not have an activity person but one had recently been hired, no activities were held during that time. -One of the medication aides (MAs) would get pulled from the floor to work in the kitchen as the cook. -The Administrator had removed so many staff. Interview with a second family member on 07/08/26 at 1:45pm revealed: -The resident had been admitted to the facility on 06/11/26. -She had not received a copy of the contract that she had signed from the Administrator.	D 176		

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-The Administrator had informed her that the facility would not be able to transport the resident to her appointments due to the distance from the facility.
-The facility had not provided any assistance to help her find transportation for her future appointments.
-The resident had State assistance and they should help with her transportation needs for her family member.
-There had been no communication from the facility related to the resident's falls and any follow-care needs.

Interview with a third family member on 07/10/26 at 8:10am revealed:
-A facility employee called her and informed her there was a video on social media she needed to see.
-She was able to recognize her family member in the video from her voice and her body.
-She was not alerted about the video from facility management.
-On 06/04/26 she went into the Administrator's office and asked her if there was anything that she needed to be made aware of, and the Administrator replied there was not.
-She asked the Administrator about the video posted on social media that was recorded at the facility and included her family member.
-The Administrator informed her that she had not had the chance to call family members about the social media videos.
-The Administrator informed her that she was made aware of the recordings on 05/31/26 and that she fired the staff member responsible for the recordings.
-Her family member (the resident) had no recollection of the video being recorded.
-She has had anxiety attacks due to the video of

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her family member being posted on social media.
-She had decided to move her family member out of the facility due to the incident.

Interview with a fourth family member on 07/14/26 at 2:00pm revealed:
-She had gone to the Administrator on four occasions related to pills that were left in the resident's room.
-The first time she spoke with the Administrator she said she would talk with the medication aide (MA) and remind them they were supposed to watch the residents take their medication.
-The second time she spoke with the Administrator she told her that she could only remind the MAs to observe the residents take their medication because she was not there to supervise them.
-The third time she spoke with the Administrator she told her that the MAs had gone through a class on administering medications and the MAs were supposed to know what to do.
-During the second week of May the resident called and said she had a cup of pills and did not know what to do with them.
-She arrived at the facility and carried the cup of pills to the Administrator.
-This was the fourth time she had spoken with the Administrator and she said she would have the MA and a personal care aide (PCA) observe the resident take her medications and sign the medications off.
-She visited at least 4 days per week and had never observed 2 staff observe the resident take her medications.
-On 05/22/26 she found a round red colored pill on the resident's room floor.
-She tried to locate the Administrator and could not so she gave the pill to a MA.
-The Administrator asked her what she wanted

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and she told her she had found a pill in the resident's room and gave it to the MA and the Administrator did not say anything and walked off.
-On 06/27/26 she was talking with the resident and could see by the camera that the MA had left a cup of pills and a glass of water then she heard the door close.
-She hung up and called the facility between 8:00pm and 9:00pm and the Special Care Coordinator (SCC) answered the phone and he said he would go check on the resident and observe her take her medications.
-She had recently gone to the Administrator and she continued to type on the computer and never looked up.
-She requested the Administrator's supervisor's phone number and then the Administrator began to communicate with her.

Interview with a resident's responsible person on 7/15/26 at 1:15pm revealed:
-On 03/13/26, the resident went on an outing to one of the local stores with a staff member and other residents and there was an incident.
-She was notified several days after the incident took place.
-There was no communication from the Administrator related to this event.
-The Administrator called her and said she did not think that the resident was happy living at the facility and wondered if she could move her to transitional living, then documented in the residents' notes that she had made this statement.
-She had requested on 04/22/26 from the Administrator parts of the resident's records to include the staff progress notes and was informed the Resident Care Coordinator (RCC) would provide her with the documents.
-She called and spoke with the Administrator on

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D 176	Continued From page 5 3-4 separate occasions and she also emailed her and the Administrator told her she would have the SCC send them. -The SCC told her that they had been short staffed and she finally received the resident's documents in June 2026, 2 months later. Telephone interview with a former employee on 07/06/26 at 10:44am revealed: -The facility did not have adequate staff for the residents and the Administrator kept admitting more residents without additional staff to care for them. -There was poor management all around. Telephone interview with a second former employee on 07/08/26 at 8:44am revealed: -There were so many things wrong with that facility that she had reported, but nothing was done about it. -The facility was exceptionally short staffed. -On 07/01/26, there was only one staff in the SCU when she arrived at 7:00am. -For about 1 hour she was the only staff on the SCU with about 20 residents and only 2 staff on the AL side with about 40 residents. -One resident in special care was not getting her monthly stipend of $70 and ran short of her personal items such as shampoo and conditioner, as well as her cigarettes. -The Administrator acted as the Business Office Manager (BOM) since April when the previous BOM was terminated. -The Administrator also filled in on the floor as a MA and as a PCA when they were short-staffed. Telephone interview with a second family member on 07/08/26 at 3:30pm revealed: -The entire staff were overworked, overwhelmed and short staffed.	D 176		

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D 176	Continued From page 6 -A few weekends back, they had been in the facility and there were dirt and dust all over the floors throughout the facility. -Residents had been eating in their rooms and in the library towards the back of the facility and the plates with leftover food had been left sitting out. -There were only 1 or 2 staff on that weekend. -At 3:00pm, one oncoming staff finally picked up the dirty plates and removed them from the library. -There was lack of communication when their family member had fallen and went to the emergency room (ER). -No one bothered to call hospice for instructions before sending the resident out. -The lack of communication resulted in the ER not knowing that the resident was a hospice patient and a battery of tests were done that insurance would not pay for since the resident was under hospice care. -The Administrator needed help to get all these things better. Interview with the Administrator on 07/07/26 at 1:52pm revealed: -She was not aware of any residents sharing glucometers. -She was not sure what the facility's policy was for sharing glucometers, but she thought it was okay as long as they cleaned the glucometer but that may have been information when she worked in a skilled nursing facility in the past. -She was not aware of Centers for Disease Control (CDC) guidelines that glucometers should not be shared and were for single patient use only. -She was not aware of a system to check the glucometers. Second interview with the Administrator on	D 176		

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D 176	Continued From page 7 07/09/26 at 9:57am revealed: -On 12/24/25, a MA came to her and reported something was not right with a resident's controlled substance pain medication. -They investigated and discovered the extra tablets a former MA added to a multi-dose pack (MDP) were an over-the-counter pain reliever instead of a resident's controlled substance medication. -She reported it to the Health Care Personnel Registry (HCPR), local law enforcement, and the resident's PCP. -The local law enforcement officers came to the facility on 12/24/25 and did some interviews but she never heard back from the officers. -She did not know if there was a police report because she never checked back with the officers. -She did not remember which officers came to the facility. -They never found the resident's missing controlled substance pain tablets. -She did not report the drug diversion to the facility's contracted pharmacy because she did not know there was a rule that required it be reported to the pharmacy. Third interview with the Administrator on 07/13/26 at 2:30pm revealed: -She and the RCC and the SCC had access to make any needed corrections to the electronic controlled substance records (eCSRs). -The RCC and the SCC were responsible to ensure the eCSR counts were correct. -She was ultimately responsible to ensure the eCSR counts were correct. -She did not have a process to review the eCSRs for accuracy. Fourth interview with the Administrator on	D 176		

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D 176	Continued From page 8 07/14/26 at 6:06pm revealed: -Her scheduled work hours were 9:00am to 5:00pm Monday through Friday. -She usually got to the facility before 9:00am and left after 7:30pm. -She was responsible for the day-to-day operations of the entire building. -She was operating as the Administrator and Business Office Manager (BOM) since 06/02/26. -She often worked as a MA and a PCA as needed. -Most days she began by walking through the facility to see if anything was out of order or any issues needed to be addressed. -After her walk through, she did a stand up meeting with the care managers, BOM, dietary manager, and maintenance director. -After the stand-up meeting, she checked her emails and made any phone calls that she needed to make. -On days she worked as an MA or PCA she was unable to devote adequate time to her Administrator duties. -The RCC and SCC were responsible for auditing electronic medication administration records (eMARs) and resident charts, and she was responsible for ensuring they were completed properly. -She could not finish daily audits, as she was occupied with additional duties. -She handled any concerns or complaints from residents or family members. -She did not always have the time to deal with resident and family member complaints and concerns in a timely manner. -She had lack of sufficient time to fully carry out her Administrator responsibilities because she had to fill in as the BOM, MA, and PCA. Non-compliance was identified in the following	D 176		

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D 176	Continued From page 9 rule areas: 1. Based on observations, interviews, and record reviews, the facility failed to ensure readily retrievable records that accurately reconciled the receipt, administration, and disposition of controlled substances for 7 of 7 residents (#1, #3, #5, #10, #15, #16, #22) sampled with orders for controlled substances used to treat moderate to severe pain (#1, #3, #5, #16) and used to treat anxiety (#3, #10, #15, #22), including a resident who had missing pain medication (#16). [Refer to Tag 392, 10A NCAC 13F .1008(a) Controlled Substances (Type B Violation).] 2. Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up to meet the routine health care needs for 5 of 8 sampled residents (#4, #8, #21, #24, #29) related to an ear, nose, and throat (ENT) referral and primary care follow-up (#24) and failure to coordinate to obtain glucometers for four diabetic residents (#4, #8, #21, #29) with orders for fingerstick blood sugar (FSBS) checks. [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type B Violation).] 3. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 6 residents (#13, #21, #25) observed during the medication pass including errors with a medication used to prevent heart attacks and strokes (#25), an antipsychotic used to treat Parkinson's disease psychosis (#13), and a vitamin supplement (#21); and for 1 of 8 residents (#6) sampled for record review including multiple errors with a rapid-acting insulin (#6). [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation).]	D 176		

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D 176	Continued From page 10 4. Based on observations, interviews, and record reviews, the facility failed to implement orders from the primary care provider for 2 of 7 sampled residents (#4, #8) related to orders for a urinalysis to check for a urinary tract infection (#4) and an order to check fingerstick blood sugars for a resident with diabetes (#8). [Refer to Tag 276, 10A NCAC 13F .0902(c)(3-4) Health Care (Type A2 Violation).] 5. Based on observations, interviews, and record reviews, the facility failed to implement infection control procedures for glucometers used to obtain fingerstick blood sugar (FSBS) readings for 6 of 7 sampled residents (#4, #6, #7, #8, #9, #21) with orders for FSBS monitoring. [Refer to Tag 610, 10A NCAC 13F .1801(a) Infection Prevention and Control Policies and Procedures (Type A2 Violation).] 6. Based on record review and interviews, the facility failed to provide the resident's authorized representative a written 30-day notice prior to any change in charges for resident services and accommodations, including the cost of different levels of service, description of level of care and services, and any other charges or fees for 2 of 3 sampled residents (#8, #9). [Refer to Tag 243, 10A NCAC 13F .0704(a)(1) Resident Contract, Information on Facility and Resident Register (Standard Deficiency).] 7. Based on observations, interviews, and record reviews, the facility failed to ensure the rights of all residents were maintained including being treated with dignity and respect related to 3 residents (#6, #26, #27) being recorded by a staff member and posted on a social media site. [Refer to Tag 338, 10A NCAC 13F .0909 Resident	D 176		

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D 176	Continued From page 11 Rights (Standard Deficiency).] 8. Based on observations, interviews, and record reviews, the facility failed to ensure the electronic medication administration records were accurate for 2 of 6 sampled residents (#3, #13) including documentation for a medication used to treat cellulitis of the leg (#3) and for an antipsychotic used to treat Parkinson's disease psychosis (#13). [Refer to Tag 367, 10A NCAC 13F .1004(j) Medication Administration (Standard Deficiency).] 9. Based on observations, interviews, and record reviews, the facility failed to ensure medications were not borrowed except in an emergency for a resident (#15) related to a controlled substance used to treat anxiety. [Refer to Tag 372, 10A NCAC 13F .1004(o) Medication Administration (Standard Deficiency).] 10. Based on record reviews and interviews, the facility failed to report drug diversion of a controlled substance to the pharmacy for a resident (#16) for a medication used to treat moderate to severe pain. [Refer to Tag 399, 10A NCAC 13F .1008(h) Controlled Substance (Standard Deficiency).] 11. Based on interviews and record reviews, the facility failed to ensure the provision of medication for a resident (#16) who went on temporary leaves from the facility related to documenting the quantities released and returned for all medications provided for the resident's leaves of absence. [Refer to Tag 411, 10A NCAC 13F .1010(d) Pharmaceutical Services (Standard Deficiency).] 12. Based on record reviews and interviews, the facility failed to ensure resident's personal needs	D 176		

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D 176	Continued From page 12 allowance was credited to the resident's account for 1 of 3 sampled residents (#9) within one business day of being received. [Refer to Tag 424, 10A NCAC 13F .1104(f) Accounting For Resident's Personal Funds (Standard Deficiency).] 13. Based on record reviews and interviews, the facility failed to ensure a refund of the amount equal to the cost of care for the remainder of the month was made within 14 days after the resident left the facility for 1 of 1 resident (#23). [Refer to Tag 427, 10A NCAC 13F .1106(a) Settlement Of Cost Of Care (Standard Deficiency).] 14. Based on interviews and record reviews, the facility failed to ensure the minimum number of staff were present at all times to meet the needs of residents residing in the special care unit (SCU) for 6 of 21 shifts sampled on 05/02/26, 06/26/26, and from 07/01/26 - 07/05/26. [Refer to Tag 465, 10A NCAC 13F .1308(a) Special Care Unit Staffing (Standard Deficiency).] 15. Based on record reviews and interviews, the facility failed to conduct unannounced fire drills quarterly on each shift and failed to maintain documentation of the fire drills to include the staff members present and a short description of the drill. [Refer to Tag 502, 10A NCAC 13F .0309(b)(c) Fire Safety and Emergency Preparedness Plans (Standard Deficiency).] _____ The Administrator failed to ensure the total operation and management of the facility to ensure care and services were provided to maintain the health, safety, and welfare of the residents. The facility failed to properly maintain a correct count of controlled substances for several residents, properly administer medication to	D 176		

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D 176	Continued From page 13 residents as ordered, provide healthcare as ordered, ensure proper infection control was being maintained with resident glucometers, provide resident funds and settlement of resident funds in a timely manner, and ensure resident rights were being maintained. The failure to ensure overall management of the facility resulted in substantial risk of physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/15/26 for this Violation. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 14, 2026.	D 176		
D 243	10A NCAC 13F .0704(a)(1) Resident Contract, Information On Facility & 10A NCAC 13F .0704 Resident Contract, Infomation on Facility and Resident Register (a) An adult care home administrator or their management designee shall furnish and review with the resident or the resident's authorized representative as defined in Rule .1103 of this Subchapter information on the facility upon admission and when changes are made to that information. The facility shall involve the resident in the review of the resident contract and information on the facility unless the resident is cognitively unable to participate in the discussion. A statement indicating that this information has been received upon admission or amendment as required by this Rule shall be signed and dated by each person to whom it is given and retained in the resident's record in the facility. The information shall consist of the following:	D 243		

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D 243	Continued From page 14 (1) the resident contract to which the following applies: (A) the contract shall specify charges for resident services and accommodations, including the cost of different levels of service, description of levels of care and services, and any other charges or fees; (B) the contract shall disclose any health needs or conditions that the facility has determined it cannot meet; (C) the contract shall be signed and dated by the administrator or management designee and the resident or the resident's authorized representative, a copy given to the resident or the resident's authorized representative and a copy kept in the resident's record; (D) the resident or the resident's authorized representative shall be given a written 30-day notice prior to any change in charges for resident services and accommodations, including the cost of different levels of service, description of level of care and services, and any other charges or fees, and be provided an amended contract or an amendment to the contract for review and confirmation of receipt; (E) gratuities in addition to the established rates shall not be accepted; and (F) the maximum monthly adult care home rate that may be charged to Special Assistance recipients as established by the North Carolina Social Services Commission and the North Carolina General Assembly. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to provide the resident's authorized representative a written 30-day notice prior to any change in charges for resident services and accommodations, including the cost of different levels of service, description of level of care and	D 243		

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services, and any other charges or fees for 2 of 3 sampled residents (#8, #9).

The findings are:

1. Review of Resident #9's current FL-2 dated 04/15/26 revealed:
-Diagnoses included fronto-temperal dementia, hyperammonemia, acute metabolic encephalopathy, type 2 diabetes mellitus with hyperglycemia, and hypertension.
-The resident current level of care was documented as assisted living facility.
-The resident recommended level of care was skilled nursing facility.
-The resident was intermittently disoriented.

Review of the Resident Register for Resident #9 revealed:
-She was admitted to the facility on 03/03/26.
-Her guardian was a social worker with the Department of Social Services (DSS).

Interview with Resident #9's primary care provider (PCP) on 07/15/26 at 1:00pm revealed the FL-2 for Resident #9 was incorrect, the level of recommended care should have been special care unit (SCU).

Interview with Resident #9's DSS guardian on 07/14/26 at 10:45am revealed:
-She participated in a care plan meeting on 04/22/26 at the facility to discuss Resident #9's level of care.
-They decided that Resident #9 needed a higher level of supervision due to safety concerns because she had been making decisions that could put her at risk.
-It was approximately a month and a half before the facility sent her a new contract to review for

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Resident #9.
-The new contract that she received for Resident #9 was incorrect, she informed the Administrator it needed to be corrected and sent back to her.
-She received another contract for Resident #9 from the Administrator on 06/16/26 which remained incorrect, she informed the Administrator it needed to be corrected and sent back to her.
-On the contract, the DSS guardian was listed as payee which was incorrect.
-She had not received a corrected contract for Resident #9.

Interview with the Resident Care Coordinator (RCC) on 07/14/26 at 11:05am revealed:
-Resident #9 was moved into the SCU on 04/24/26.
-A care plan meeting took place at the facility on 04/22/26.
-Resident #9 was moved to the SCU because they were worried about her safety.
-The Administrator was responsible for completing and maintaining resident agreements/contracts.

Interview with the Administrator on 07/14/26 at 4:00pm revealed:
-Resident #9 was moved into the SCU on 04/24/26.
-The Business Office Manager (BOM) was responsible for ensuring there were new contracts created and sent to resident guardian or Power of Attorney (POA) when there were changes made to a resident's level of service or charges.
-The facility no longer had a BOM as of 06/20/26.
-She was responsible for the BOM responsibilities until they hired a new BOM.
-She sent Resident #9's DSS guardian the new

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contract to sign on 06/16/26, and the DSS guardian sent the contract back to her for corrections.
-She sent the correct contract to DSS on 07/13/26.
-When changes had been made to resident contracts, there should be a new contract sent to the POA or guardian within 24 hours of changes being made.

2. Review of the facility financial agreement dated 04/01/24 revealed the community will provide 30 days advanced written notice before any increase to the monthly unit base rent.

Review of Resident #8's FL-2 dated 08/11/25 revealed:
-Diagnoses included diabetes, chronic kidney disease, and atrial fibrillation.
-The resident's current level of care was documented as assisted living facility.

Review of Resident #8's Resident Register revealed she was admitted to the facility on 01/10/23.

Interview with Resident #8's family member on 07/15/26 at 12:35pm revealed:
-She had Resident #8's rent automatically deducted from her account on the 5th of each month.
-In February 2026 there was a withdrawal for $5200.00.
-In March 2026 there was a withdrawal for $5346.00.
-She spoke with the Business Office Manager (BOM) in March 2026 because the bill went up and the family was not provided a 30-day notice.
-The BOM could not provide a copy of the 30-day notice letter that should have been sent for a rate

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D 243	Continued From page 18 increase. -In July 2026 there was a withdrawal of $5796.00. -The family had not received a 30-day notice for the two rate increases in March 2026 and July 2026. -The family spoke with the Administrator on 07/08/26 and was informed she would email the person who drafted the funds from Resident #8's account. -The Administrator could not provide documentation of the 30-day notices for the rate increases. Interview with the Administrator on 07/15/26 at 2:00pm revealed: -The rate increase for the facility was annually and the home office would send out a letter for the yearly rate increase. -She did not know how far in advance of the rate increase the letter was sent. -She did not know why Resident #8 had rate increases. -She did not have copies of the rate increase letters.	D 243		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up to meet the routine health care needs for 5 of 8 sampled residents (#4, #8, #21, #24,	D 273		

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#29) related to an ear, nose, and throat (ENT) referral and primary care follow-up (#24) and failure to coordinate to obtain glucometers for four diabetic residents (#4, #8, #21, #29) with orders for fingerstick blood sugar (FSBS) checks.

The findings are:

1. Review of Resident #24's current FL-2 dated 06/01/26 revealed:
-Diagnoses included vascular dementia, diabetes, bladder cancer, chronic kidney disease, chronic obstructive pulmonary disease, and depression.
-Current level of care was domiciliary
-Resident #24 was intermittently disoriented.
-Resident #24 was incontinent of bladder.

Review of Resident #24's Resident Register revealed she was admitted to the facility on 06/11/26.

Review of Resident #24's care plan dated 06/29/26 revealed:
-Resident #24 was totally dependent for bathing.
-Resident #24 needed extensive assistance for dressing, grooming and personal hygiene, and transferring.
-Resident #24 needed limited assistance with ambulation and toileting.

Review of Resident #24's incident/accident report dated 06/28/26 at 4:10am revealed:
-A personal care aide (PCA) was making rounds and went to answer Resident #24's call bell and found her lying on the floor with blood pooled around her.
-Resident #24's bed alarm was laying on her dresser.
-Resident #24 appeared to be injured with blood coming out of her bruised nose, laceration/skin

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tear to right side of hand on her little finger, laceration/skin tear to right and left knees.
-Resident #24 stated she fell out of bed while trying to go to bathroom.

Review of Resident #24's emergency documentation dated 06/28/26 revealed:
-Resident #24 was seen for a fall where she rolled out of bed.
-Resident #24's vital signs at time of arrival were notable for bradycardia (decreased heart rate).
-Computed Tomography (CT) scan of maxillofacial without contrast showed acute angulated and buckled fracture of the nasal septum, the right greater than the left acute nasal bone fractures with angulation.
-A follow-up was needed with an ear, nose, and throat (ENT) specialist for fractured nose.
-A follow-up was needed with the primary care provider (PCP).

Observation of Resident #24 on 07/10/26 at 11:05am revealed:
-Both of Resident #24's legs had multiple bruises and skin tears, two steri strips were on her right knee.
-Both of Resident #24's arms from the elbows to her fingers had multiple bruises and skin tears.
-Resident #24 had bruises on her face around the eyes and nose.

Interview with Resident #24's family member on 07/13/26 at 11:02am revealed:
-She did not know that Resident #24 needed an appointment with an ENT or PCP from her fall on 06/28/26.
-She called the hospital on 06/28/26 and found out she had a fractured nose.

Interview with Resident #24's PCP office staff on

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D 273	Continued From page 21 07/14/26 at 8:30am revealed: -The facility sent Resident #24's care plan for the PCP to sign related to the 06/28/26 fall. -The facility had not requested a follow-up appointment for Resident #24's fall on 06/28/26. -The PCP office had not seen any hospital paperwork from the fall on 06/28/26. Interview with a medication aide (MA) on 07/13/26 at 11:38am revealed: -The MA always checked a resident in when they returned from the hospital. -She reviewed the orders and sent prescriptions and wound care orders to the pharmacy. -The Resident Care Coordinator (RCC) or Special Care Coordinator (SCC) handled all referrals and if on the weekend it waited until Monday. -She had always received the hospital paperwork when the resident returned. -She would complete a head-to-toe assessment and noted any injuries or sutures in the facility progress notes. Interview with the RCC on 07/13/26 at 11:27am revealed: -She did not see on Resident #24's hospital documents that she needed a referral to ENT or a follow-up with her PCP until it was pointed out on 07/13/26. -She had not made Resident #24 a PCP follow-up appointment or made a referral appointment for ENT. -She had never called Resident #24's PCP only sent the office faxes. -There was not a process to ensure orders from provider office visits or hospital visits were completed. Interview with the Administrator on 07/14/26 at 4:38pm revealed:	D 273		

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-The RCC and the SCC were responsible for obtaining the documents from the residents' visits to outside providers and hospitals.
-If the RCC or the SCC were not in the facility the MA would obtain the documents and place them under their door or in the RCC or SCC's box.
-Her expectation was that the RCC and SCC ensured that they received the residents' documents from outside visits.
-She did not know that referrals and follow-up appointments had not been made from Resident #24's 06/28/26 hospital visit.

Based on observations, interviews, and record reviews, it was determined that Resident #24 was not interviewable.

2. Review of Resident #4's current FL-2 dated 07/16/26 revealed:
-Diagnoses included dementia with behaviors, type 1 diabetes mellitus, hypertension, hallucinations, memory loss, and weight loss.
-There was an order to check fingerstick blood sugar (FSBS) 3 times a day before meals.

Review of Resident #4's June 2026 electronic medication administration record (eMAR) revealed:
-There was an entry to check FSBS 3 times a day before meals scheduled at 7:30am, 11:30am, and 5:30pm.
-The resident's FSBS was documented as being checked 3 times a day from 06/01/26 - 06/30/26.
-The resident's FSBS ranged from 97 - 363 from 06/01/26 - 06/30/26.

Review of Resident #4's July 2026 eMAR dated 07/01/26 - 07/07/26 revealed:
-There was an entry to check FSBS 3 times a day before meals scheduled at 7:30am, 11:30am, and

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D 273	Continued From page 23 5:30pm. -The resident's FSBS was documented as being checked 3 times a day from 07/01/26 - 07/07/26 (11:30am). -The resident's FSBS ranged from 110 - 433 from 07/01/26 - 07/07/26. Observation of Resident #4's medications on hand on 07/07/26 at 10:51am revealed: -There was a glucometer in the back of the top drawer on the medication cart in the special care unit (SCU) with Resident #4's name written on the back of it. -Resident #4's glucometer would not turn on. -There was no glucometer with Resident #4's name stored in the front drawer of the medication cart with the other glucometers. -There was a red glucometer stored with the actively used glucometers with no resident's name. Interview with the medication aide (MA) on 07/07/26 at 10:51am revealed: -She did not use Resident #4's glucometer because it was broken and would not turn on. -She also thought there may have been some issues with getting strips for the glucometer because of insurance at some point. -She used the red glucometer for Resident #4 and another resident because both of their glucometers were broken. -Resident #4's glucometer had been broken for the last couple of months. -She did not know if anyone was trying to obtain a new glucometer for Resident #4. -She was not sure if the broken glucometer had been reported to anyone. Review of Resident #4's facility progress notes for May 2026 - July 2026 revealed no documentation	D 273		

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D 273	Continued From page 24 related to any issues with the resident's glucometer or any attempts to contact the pharmacy or primary care provider (PCP) to obtain a new glucometer. Interview with the Special Care Coordinator (SCC) on 07/07/26 at 1:15pm revealed: -Each resident was supposed to have their own glucometer. -The facility did not share glucometers to prevent cross-contamination. -He was not aware Resident #4's glucometer was broken and a red glucometer was being shared until today, 07/07/26. -The MAs should contact the pharmacy to get a new glucometer if one was broken. -He should be the first person notified by the MAs when a resident's glucometer was broken. -He was supposed to check glucometers when he did weekly cart audits but he was new in this position and had not done that yet. Interview with the Administrator on 07/07/26 at 1:52pm revealed: -Each diabetic resident had their own glucometer. -She was not aware Resident #4's glucometer was broken. -The MAs should notify her, the Resident Care Coordinator (RCC), or the SCC if a resident's glucometer was not working. -If the MAs had reported it, she would have ordered or bought a new glucometer for Resident #4. Telephone interview with Resident #4's PCP on 07/07/26 at 4:25pm revealed: -She completed face-to-face exams on all diabetic residents every 6 months for diabetic supplies. -The facility would need to contact her for a new	D 273		

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prescription to obtain a glucometer so insurance would pay for it.
-No one from the facility had notified her that Resident #4's glucometer was broken or that he needed a new prescription.
-Glucometers should not be shared.
-Each resident should have their own glucometer for better hygiene and better safety and to prevent transmission of diseases.

Based on observations, interviews, and record reviews, it was determined that Resident #4 was not interviewable.

[Refer to Tag 610, 10A NCAC 13F .1801(a) Infection Prevention and Control Policies and Procedures.]

3. Review of Resident #21's current FL-2 dated 04/02/26 reveled:
-Diagnoses included dementia with behavioral disturbances, anemia, type 2 diabetes mellitus, hypertension, breast cancer, and Vitamin D deficiency.
-There was an order to check fingerstick blood sugar (FSBS) every morning.

Review of Resident #21's Resident Register revealed she was admitted to the facility on 04/02/26.

Review of Resident #21's June 2026 electronic medication administration record (eMAR) revealed:
-There was an entry to check FSBS every morning scheduled at 6:00am.
-The resident's FSBS was documented as being every morning at 6:00am from 06/01/26 - 06/30/26.
-The resident FSBS ranged from 110 - 239 from

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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 273	Continued From page 26 06/01/26 - 06/30/26. Review of Resident #21's July 2026 eMAR dated 07/01/26 - 07/08/26 revealed: -There was an entry to check FSBS every morning scheduled at 6:00am. -The resident's FSBS was documented as being every morning at 6:00am from 07/01/26 - 07/07/26. -The resident FSBS ranged from 118 - 189 from 07/01/26 - 07/08/26. Observation of Resident #21's medications on hand on 07/07/26 at 10:52am revealed: -There was an unlabeled glucometer identified by the medication aide (MA) as belonging to Resident #21. -Resident #21's glucometer would turn on but would turn off a few seconds later and would not stay turned on. -There was no glucometer in the medication cart with Resident #21's name. -There was a red glucometer stored with the actively used glucometers with no resident's name. Interview with the MA on 07/07/26 at 10:52am revealed: -She did not use Resident #21's glucometer because it was broken and would not stay turned on. -She used the red glucometer for Resident #21 and another resident because both of their glucometers were broken. -Resident #21's glucometer had been broken for the last couple of months. -She did not know if anyone was trying to obtain a new glucometer for Resident #21. -She was not sure if the broken glucometer had been reported to anyone.	D 273		

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D 273	Continued From page 27 Review of Resident #21's facility progress notes for April 2026 - July 2026 revealed no documentation related to any issues with the resident's glucometer or any attempts to contact the pharmacy or primary care provider (PCP) to obtain a new glucometer. Interview with Resident #21 on 07/08/26 at 8:45am revealed: -Her FSBS was checked but she did not know how often. -She did not know if she had her own glucometer. Interview with the Special Care Coordinator (SCC) on 07/07/26 at 1:15pm revealed: -Each resident was supposed to have their own glucometer. -The facility did not share glucometers to prevent cross-contamination. -He was not aware Resident #21's glucometer was broken and a red glucometer was being shared until today, 07/07/26. -The MAs should contact the pharmacy to get a new glucometer if one was broken. -He should be the first person notified by the MAs when a resident's glucometer was broken. -He was supposed to check glucometers when he did weekly cart audits, but he was new in this position and had not done that yet. Interview with the Administrator on 07/07/26 at 1:52pm revealed: -Each diabetic resident had their own glucometer. -She was not aware of Resident #21's glucometer being broken. -The MAs should notify her, the Resident Care Coordinator (RCC), or the SCC if a resident's glucometer was not working. -If the MAs had reported it, she would have	D 273		

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ordered or bought a new glucometer for Resident #21.

Telephone interview with Resident #21's PCP on 07/07/26 at 4:25pm revealed:
-She completed face-to-face exams on all diabetic residents every 6 months for diabetic supplies.
-The facility would need to contact her for a new prescription to obtain a glucometer so insurance would pay for it.
-No one from the facility had notified her that Resident #21's glucometer was broken or that she needed a new prescription.
-Glucometers should not be shared.
-Each resident should have their own glucometer for better hygiene and better safety and to prevent transmission of diseases.

[Refer to Tag 610, 10A NCAC 13F .1801(a) Infection Prevention and Control Policies and Procedures.]

4. Review of Resident #7's current FL-2 dated 04/30/26 revealed:
-Diagnoses included type 2 diabetes mellitus, hypertension, atrial fibrillation, chronic heart failure, respiratory failure, ulcerative pancolitis, muscle weakness, cardiac pacemaker, gastroesophageal reflux disease, pain, and anemia.
-There was an order to check fingerstick blood sugar (FSBS) twice a day at 8:00am and 5:00pm for Novolog sliding scale insulin (SSI): if less than (<) 60 call primary care provider (PCP); 0 - 150 = 0 units; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; if greater than (>) 400 = 12 units and call PCP. (Novolog is rapid-acting insulin used to lower blood sugar.)

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D 273	Continued From page 29 Review of Resident #7's June 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Novolog SSI check FSBS twice daily: < 60 call PCP; 0 - 150 = 0 units; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; > 400 = 12 units and call PCP scheduled at 8:00am and 5:00pm from 06/01/26 - 06/30/26. -The resident's FSBS was documented as being checked twice a day at 8:00am and 5:00pm. -The resident FSBS ranged from 105 - 363 from 06/01/26 - 06/30/26. Review of Resident #7's July 2026 eMAR dated 07/01/26 - 07/07/26 revealed: -There was an entry for Novolog SSI check FSBS twice daily: < 60 call PCP; 0 - 150 = 0 units; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; > 400 = 12 units and call PCP scheduled at 8:00am and 5:00pm. -The resident's FSBS was documented as being checked twice a day at 8:00am and 5:00pm from 07/01/26 - 07/07/26(8:00am). -The resident FSBS ranged from 90 - 357 from 07/01/26 - 07/07/26. Observation of Resident #7's medications on hand on 07/07/26 at 10:05am revealed: -There was a black zipper pouch (used for storing a glucometer) in the medication cart with a piece of tape with Resident #7's first initial and last name written on the tape. -When unzipped, the glucometer inside had a piece of tape with "house" written on the tape. -There were no glucometers in the medication cart with Resident #7's name.	D 273		

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D 273	Continued From page 30 Interview with the medication aide (MA) on 07/07/26 at 10:05am revealed: -She did not know where Resident #7's glucometer was and she did not have another glucometer with Resident #7's name. -"House" meant the glucometer was house stock and it belonged to this particular medication cart to use if a resident did not have their own glucometer. -She did not know if the house stock glucometer stored in Resident #7's pouch had been used to check FSBS for any other residents. -The MAs cleaned the glucometers with alcohol wipes and used disposable lancets. -She had not notified anyone that Resident #7 did not have a glucometer because she had not noticed the label on the back of the glucometer noted "house". Interview with Resident #7 on 07/08/26 at 4:10pm revealed: -She received FSBS checks in the morning and at bedtime. -The facility had a glucometer they used to check her FSBS. -She was not sure if she had her own glucometer. Interview with the Resident Care Coordinator (RCC) on 07/07/26 at 1:37pm revealed: -When she started working as the RCC in February or March 2026, all diabetic residents had their own labeled glucometers. -The facility's policy was for all diabetic residents to have their own glucometer labeled with their names on the pouch and the glucometer. -She was not aware the glucometer used for Resident #7 was labeled as a "house" glucometer. -"House" meant the facility had some extra glucometers in case a resident needed one.	D 273		

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D 273	Continued From page 31 -The MAs should have notified her there was no glucometer with Resident #7's name. -If notified she would have contacted the PCP and pharmacy to get a new one. -There was no system to check the glucometers. Interview with the Administrator on 07/07/26 at 1:52pm revealed: -Each diabetic resident had their own glucometer. -She was not aware there was no labeled glucometer for Resident #7's. -The facility did not have house stock glucometers, and she was not sure why there was glucometer labeled "house". -The MAs should notify her, the RCC, or the Special Care Coordinator (SCC) if a resident did not have a glucometer. -If the MAs had reported it, she would have ordered or bought a new glucometer for Resident #7. Telephone interview with Resident #7's PCP on 07/07/26 at 4:25pm revealed: -She completed face-to-face exams on all diabetic residents every 6 months for diabetic supplies. -The facility would need to contact her for a new prescription to obtain a glucometer so insurance would pay for it. -No one from the facility had notified her that Resident #7's glucometer was broken or that she needed a new prescription. -Glucometers should not be shared. -Each resident should have their own glucometer for better hygiene and better safety and to prevent transmission of diseases. [Refer to Tag 610, 10A NCAC 13F .1801(a) Infection Prevention and Control Policies and Procedures.]	D 273		

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D 273	Continued From page 32 5. Review of Resident #29's current FL-2 dated 07/25/25 revealed diagnoses included diabetes, hypertension, hyperlipidemia, and depression. Review of Resident #29's physician's order dated 04/20/26 revealed an order to check fingerstick blood sugar (FSBS) twice weekly. Review of Resident #29's June 2026 and July 2026 electronic medication administration record (eMAR) dated 06/01/26 - 07/08/26 revealed: -There was an entry to check FSBS twice weekly scheduled at 8:00am for June 2026 and July 2026. -There were 8 FSBS documented from 06/01/26 - 07/08/26. -The resident's FSBS ranged from 132 - 272 from 06/01/26 - 07/08/26. -The last time the FSBS was initialed as being checked was on 07/06/26. Observation of Resident #29's medications on hand on 07/07/26 at 9:52am revealed: -There was a black zipper pouch (used for storing a glucometer) in the medication cart with a piece of tape with Resident #29's last name written on the tape. -When unzipped, there was a bottle of test strips and one unopened alcohol wipe but no glucometer. -There were no glucometers in the medication cart with Resident #29's name. Interview with the medication aide (MA) on 07/07/26 at 9:52am revealed: -She did not know where Resident #29's glucometer was and she did not have another glucometer for the resident. -She last saw Resident #29's glucometer on	D 273		

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D 273	Continued From page 33 Saturday (07/04/26) when she worked on the assisted living (AL) side of the facility. -She had not checked Resident #29's FSBS today, because the resident's FSBS was not usually checked every day so, the FSBS had not "popped" on the eMAR to be checked today. Interview with Resident #29 on 07/08/26 at 4:03pm revealed: -His FSBS was checked but he was not sure how often. -The glucometer was kept on the medication cart. -He did not know if he had his own glucometer. Interview with the Resident Care Coordinator (RCC) on 07/07/26 at 1:37pm revealed: -When she started working as the RCC in February or March 2026, all diabetic residents had their own labeled glucometers. -The facility's policy was for all diabetic residents to have their own glucometer labeled with their names on the pouch and the glucometer. -She was not aware there was no glucometer in the medication cart for Resident #29. -No one had reported it to her. -The MAs should have notified her there was no glucometer with Resident #29's name. -If notified she would have contacted the primary care provider (PCP) and pharmacy to get a new one. -There was no system to check the glucometers. Interview with the Administrator on 07/07/26 at 1:52pm revealed: -Each diabetic resident had their own glucometer. -She was not aware of Resident #29's glucometer being missing. -The MAs should notify her, the RCC, or the Special Care Coordinator (SCC) if a resident did not have a glucometer.	D 273		

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D 273	Continued From page 34 -If the MAs had reported it, she would have ordered or bought a new glucometer for Resident #29. Attempted telephone interview with Resident #29's PCP on 07/14/26 at 10:21am was unsuccessful. _____ The facility failed to ensure health care referral and follow-up for Resident #24 who had a fall with injuries requiring a hospital visit in June 2026, including a broken nose. The referral to see an ear, nose, throat (ENT) provider for the broken nose was not done. Resident #24's primary care provider (PCP) was not notified of the need for follow-up visits after the fall. Resident #4 and Resident #21 had broken glucometers, while Resident #7 and Resident #29 did not have their own glucometers and the facility failed to notify the PCP and get replacement glucometers resulting in glucometers being shared, putting the residents at risk of transmission of diseases. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/13/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 29, 2026.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record:	D 276		

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D 276	Continued From page 35 (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: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to implement orders from the primary care provider for 2 of 7 sampled residents (#4, #8) related to orders for a urinalysis to check for a urinary tract infection (#4) and an order to check fingerstick blood sugars for a resident with diabetes (#8). The findings are: 1. Review of Resident #4's current FL-2 dated 07/16/26 revealed: -Diagnoses included dementia with behaviors, type 1 diabetes mellitus, hypertension, hallucinations, memory loss, and weight loss. -The resident's current level of care was special care unit (SCU). -The resident was documented as intermittently disoriented. -The resident was documented as incontinent of bladder. Review of Resident #4's current assessment and care plan dated 03/10/26 revealed: -Resident #4 was sometimes disoriented, forgetful, and needed reminders. -The resident had daily incontinence of bladder. -The resident was totally dependent on staff for assistance with toileting. -The resident needed extra assistance with	D 276		

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toileting due to higher incontinence episodes.

Review of Resident #4's primary care provider (PCP) visit notes dated January 2026 - April 2026 revealed:
-Resident #4 was seen and treated for a urinary tract infection (UTI) on 01/14/26.
-Resident #4 was seen and treated for a UTI on 04/08/26.

Review of Resident #4's PCP visit note dated 06/03/26 revealed:
-The resident was being seen for dysuria (pain or discomfort when urinating).
-The resident had been more confused recently and more agitated at times.
-There was an order for a urinalysis (UA). (UA is a laboratory test performed on a urine specimen to evaluate potential disorders of the urinary tract, including infections.)

Review of Resident #4's June 2026 laboratory results revealed no documentation of a UA being completed for the 06/03/26 order.

Review of Resident #4's facility progress notes revealed:
-On 06/01/26 at 4:16pm: informed PCP that Resident #4 was very sleepy and had several crying episodes today with complaints of pain in his private area.
-On 06/03/26 at 2:06pm: the resident was seen by PCP for dysuria; UA was ordered.
-On 06/08/26 at 3:04pm: the resident was crying today.
-On 06/10/26 at 1:55pm: the resident's behavior had been sporadic today; he had been yelling and aggressive with staff during toileting; the resident was overheard yelling from the hallway at staff who was assisting him with changing clothes; the

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PCP and family were notified.
-On 06/17/26 at 5:31pm: a urine specimen was collected per PCP and pick-up would be ordered.
-On 06/19/26 at 11:31am: the resident was sent out earlier in the morning for an unwitnessed fall from the bed; emergency medical services (EMS) transported the resident to the hospital.
-On 06/19/26 at 12:02pm: the Special Care Coordinator (SCC) contacted the contracted lab company due to a specimen not being picked up on time; SCC was assured the specimen would be picked up today.
-On 06/19/26 at 2:06pm: the resident returned to the facility from the hospital emergency room (ER) with an order for an antibiotic.

Review of Resident #4's hospital ER visit notes dated 06/19/26 revealed:
-Resident #4 had an unwitnessed fall and was found this morning.
-The resident complained of leg/knee pain and pain on his left side.
-The resident complained of having dysuria.
-The resident had tenderness to palpation of the left leg and knee; x-rays were negative for acute traumatic injury.
-The resident's urinalysis demonstrated evidence of acute UTI and the resident was complaining of some dysuria.
-An antibiotic was ordered for 7 days for the UTI, and the resident was discharged back to the facility.

Review of Resident #4's PCP visit note dated 06/24/26 revealed:
-Resident #4 was seen today for a hospital follow-up visit.
-The resident sustained a fall with no injuries on 06/19/26 and returned to the facility on the same day.

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-On 06/01/26, facility staff reported Resident #4 was having crying episodes and grabbing at his penis.
-On 06/10/26, the PCP inquired about the UA and was told it was collected and sent out.
-On 06/16/26, the PCP was told that a tracking number for the UA was not obtained so a new order for a UA would need to be ordered.
-Three days later (06/19/26), the resident sustained a fall and the hospital ER diagnosed the resident with a UTI.
-The resident's UA was finally obtained and the urine culture resulted today, so she sent an order for another antibiotic.
-Fortunately, the resident did not get sepsis (a life-threatening condition that develops when an existing infection triggers an extreme immune response in the body) while waiting on the UA and the ER treated the resident and sent him back to the facility.

Telephone interview with a Customer Relations Representative at the contracted lab company on 07/15/26 at 1:3pm revealed:
-There was an electronic order for a UA for Resident #4 on 06/02/26.
-The lab company never received a urine specimen until 06/20/26 for a specimen that was collected on 06/17/26.
-She was not sure why there was a delay in getting the urine specimen.

Interview with a medication aide (MA) on 07/14/26 at 11:15am revealed:
-The MAs or personal care aides (PCAs) collected urine specimens for UA orders.
-Once PCAs collected the urine, the PCAs notified the MAs.
-The urine specimen did not have to be refrigerated because they used a urine swab

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THE LANDINGS OF SWANSBORO	280 SWANSBORO LOOP ROAD SWANSBORO, NC 28584

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specimen.
-The MAs labeled the urine swab specimen and did the pick-up order with the contracted lab company.
-The urine swab specimen was put in a mail carrier bag, taken to the front desk for pick-up by the mail carrier and documented in the lab book.
-The MAs notified the Resident Care Coordinator (RCC) or SCC and the PCP that the urine was collected and documented it was collected in the resident's progress notes.
-If the MAs or PCAs were unable to get a urine specimen after a couple of days, they would notify the PCP.
-She was not sure why a urine specimen was not collected for Resident #4 for the UA ordered on 06/03/26.
-Staff sometimes forgot to document when urine was collected.
-They had collected urine specimens from Resident #4 in the past with no issues.

Interview with the SCC on 07/14/26 at 11:34am revealed:
-Resident #4 was having crying spells and increased agitation so the PCP ordered a UA at the beginning of June 2026.
-Resident #4's UA ordered on 06/03/26 was not collected.
-UA orders were usually given to the MAs.
-Either he or the MAs were responsible for collecting urine specimens when an order was received.
-Once the urine was collected, they notified the PCP and a tracking number was sent to the facility.
-The contracted lab company set up a pick-up for the urine specimen, and it was usually picked up by the end of the same day or sometimes the next day.

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D 276	Continued From page 40 -He was not sure why Resident #4's urine specimen was not collected for the UA ordered on 06/03/26. -If staff was having difficulty getting a urine specimen from a resident, they should notify him. -He was not notified of any issues with getting a urine specimen from Resident #4. -On the weekend of 06/13/26 - 06/14/26, he noticed that Resident #4 was still having behaviors. -The resident was more confused, more agitated, and more difficult to redirect. -The resident was having a "range of emotions" from crying to angry very quickly. -He knew something was not right with the resident because the resident did not usually cry, so he asked SCU staff about the results of the UA. -The SCU staff did not know anything about Resident #4's order for a UA on 06/03/26. -He had to request a new order because the previous order expired after 12 days. -He thought he received a new order for a UA on 06/16/26. -He collected a urine specimen from Resident #4 on 06/17/26. -He contacted the lab on 06/19/26 because the urine specimen swab had not been picked up and was told they would send a mail carrier that day. -He usually tried to check the lab book every day, but when he checked later, he was unable to locate documentation of Resident #4's UA ordered on 06/03/26. Interview with the Regional Vice President of Operations (RVPO) on 07/14/26 at 11:58am revealed: -The RCC, SCC, or MAs were responsible for collecting urine specimens for a UA order. -The RCC, SCC, or MAs were responsible for	D 276		

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notifying the contracted lab company when a urine specimen was ready to be picked up.
-The RCC or SCC were responsible for making sure urine specimens were collected and picked up.

Telephone interview with Resident #4's PCP on 07/15/26 at 1:28pm revealed:
-A contracted lab company was used for UAs and there was a process that had to be followed.
-The facility staff usually notified her if a resident complained of dysuria or had altered mental status.
-She would notify her scribe, who would email a code for the UA to the facility.
-The facility staff printed the label, collected the urine swab specimen, labeled it, put the swab in a specimen bag with an order sheet, and then called the mail carrier with a tracking number to pick up the specimen.
-Resident #4's urine specimen was not collected for the UA ordered on 06/03/26.
-Resident #4 had a fall (on 06/19/26) and it was possible the resident's UTI contributed to the fall.
-The delay in implementing the order for the UA to identify and treat the resident's UTI could have caused the resident to become septic which could cause the resident to have a fever, altered mental status, or worse; it could have caused death.

Based on observations, interviews, and record reviews, it was determined that Resident #4 was not interviewable.

2. Review of Resident #8's FL-2 dated 08/11/25 revealed:
-Diagnoses included diabetes, chronic kidney disease, and atrial fibrillation.
-Resident #8 was continent of bowel and bladder.
-Resident #8 was semi-ambulatory.

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D 276	Continued From page 42 Review of Resident #8's Resident Register revealed she was admitted to the facility on 01/10/23. Interview with Resident #8's facility contracted Pharmacist on 07/08/26 at 11:45am revealed there was an order that was profile only dated 12/01/25 for blood sugar (BS) checks before breakfast and dinner. Review of Resident #8's signed primary care provider (PCP) orders dated 06/03/26 revealed an order for blood sugar (BS) checks twice daily before breakfast and dinner. Review of Resident #8's April 2026 electronic medication administration record (eMAR) revealed: -There was an entry for BS checks twice daily every morning and evening before breakfast and dinner at 7:30am and 5:30pm. -There were no BSs documented at 7:30am on 04/01/26 to 04/03/26, 04/05/26 to 04/09/26, 04/11/26, 04/14/26, 04/18/26 to 04/22/26, 04/24/26 to 04/25/26, and 04/28/26 to 04/30/26. -There were no BSs documented at 5:30pm on 04/02/26, 04/05/26, 04/07/26, 04/10/26 to 04/11/26, 04/14/26, 04/22/26, 04/25/26, 04/28/26, and 04/30/26. -There were staff initials or "-" dashes in the spaces. -The BS range for April 2026 at 7:30am was 113 to 239. -The BS range for April 2026 at 5:30pm was 113 to 364. Review of Resident #8's May 2026 eMAR revealed: -There was an entry for BS checks twice daily	D 276		

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D 276	Continued From page 43 every morning and evening before breakfast and dinner at 7:30am and 5:30pm. -There were no BSs documented at 7:30am on 05/01/26, 05/05/26 to 05/07/26, and 05/09/26. -There were no BSs documented at 5:30pm on 05/02/26 to 05/03/26, 05/05/26 to 05/06/26, and 05/16/26. -There were staff initials in the spaces. -The BS range for May 2026 at 7:30am was 102 to 220. -The BS range for May 2026 at 5:30pm was 138 to 402. Interview with a medication aide (MA) on 07/09/26 at 2:30pm revealed: -When it was time to obtain a BS check it would come up on the eMAR. -There were times when the eMAR did not require the BS result. Interview with a second MA on 07/09/26 at 2:40pm revealed: -When it was time to obtain a BS the MA had to enter the BS result to clear the order. -The eMAR was the only place that a MA documented the BS result. Interview with the Resident Care Coordinator (RCC) on 07/13/26 at 11:27am revealed: -She did not know that Resident #8's BSs were not documented as ordered on the eMAR. -The eMAR was where the MA had to document the BS, the order would not clear if the BS result was not entered. -There was not a process for her to review BSs on the eMAR. -She did not know why the BS was documented on some days and not documented on other days.	D 276		

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D 276	Continued From page 44 Interview with the Administrator on 07/14/26 at 4:38pm revealed: -She had not been notified that Resident #8's BSs were not documented. -It was the RCC and Special Care Coordinator (SCC) responsibility to ensure that Resident #8's BS was completed. -She did not have a process to review missed BSs. -The primary care provider's (PCP) order should be followed. -Missed BSs could affect Resident #8's diabetes and she could have to go to the hospital for treatment. Based on observation, interviews, and record reviews, it was determined that Resident #8 was not interviewable. Attempted telephone interview with Resident #8's PCP on 07/14/26 at 10:00am was unsuccessful. _____ The facility failed to implement health care orders for Resident #4 and Resident #8. Resident #4 who had a history of urinary tract infections (UTIs) and was having painful urination did not have a urine specimen collected as ordered on 06/03/26. Resident #4 had a fall on 06/19/26 requiring a visit to the hospital emergency room (ER) where he was diagnosed with a UTI and began receiving antibiotics to treat the infection. Failing to collect Resident #4's urine specimen for the UA to identify the UTI put the resident at risk of becoming septic which could cause the resident to have a fever, altered mental status, or worse; it could have caused death. This failure placed the residents at substantial risk of serious physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in	D 276		

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D 276	Continued From page 45 accordance with G.S. 131D-34 on 07/14/26 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 14, 2026.	D 276		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION. The Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to ensure the rights of all residents were maintained including being treated with dignity and respect related to 3 residents (#6, #26, #27) being recorded by a staff member and posted on a social media site. The findings are: Review of the facility social networking and blogging policy dated 04/01/25 revealed: -It was a violation of community policy to record conversations, take photographs, or take videos with a recording device without prior permission from a supervisor or management. -The use of personal cellular phones was limited to the employee's break time and break area unless there was a business need.	D 338		

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D 338	Continued From page 46 -The community strictly prohibited the sharing on social media of any information pertaining to residents of the community. Review of videos that were provided by the Department of Social Services (DSS) that were posted on a staff member's social media account on 07/07/26 at 12:00pm revealed: -The first video recording was a woman in a nightgown, her face was not shown in the video. -The individual that recorded the video asked if the resident wanted anything and told her to go walk the halls or watch television. -The second video recording was a woman sitting, her face was not shown in the video. -The resident asked the individual who was recording the video if he could "get her drugs", the individual recording the video replied that he could "get her cocaine or crack for $35.00". -The third video recording was a woman sitting in a chair, her face was not shown in the video. -The resident was asking the individual who was recording the video if she could "pinch it", the individual recording the video replied "what are you talking about?", the resident replied "you know what I'm talking about", the individual recording the video replied "no". 1. Review of Resident #6's current FL-2 dated 01/28/26 revealed: -Diagnoses included dementia, cognitive impairment due to anoxic impairment, bipolar disorder, and polysubstance abuse. -The recommended level of care was special care unit (SCU). -The resident was constantly disoriented. Based on observation, interview, and record review it was determined that Resident #6 was not interviewable.	D 338		

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D 338	Continued From page 47 Refer to interview with the Resident Care Coordinator (RCC) on 07/10/26 at 8:50am. Refer to interview with the Administrator on 07/10/26 at 9:10am. 2. Review of Resident #26's current FL-2 dated 07/16/25 revealed: -Diagnosis included vascular dementia. -The recommended level of care was assisted living facility. -The was no information on orientation. Interview with Resident #26's family member on 07/10/26 at 8:10am revealed: -A facility employee called her and informed her there was a video on social media she needed to see. -She was able to recognize her family member in the video from her voice and her body. -She was not informed about the video from facility management. -On 06/04/26 she went into the Administrator's office and asked her if there was anything that she needed to be made aware of, the Administrator replied that there was not. -She asked the Administrator about the video posted on social media that was recorded at the facility and included her family member. -The Administrator informed her that she had not had the chance to call family members about the social media videos. -The Administrator informed her that she was made aware of the recordings on 05/31/26 and that she fired the staff member responsible for the recordings. -Her family member had no recollection of the video that was recorded. -She had anxiety attacks due to the video of her	D 338		

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D 338	Continued From page 48 family member being posted on social media. -She decided to move her family member out of the facility due to the incident. Refer to interview with the Resident Care Coordinator (RCC) on 07/10/26 at 8:50am. Refer to interview with the Administrator on 07/10/26 at 9:10am. 3. Review of Resident #27's current FL-2 dated 04/25/26 revealed: -Diagnoses included advanced dementia, gait instability, and hypertension -The recommended level of care was special care unit. -The resident was constantly disoriented. Refer to interview with the Resident Care Coordinator (RCC) on 07/10/26 at 8:50am. Refer to interview with the Administrator on 07/10/26 at 9:10am. _____ Interview with the Resident Care Coordinator (RCC) on 07/10/26 at 8:50am revealed: -Residents #26 and #27 were in the social media videos that a staff member posted online. -She was not sure of the date the videos were posted online. -The staff member was suspended when facility management saw the video. -Staff was prohibited from having their phones out while working on the floor. -She was not sure if the Administrator called the family members to inform them about the videos. -The Administrator was responsible for investigating the videos of the residents that were posted on social media.	D 338		

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D 338	Continued From page 49 Interview with the Administrator on 07/10/26 at 9:10am revealed: -Residents #6, #26, and #27 were in the social media videos that Staff A posted online. -On 05/24/26 a Department of Social Services (DSS) employee came to the facility and showed the social media video to the her. -Staff members told her that there was a social media video that was recorded in the facility with residents, but staff refused to tell her the name of the staff member that posted the video. -The staff member was working on the floor the day she first observed the video, he was immediately suspended and sent home. -Staff member A was terminated around 06/01/26. -She did not inform the family members of the residents that were involved in the videos. -On approximately 05/30/26 Resident #26's family member informed her that a former staff member sent a copy of the videos to her. -She called Resident #27's family member around 05/30/26 and left a message for them to return her call so that she could inform them about the social media video. -She did not inform Resident #27's family member about the incident. -She did not call Resident #6's family member to inform them about the social media video. -Staff was prohibited from having their phones out while working on the floor. -The staff member was trained on resident rights, and signed a copy of the social networking, camera, and personal use of telephone policy upon hire. -It was her responsibility to call family members immediately to inform them about the social media video. Attempted telephone interview with the staff	D 338		

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D 338	Continued From page 50 member who recorded the video on 07/16/26 at 1:00pm was unsuccessful.	D 338		
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 3 of 6 residents (#13, #21, #25) observed during the medication pass including errors with a medication used to prevent heart attacks and strokes (#25), an antipsychotic used to treat Parkinson's disease psychosis (#13), and a vitamin supplement (#21); and for 1 of 8 residents (#6) sampled for record review including multiple errors with a rapid-acting insulin (#6). The findings are: Review of the facility's Medication Administration-General Guidelines dated November 2018 revealed: -Medications were administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized	D 358		

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D 358	Continued From page 51 to do so. -The five rights, right resident, right drug, right dose, right route and right time, were applied for each medication being administered. -A triple check of these 5 Rights was recommended at three steps in the process of preparation of a medication for administration: (1) when the medication was selected, (2) when the dose was removed from the container, and finally (3) just after the dose was prepared and the medication put away. -Check #1: Select the Medication - label, container and contents were checked for integrity, and compared against the medication administration record (MAR) by reviewing the 5 Rights. -Check #2: Prepare the dose- the dose was removed from the container and verified against the label and the MAR by reviewing the 5 Rights. -Check #3: Complete the preparation of the dose and re-verify the label against the MAR by reviewing the 5 Rights when putting the medication away. -The MAR was always employed during medication administration. -Prior to administration of any medication, the medication and dosage schedule on the resident's MAR were compared with the medication label. -If the label and MAR were different and the container had not already been flagged indicating a change in directions, or if there was any other reason to question the dosage or directions, the physician's orders were checked for the correct dosage schedule. -Medications were administered in accordance with written orders of the prescriber. 1. The medication error rate was 10% as evidenced by 3 errors out of 29 opportunities	D 358		

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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 during the 8:00am - 9:00am medication pass on 07/08/26. a. Review of Resident #13's current FL-2 dated 04/01/26 revealed diagnoses included Parkinson's disease (a progressive neurological disorder that primarily affects movement but can also cause cognitive impairment), Parkinson's dementia, hyperkalemia, gastroesophageal reflux disease, and osteoarthritis. Review of Resident #13's Neurologist visit note dated 05/12/26 revealed: -Resident #13 was seen for management of Parkinson's disease. -The resident was having trouble with motor wearing off (medication effects diminish before the next dose causing breakthrough symptoms) and with severe tremor and mobility problems such as motor freezing (temporary, involuntary ability to move). -The resident was also having issues with hallucinations. -The resident also reported having cognitive issues when his medication wore off. Review of Resident #13's Neurologist order dated 06/17/26 revealed an order for Nuplazid 34mg 1 capsule daily. (Nuplazid is an antipsychotic medication used to treat hallucinations and delusions associated with Parkinson's disease psychosis.) Observation of the 8:00am medication pass on 07/08/26 revealed: -The medication aide (MA) prepared and administered morning medications to Resident #13 at 8:00am. -The MA did not prepare or administer Nuplazid to Resident #13 as ordered.	D 358		

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D 358	Continued From page 53 Review of Resident #13's June 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Nuplazid 34mg 1 capsule once daily scheduled at 8:00am. -The start dated was documented as 06/24/26. -Documentation for the administration of Nuplazid started on 06/25/26. -Nuplazid was documented as administered on 06/25/26; not available on 06/26/26 and held from 06/27/26 - 06/30/26. Review of Resident #13's July 2026 eMAR revealed: -There was an entry for Nuplazid 34mg 1 capsule once daily scheduled at 8:00am. -Nuplazid was documented as not being administered on 07/02/26 due to the medication being unavailable; 07/05/26 due to being charted in error; 07/07/26 - 07/08/26 due to being held. Observation of Resident #13's medications on hand on 07/08/26 at 8:00am revealed there was no Nuplazid available for administration. Interview with the MA on 07/08/26 at 1:27pm revealed: -She did not administer Nuplazid to Resident #13 this morning because there was none available to administer. -Resident #13's Nuplazid was on hold because the family did not pay for it because it was expensive. Review of Resident #13's physician's orders revealed no orders to hold or discontinue Nuplazid. Telephone interviews with a pharmacist at the	D 358		

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D 358	Continued From page 54 facility's contracted pharmacy on 07/10/26 at 2:40pm and 07/15/26 at 11:45am revealed: -The pharmacy received an electronic order for Resident #13's Nuplazid on 06/17/26 prescribed by a Neurologist. -Resident #13's family denied cost authorization for Resident #13's Nuplazid due to the high cost of the medication. -The pharmacy never received an order to hold or discontinue Resident #13's Nuplazid. -It was still an active order in the eMAR system for Resident #13. -The pharmacy never dispensed any Nuplazid for Resident #13. Review of Resident #13's Medication Coverage Notification form (undated) revealed: -The medication was Nuplazid 34mg capsules at a cost of $1,312.35 for a 30-day supply. -The pharmacy noted the resident's family had denied cost of authorization. -The section of the form to indicate the action to be taken was blank. -The options included: do not send, facility to supply; do not send, family to supply; facility would guarantee payment for item listed above; or bill responsible party. Review of Resident #13's June 2026 - July 2026 facility progress notes revealed: -On 07/06/26 at 1:17pm, staff contacted the pharmacy about Resident #13's Nuplazid. -The pharmacy staff reported the resident's power of attorney (POA) signed a denial form and the pharmacy would fax the form to the facility. -There was no documentation that the facility contacted the Neurologist about the Nuplazid not being administered. -There was no documentation that the facility contacting the pharmacy about the Nuplazid	D 358		

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being unavailable prior to 07/06/26.
-On 07/09/26 at 8:32pm, staff contacted the Neurologist's office to obtain either a hold order or a discontinue order for Resident #13's Nuplazid due to the medication being very costly and the resident could not pay for it; the resident's family was trying to get a grant to cover the cost; someone at the office indicated they would let the Neurologist know.
-On 07/14/26 at 1:17pm, the Resident Care Coordinator (RCC) spoke with a nurse at the Neurologist's office who stated the Neurologist was not going to send any orders to hold Nuplazid because the resident needed the medication and it was necessary for the resident to have the medication.
-The RCC informed the nurse that the facility had received the Nuplazid.

Interview with the Administrator on 07/10/26 at 8:03am revealed:
-They were unable to locate a hold order for Resident #13's Nuplazid.
-They were waiting to hear back from Resident #13's Neurologist to obtain a hold order for the Nuplazid.

Second interview with the MA on 07/14/26 at 6:45pm revealed:
-She documented Resident #13's Nuplazid as held because he did not have any available because the family did not pay for it because it was too expensive.
-She did not contact Resident #13's Neurologist about the resident not receiving the Nuplazid; she just documented it was on hold.
-She did not know if there was an order to hold or discontinue the medication.
-They just received Resident #13's Nuplazid a couple of days ago.

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D 358	Continued From page 56 Second observation of Resident #13's medications on hand on 07/14/26 at 7:49pm revealed: -There was a supply of 30 Nuplazid 34mg capsules dispensed on 07/07/26 by a pharmaceutical manufacturer. -The instructions were to take 1 capsule daily. Interview with Resident #13 on 07/14/26 at 6:52pm revealed: -He was having a difficult time with his Parkinson's symptoms. -He just started receiving the new medication his Neurologist prescribed a few days ago. -He felt like the new medication was helping with his Parkinson's symptoms. Second interview with the Administrator on 07/14/26 at 5:47pm revealed: -The RCC and Special Care Coordinator (SCC) were responsible for contacting providers for orders to hold medications. -She was not sure when Resident #13's Neurologist was contacted to get a hold order, but it should be documented. Attempted telephone interview with Resident #13's family member on 07/15/26 at 2:09pm was unsuccessful. Attempted telephone interview with Resident #13's Neurologist on 07/14/26 at 10:07am was unsuccessful. b. Review of Resident #25's current FL-2 dated 01/19/26 revealed: -Diagnoses included cerebrovascular accident (stroke), hypertensive disorder, coronary atherosclerosis, hyperlipidemia, diffuse	D 358		

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D 358	Continued From page 57 non-Hodgkin's lymphoma, dementia with behavioral disturbances, and chronic pain syndrome. -There was an order for Aspirin 81mg 1 tablet daily. (Aspirin is used to prevent heart attacks and strokes.) Review of Resident #25's physician's order dated 06/01/26 revealed an order to discontinue Aspirin until 06/06/26. Observation of the 8:00am medication pass on 07/08/26 revealed: -The medication aide (MA) prepared and administered morning medications to Resident #25 at 8:09am. -The MA did not prepare or administer Aspirin 81mg to Resident #25. Review of Resident #25's July 2026 electronic medication administration record (eMAR) revealed there was no entry for Aspirin and none was documented as administered. Observation of Resident #25's medications on hand on 07/08/26 at 8:05am revealed there were no Aspirin 81mg tablets available for administration. Interview with the MA on 07/08/26 at 1:27pm revealed: -Resident #25 used to take Aspirin but she did not recall how long ago. -Resident #25 had to get a medical procedure done so the Aspirin was stopped, then it was started again, then stopped again for another procedure. -She was unsure of the dates it was stopped. -She had not seen Aspirin on Resident #25's eMARs since it was last stopped.	D 358		

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D 358	Continued From page 58 -She was not sure what kind of procedures the resident had or when they were done. Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/10/26 at 2:40pm revealed: -The pharmacy never received an order to restart Resident #25's Aspirin after the hold order dated 06/01/26. -The pharmacy did not receive any requests from the facility to refill Resident #25's Aspirin after the hold order dated 06/01/26. Interview with the Administrator on 07/08/26 at 4:20pm revealed: -A clarification request was sent but no response was received from Resident #25's primary care provider (PCP). -She was unsure when a clarification request was sent. -Resident #25 used an outside PCP and it was difficult to get a response from the PCP. Attempted telephone interview with Resident #25's PCP on 07/10/26 at 11:06am was unsuccessful. c. Review of Resident #21's current FL-2 dated 04/02/26 reveled: -Diagnoses included dementia with behavioral disturbances, anemia, type 2 diabetes mellitus, hypertension, breast cancer, and Vitamin D deficiency. -There was an order for Vitamin B12 1000mcg 1 tablet once daily. (Vitamin B12 is a supplement used to treat Vitamin B12 deficiency.) Observation of the 8:00am medication pass on 07/08/26 revealed: -The medication aide (MA) prepared and	D 358		

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administered morning medications, including 1 Vitamin B12 100mcg tablet to Resident #21 at 8:42am.
-Resident #21 received Vitamin B12 100mcg instead of 1000mcg as ordered.

Review of Resident #21's July 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for Vitamin B12 100mcg 1 tablet once daily scheduled at 8:00am.
-Vitamin B12 100mcg was documented as administered from 07/01/26 - 07/08/26.
-There was no entry for Vitamin B12 1000mcg daily.

Observation of Resident #21's medications on hand on 07/08/26 at 8:40am revealed:
-The resident's medications were packaged in a multi-dose pack (MDP) dated 07/02/26.
-The morning MDP included Vitamin B12 100mcg tablets with instructions to take 1 tablet daily.

Interview with the MA on 07/08/26 at 1:39pm revealed:
-Resident #21 had always received Vitamin B12 100mcg every day to her knowledge.
-She was not aware of an order for Vitamin B12 1000mcg once daily.
-There were no Vitamin B12 1000mcg tablets available for administration.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/10/26 at 2:40pm revealed:
-The pharmacy had an order for Resident #21 dated 03/26/26 for Vitamin B12 100mcg 1 tablet daily.
-The pharmacy did not have a copy of Resident #21's FL-2 dated 04/02/26 with an order for

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D 358	Continued From page 60 Vitamin B12 1000mcg once daily. Interview with the Administrator on 07/08/26 at 4:20pm revealed: -Resident #21 was taking Vitamin B12 1000mcg when the resident was admitted to the facility. -She thought the order may have been entered incorrectly into the eMAR system. -She and the Resident Care Coordinator (RCC) and the Special Care Coordinator (SCC) did weekly chart audits and should have caught the discrepancy with Resident #21's Vitamin B12. Interview with Resident #21's PCP on 07/08/26 at 2:09pm revealed: -She would have to check Resident #21's lab levels again to determine if the resident needed to be on 100mcg or 1000mcg. -She would adjust the dosage based on the lab levels. 2. Review of Resident #6's FL-2 dated 01/28/26 revealed: -Diagnoses included cognitive impairment, diabetes, bipolar, polysubstance abuse, and dementia. -Resident #6 was constantly disoriented. Review of Resident #6's Resident Register revealed she was admitted to the facility on 01/08/26. Review of Resident #6's physician order sheet dated 01/28/26 revealed: -There was an order for Lispro 100units/ml, check blood sugar (BS) before meals and administer subcutaneously as directed per sliding scale (SS), 141-180 administer 4 units, 181-220 administer 8 units, 221-260 administer 8 units, 261-300 administer 10 units, 301-350 administer	D 358		

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D 358	Continued From page 61 12 units, 351-400 administer 16 units, greater than 400 administer 20 units and call primary care provider (PCP). -There was an order for Lispro 100 units/ml, check BS at bedtime and administer subcutaneously as directed per SS, 141-180 administer 2 units, 181-220 administer 4 units, 221-260 administer 4 units, 261-300 administer 5 units, 301-350 administer 6 units, 351-400 administer 8 units, greater than 400 administer 10 units and call PCP. Review of Resident #6's March 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Lispro 100units/ml check BS before meals and administer as directed by SS, 141-180 administer 4 units, 181-220 administer 8 units, 221-260 administer 8 units, 261-300 administer 10 units, 301-350 administer 12 units, 351-400 administer 16 units, greater than 400 administer 20 units and call primary care provider (PCP). -There was an entry for Lispro 100 units/ml, check BS at bedtime and administer subcutaneously as directed per SS, 141-180 administer 2 units, 181-220 administer 4 units, 221-260 administer 4 units, 261-300 administer 5 units, 301-350 administer 6 units, 351-400 administer 8 units, greater than 400 administer 10 units and call PCP. -There was not an entry for the number of units of Lispro administered from 03/01/26 to 03/31/26. -BS on 03/06/26 at 7:30am was 198 and there was no insulin documented as administered. -BS on 03/12/26 at 7:30am was 198 and there was no insulin documented as administered. -BS on 03/02/26 at 11:30am was 219 and there was no insulin documented as administered. -BS on 03/02/26 at 11:30am was 219 and there	D 358		

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D 358	Continued From page 62 was no insulin documented as administered. -BS on 03/04/26 at 11:30am was 267 and there was no insulin documented as administered. -BS on 03/06/26 at 11:30am was 357 and there was no insulin documented as administered. -BS on 03/10/26 at 11:30am was 241 and there was no insulin documented as administered. -BS on 03/13/26 at 11:30am was 384 and there was no insulin documented as administered. -BS on 03/20/26 at 11:30am was 269 and there was no insulin documented as administered. -BS on 03/22/26 at 11:30am was 168 and there was no insulin documented as administered. -BS on 03/24/26 at 11:30am was 350 and there was no insulin documented as administered. -BS on 03/27/26 at 11:30am was 267 and there was no insulin documented as administered. -BS on 03/30/26 at 11:30am was 284 and there was no insulin documented as administered. -BS on 03/31/26 at 11:30am was 228 and there was no insulin documented as administered. -BS on 03/10/26 at 5:30pm was 302 and there was no insulin documented as administered. -BS on 03/19/26 at 5:30pm was 249 and there was no insulin documented as administered. -BS on 03/22/26 at 5:30pm was 239 and there was no insulin documented as administered. -BS on 03/13/26 at 8:00pm was 174 and there was no insulin documented as administered. -BS on 03/19/26 at 8:00pm was 242 and there was no insulin documented as administered. -BS on 03/21/26 at 8:00pm was 144 and there was no insulin documented as administered. -BS on 03/22/26 at 8:00pm was 263 and there was no insulin documented as administered. -BS on 03/31/26 at 8:00pm was 187 and there was no insulin documented as administered. Review of Resident #6's April 2026 eMAR revealed:	D 358		

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D 358	Continued From page 63 -There was an entry for Lispro 100units/ml check BS before meals and administer as directed by SS, 141-180 administer 4 units, 181-220 administer 8 units, 221-260 administer 8 units, 261-300 administer 10 units, 301-350 administer 12 units, 351-400 administer 16 units, greater than 400 administer 20 units and call primary care provider (PCP). -There was an entry for Lispro 100 units/ml, check BS at bedtime and administer subcutaneously as directed per SS, 141-180 administer 2 units, 181-220 administer 4 units, 221-260 administer 4 units, 261-300 administer 5 units, 301-350 administer 6 units, 351-400 administer 8 units, greater than 400 administer 10 units and call PCP. -There was not an entry for the number of units of Lispro administered from 04/01/26 to 04/30/26. -BS on 04/01/26 at 11:30am was 177 and there was no insulin documented as administered. -BS on 04/09/26 at 8:00pm was 319 and there was no insulin documented as administered. -BS on 04/10/26 at 7:30am was 366 and there was no insulin documented as administered. -BS on 04/10/26 at 8:00pm was 157 and there was no insulin documented as administered. -BS on 04/11/26 at 11:30am was 258 and there was no insulin documented as administered. -BS on 04/13/26 at 8:00pm was 174 and there was no insulin documented as administered. -BS on 04/17/26 at 11:30am was 429 and there was no insulin documented as administered. -BS on 04/17/26 at 5:30pm was 228 and there was no insulin documented as administered. -BS on 04/18/26 at 8:00pm was 364 and there was no insulin documented as administered. -BS on 04/19/26 at 11:30am was 191 and there was no insulin documented as administered. -BS on 04/19/26 at 5:30pm was 164 and there was no insulin documented as administered.	D 358		

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D 358	Continued From page 64 -BS on 04/21/26 at 7:30am was 146 and there was no insulin documented as administered. -BS on 04/21/26 at 11:30am was 339 and there was no insulin documented as administered. -BS on 04/21/26 at 5:30pm was 350 and there was no insulin documented as administered. -BS on 04/22/26 at 11:30am was 242 and there was no insulin documented as administered. -BS on 04/22/26 at 5:30pm was 231 and there was no insulin documented as administered. -BS on 04/22/26 at 8:00pm was 178 and there was no insulin documented as administered. -BS on 04/23/26 at 11:30am was 169 and there was no insulin documented as administered. -BS on 04/23/26 at 5:30pm was 171 and there was no insulin documented as administered. -BS on 04/24/26 at 7:30am was 218 and there was no insulin documented as administered. -BS on 04/24/26 at 11:30am was 154 and there was no insulin documented as administered. -BS on 04/24/26 at 5:30pm was 189 and there was no insulin documented as administered. -BS on 04/24/26 at 8:00pm was 321 and there was no insulin documented as administered. -BS on 04/25/26 at 11:30am was 401 and there was no insulin documented as administered. -BS on 04/27/26 at 8:00pm was 229 and there was no insulin documented as administered. -BS on 04/28/26 at 11:30am was 248 and there was no insulin documented as administered. -BS on 04/30/26 at 11:30am was 298 and there was no insulin documented as administered. -BS on 04/30/26 at 5:30pm was 221 and there was no insulin documented as administered. Review of Resident #6's May 2026 eMAR revealed: -There was an entry for Lispro 100units/ml check BS before meals and administer as directed by SS, 141-180 administer 4 units, 181-220	D 358		

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administer 8 units, 221-260 administer 8 units, 261-300 administer 10 units, 301-350 administer 12 units, 351-400 administer 16 units, greater than 400 administer 20 units and call primary care provider (PCP).
-There was an entry for Lispro 100 units/ml, check BS at bedtime and administer subcutaneously as directed per SS, 141-180 administer 2 units, 181-220 administer 4 units, 221-260 administer 4 units, 261-300 administer 5 units, 301-350 administer 6 units, 351-400 administer 8 units, greater than 400 administer 10 units and call PCP.
-There was not an entry for the number of units of Lispro administered from 05/01/26 to 05/31/26.
-BS on 05/01/26 at 7:30am was 395 and there was no insulin documented as administered.
-BS on 05/01/26 at 11:30am was 237 and there was no insulin documented as administered.
-BS on 05/01/26 at 5:30pm was 241 and there was no insulin documented as administered.
-BS on 05/02/26 at 11:30am was 219 and there was no insulin documented as administered.
-BS on 05/04/26 at 11:30am was 266 and there was no insulin documented as administered.
-BS on 05/04/26 at 5:30pm was 169 and there was no insulin documented as administered.
-BS on 05/06/26 at 11:30am was 157 and there was no insulin documented as administered.
-BS on 05/06/26 at 5:30pm was 157 and there was no insulin documented as administered.
-BS on 05/07/26 at 7:30am was 142 and there was no insulin documented as administered.
-BS on 05/08/26 at 8:00pm was 175 and there was no insulin documented as administered.
-BS on 05/09/26 at 11:30am was 437 and there was no insulin documented as administered.
-BS on 05/09/26 at 8:00pm was 169 and there was no insulin documented as administered.
-BS on 05/11/26 at 5:30pm was 264 and there

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was no insulin documented as administered.
-BS on 05/12/26 at 7:30am was 222 and there was no insulin documented as administered.
-BS on 05/12/26 at 5:30pm was 198 and there was no insulin documented as administered.
-BS on 05/13/26 at 8:00pm was 248 and there was no insulin documented as administered.
-BS on 05/14/26 at 11:30am was 220 and there was no insulin documented as administered.
-BS on 05/14/26 at 5:30pm was 167 and there was no insulin documented as administered.
-BS on 05/15/26 at 11:30am was 186 and there was no insulin documented as administered.
-BS on 05/15/26 at 5:30pm was 227 and there was no insulin documented as administered.
-BS on 05/16/26 at 5:30pm was 143 and there was no insulin documented as administered.
-BS on 05/16/26 at 8:00pm was 230 and there was no insulin documented as administered.
-BS on 05/17/26 at 11:30am was 215 and there was no insulin documented as administered.
-BS on 05/17/26 at 5:30pm was 178 and there was no insulin documented as administered.
-BS on 05/17/26 at 8:00pm was 222 and there was no insulin documented as administered.
-BS on 05/18/26 at 11:30am was 242 and there was no insulin documented as administered.
-BS on 05/19/26 at 11:30am was 293 and there was no insulin documented as administered.
-BS on 05/19/26 at 5:30pm was 226 and there was no insulin documented as administered.
-BS on 05/19/26 at 8:00pm was 171 and there was no insulin documented as administered.
-BS on 05/20/26 at 11:30am was 227 and there was no insulin documented as administered.
-BS on 05/20/26 at 8:00pm was 280 and there was no insulin documented as administered.
-BS on 05/22/26 at 8:00pm was 171 and there was no insulin documented as administered.
-BS on 05/25/26 at 8:00pm was 286 and there

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was no insulin documented as administered.
-BS on 05/26/26 at 11:30am was 222 and there was no insulin documented as administered.
-BS on 05/26/26 at 5:30pm was 301 and there was no insulin documented as administered.
-BS on 05/27/26 at 11:30am was 217 and there was no insulin documented as administered.
-BS on 05/27/26 at 8:00pm was 169 and there was no insulin documented as administered.
-BS on 05/30/26 at 11:30am was 304 and there was no insulin documented as administered.
-BS on 05/31/26 at 11:30am was 318 and there was no insulin documented as administered.
-BS on 05/31/26 at 5:30pm was 157 and there was no insulin documented as administered.

Review of Resident #6's June 2026 eMAR revealed:
-There was an entry for Lispro 100units/ml check BS before meals and administer as directed by SS, 141-180 administer 4 units, 181-220 administer 8 units, 221-260 administer 8 units, 261-300 administer 10 units, 301-350 administer 12 units, 351-400 administer 16 units, greater than 400 administer 20 units and call primary care provider (PCP).
-There was an entry for Lispro 100 units/ml, check BS at bedtime and administer subcutaneously as directed per SS, 141-180 administer 2 units, 181-220 administer 4 units, 221-260 administer 4 units, 261-300 administer 5 units, 301-350 administer 6 units, 351-400 administer 8 units, greater than 400 administer 10 units and call PCP.
-BS on 06/01/26 at 11:30am was 265 and there was no insulin documented as administered.
-BS on 06/03/26 at 5:30pm was 178 and there was no insulin documented as administered.
-BS on 06/03/26 at 8:00pm was 198 and there was no insulin documented as administered.

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D 358	Continued From page 68 Telephone interview with Resident #6's facility contracted Pharmacist on 07/15/26 at 11:44am revealed: -Lispro was dispensed for Resident #6 on 01/31/26 for 21ml, 7 pens. -Lispro was dispensed for Resident #6 on 05/13/26 for 21ml, 7 pens Interview with Resident #6's facility contracted primary care provider (PCP) on 07/09/26 at 2:10pm revealed: -Resident #6's diabetes was hard to regulate and she had adjusted her insulin. -She had been notified when Resident #6's BS was out of range. -She reviewed Resident #6's BS online. Interview with the Regional Clinical Director (RCD) on 07/09/26 at 2:47pm revealed: -The facility had been using the new computer system for about 7 months. -The BS result must be entered to clear the order. -She did not know how the MAs were able to clear the BS order without entering a BS result. Interview with the Administrator on 07/14/26 at 4:38pm revealed: -She had not been notified that Resident #6's BS or insulin units administered were not documented. -Missed orders should be reviewed daily by the Resident Care Coordinator (RCC) and SCC. -Resident #6's orders should be followed as written. -It was important for Resident #6's control of her diabetes to have her BS check and her insulin administered. -Resident #6 could have had to go to the hospital if her BS was not controlled.	D 358		

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D 358	Continued From page 69 Based on observations, interviews, and record reviews, it was determined that Resident #6 was not interviewable. Attempted telephone interview with Resident #6's responsible person on 07/14/26 at 10:15am was unsuccessful. _____ The facility failed to administer medications as ordered to 3 of 6 residents observed during the medication pass on 07/08/26. Resident #13 who was diagnosed with Parkinson's disease did not receive a medication used to treat hallucinations associated with Parkinson's disease for at least 25 days due to the facility putting the medication on hold without an order. Resident #25's Aspirin was not restarted in June 2026 after a brief hold order and he had a history of stroke. Resident #6's diabetes was difficult to regulate according to the primary care provider and the resident's sliding scale insulin dosage was not documented on multiple occasions so it could not be determined if the resident received any insulin or received the correct amount of sliding scale insulin. This failure of the facility was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/13/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 29, 2026.	D 358		
D 367	10A NCAC 13F .1004 (j) Medication Administration	D 367		

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D 367	Continued From page 70 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the electronic medication administration records were accurate for 2 of 6 sampled residents (#3, #13) including documentation for a medication used to treat cellulitis of the leg (#3) and for an antipsychotic used to treat Parkinson's disease psychosis (#13). The findings are: 1. Review of Resident #3's FL-2 dated 07/17/25 revealed: -Diagnoses included diabetes, hypertension, sick sinus syndrome, atherosclerotic heart disease,	D 367		

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and atrial fibrillation.
-Resident #3 was ambulatory.
-Resident #3 was incontinent of bladder.

Review of Resident #3's Resident Register revealed the resident was admitted on 10/07/22.

Review of Resident #3's office visit note with her primary care provider (PCP) dated 04/15/26 revealed:
-Resident #3 was seen for a wound on her right lower leg and a cough.
-There was a diagnosis of cellulitis of right lower leg.
-There was an entry for medication changes for Bactrim DS administer twice daily for 10 days with a start date of 04/15/26 (Bactrim is used to treat bacterial infections).
-Medication and wound care orders were called to Resident #3's assisted living facility.

Review of Resident #3's primary care provider's (PCP) prescription dated 04/15/26 revealed an order for Bactrim DS 800-160mg take 1 tablet twice daily for 10 days.

Review of Resident #3's April 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for Bactrim DS 800-160 take 1 tablet by mouth twice daily for 10 days at 8:00am and 8:00pm.
-Bactrim DS was documented as administered at 8:00am from 04/16/26 to 04/20/26.
-Bactrim DS was documented as discontinued at 8:00am from 04/21/26 to 04/25/26.
-Bactrim DS was documented as administered at 8:00pm from 04/15/26 to 04/20/26.
-Bactrim DS was documented as discontinued at 8:00pm from 04/21/26 to 04/25/26.

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D 367	Continued From page 72 -There was a second entry for Bactrim DS 800-160 take 1 tablet by mouth twice daily for 10 days at 8:00am and 8:00pm. -Bactrim DS was documented as administered at 8:00am from 04/18/26 to 04/27/26. -Bactrim DS was documented as administered at 8:00pm from 04/17/26 to 04/27/26. -The same MA documented the Bactrim DS was administered at 8:00am on 04/18/26 to 04/20/26, this MA was different from the MAs that documented on the first entry at 8:00am 04/16/26 to 04/20/26. -Bactrim DS was documented as administered twice on the eMAR at 8:00pm on 04/17/26 to 04/20/26. -The same MA documented the Bactrim DS was administered at 8:00pm on 04/17/26 to 04/20/26, this MA was different from the MAs that documented on the first entry at 8:00pm 04/15/26 to 04/20/26. Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/10/26 at 2:43pm revealed: -The pharmacy received a faxed prescription on 04/15/26 at 4:10pm for Bactrim DS administer twice daily for 10 days for Resident #3 from the PCP. -The pharmacy received a fax to discontinue the prescription Bactrim DS on 04/15/26 at 4:13pm from the PCP. -The pharmacy received a faxed prescription on 04/17/25 at 12:52pm for Bactrim DS for Resident #3 administer twice daily for 10 days. -The prescription for Bactrim DS was dispensed on 04/17/26 for 20 tablets. Interview with a medication aide (MA) on 07/09/26 at 3:00pm revealed: -She did not know why Resident #3 had 2 entries	D 367		

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for Bactrim DS.
-MAs could not enter orders or discontinue orders on the eMARs.
-MAs must enter something on the eMARs to be able to continue administering medications.

Interview with the Resident Care Coordinator (RCC) on 07/10/26 at 2:52pm revealed:
-She did not know why Resident #3's Bactrim was entered twice on the eMAR.
-The pharmacy entered the orders on the eMAR.
-She was not sure why her initials had signed off the Bactrim DS on the second entry from 04/17/26 to 04/20/26.
-No other staff had her log in to document on the eMAR.

Interview with the Regional Clinical Director (RCD) on 07/09/26 at 2:47pm revealed:
-The pharmacy entered orders on the eMARs.
-She did not know why Resident #3's Bactrim DS was entered twice with different start dates.
-The eMAR showed that the Bactrim DS was documented twice from 04/17/26 to 04/20/26.
-She did not know why there were different initials on the second Bactrim entry from the first entry.

Interview with the Administrator on 07/14/26 at 4:38pm revealed:
-The RCC, Special Care Coordinator (SCC), and herself reviewed the eMARs for accuracy.
-She was not sure why there were two entries for Bactrim DS for Resident #3.
-When there was documentation on both entries it appeared to be administered twice.
-She was not sure why the initials were not the same on both entries when they were documented on the same day.

2. Review of Resident #13's current FL-2 dated

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D 367	Continued From page 74 04/01/26 revealed diagnoses included Parkinson's disease (a progressive neurological disorder that primarily affects movement but can also cause cognitive impairment), Parkinson's dementia, hyperkalemia, gastroesophageal reflux disease, and osteoarthritis. Review of Resident #13's Neurologist order dated 06/17/26 revealed an order for Nuplazid 34mg 1 capsule daily. (Nuplazid is an antipsychotic medication used to treat hallucinations and delusions associated with Parkinson's disease psychosis). Review of Resident #13's June 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Nuplazid 34mg 1 capsule once daily scheduled at 8:00am. -The start dated was documented as 06/24/26. -Nuplazid was documented as administered on 06/25/26. -Nuplazid was documented as not available on 06/26/26 and held from 06/27/26 - 06/30/26. Review of Resident #13's July 2026 eMAR revealed: -There was an entry for Nuplazid 34mg 1 capsule once daily scheduled at 8:00am. -Nuplazid was documented as administered at 8:00am on 07/01/26, 07/02/26, 07/03/26, 07/04/26 and 07/06/26. -Nuplazid was documented as not being administered on 07/02/26 due to the medication being unavailable; 07/05/26 due to being charted in error; 07/07/26 - 07/08/26 due to being held. Observation of Resident #13's medications on hand on 07/08/26 at 8:00am revealed there was no Nuplazid available for administration.	D 367		

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D 367	Continued From page 75 Interview with the MA on 07/08/26 at 1:27pm revealed: -She did not administer Nuplazid to Resident #13 that morning because there was none available to administer. -She was not sure why she documented Resident #13's Nuplazid as administered (on 06/25/26, 07/03/26, 07/04/26) because the facility never received the medication from the pharmacy. -Resident #13's Nuplazid was on hold because the family did not pay for it because it was expensive. Telephone interviews with a pharmacist at the facility's contracted pharmacy on 07/10/26 at 2:40pm and 07/15/26 at 11:45am revealed: -The pharmacy received an electronic order for Resident #13's Nuplazid on 06/17/26 prescribed by a Neurologist. -Resident #13's family denied cost authorization for Resident #13's Nuplazid due to the high cost of the medication. -The pharmacy never dispensed any Nuplazid for Resident #13. Review of Resident #13's Medication Coverage Notification form (undated) revealed: -The medication was Nuplazid 34mg capsules at a cost of $1,312.35 for a 30-day supply. -The pharmacy noted the resident's family had denied cost of authorization. Interview with the Resident Care Coordinator (RCC) on 07/09/26 at 9:06am revealed: -The MAs should not document a medication was administered on the eMAR if the medication was not available. -She and the Special Care Coordinator (SCC) were responsible for weekly audits, including the	D 367		

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D 367	Continued From page 76 eMARs. Interview with the Administrator on 07/10/26 at 8:03am revealed: -They were unable to locate a hold order for Resident #13's Nuplazid. -The MAs should not document a medication as administered if it was unavailable.	D 367		
D 372	10A NCAC 13F .1004 (o) Medication Administration 10A NCAC 13F .1004 Medication Administration (o) A resident's medication shall not be administered to another resident except in an emergency. In the event of an emergency, the borrowed medications shall be replaced promptly and the borrowing and replacement of the medication shall be documented. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were not borrowed except in an emergency for a resident (#15) related to a controlled substance used to treat anxiety. The findings are: Review of the facility's Medication Administration - General Guidelines revised November 2018 revealed medications supplied for one resident were never administered to another resident. Review of the facility's Medication Policies and Procedures dated September 2021 revealed: -Any medication ordered for a resident should not be used by any other resident, staff, or individual	D 372		

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D 372	Continued From page 77 except for emergency borrowing as defined in 10A NCAC 13F .1004(o). -Medication should never be borrowed as an expediency measure or for the convenience of staff. -Any borrowed medication must be replaced promptly and documented on the Borrowed Medication Form to indicate from whom the medication was borrowed and to whom it was given. -This documentation must be done at the time of borrowing. -This form must be signed by the Care Coordinator and the Administrator and maintained in the facility. Review of Resident #15's current FL-2 dated 07/16/25 revealed: -Diagnoses included anxiety, hypertension, intervertebral disc degeneration, sciatica, and flushing. -There was an order for Alprazolam 0.5mg 2 tablets at bedtime. (Alprazolam is a controlled substance used to treat anxiety.) Telephone interviews with a pharmacist at the facility's contracted pharmacy on 07/10/26 at 2:40pm and 07/15/26 at 11:45am revealed: -There were 60 (30-day supply) Alprazolam 0.5mg tablets dispensed on 03/05/26 for Resident #15. -The supply of Alprazolam dispensed on 03/05/26 was delivered to the facility on 03/06/26 at 5:50am. -There were 60 (30-day supply) Alprazolam 0.5mg tablets dispensed on 04/13/26 for Resident #15. -The supply of Alprazolam dispensed on 04/13/26 was delivered to the facility on 04/14/26 at 5:30am.	D 372		

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D 372	Continued From page 78 -There were 60 (30-day supply) Alprazolam 0.5mg tablets dispensed on 05/07/26 for Resident #15. -The supply of Alprazolam dispensed on 05/07/26 was delivered to the facility on 05/08/26 at 5:22am. -There were 60 (30-day supply) Alprazolam 0.5mg tablets dispensed on 06/04/26 for Resident #15. -The supply of Alprazolam dispensed on 06/04/26 was delivered to the facility on 06/05/26 at 6:32am. Review of Resident #15's March 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Alprazolam 0.5mg 2 tablets (1mg) at bedtime scheduled at 8:00pm. -Alprazolam was documented as administered at 8:00pm from 03/01/26 - 03/04/26. -There was a second entry for Alprazolam 0.5mg 2 tablets (1mg) at bedtime scheduled at 8:30pm. -Alprazolam was documented as administered at 8:30pm from 03/05/26 - 03/31/26. -There were 31 doses (62 tablets) of Alprazolam 0.5mg documented as administered from 03/01/26 - 03/31/26. Review of Resident #15's April 2026 eMAR revealed: -There was an entry for Alprazolam 0.5mg 2 tablets (1mg) at bedtime scheduled at 8:30pm. -There were 30 doses (60 tablets) of Alprazolam 0.5mg documented as administered from 04/01/26 - 04/30/26. Review of Resident #15's March 2026 and April 2026 electronic controlled substance records (eCSRs) for Alprazolam revealed: -The beginning balance on 03/01/26 was 0.	D 372		

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D 372	Continued From page 79 -There were 16 doses (32 tablets) of Alprazolam 0.5mg tablets documented as administered from 03/01/26 - 03/16/26 but none was declined from the count and the balance remained 0. -On 03/17/26 at 12:19pm, there was a medication check-in with 46 tablets (60 tablets received from pharmacy on 03/06/26) added to the count for a balance of 46. -These 23 doses (46 tablets) were documented as administered from 03/17/26 - 04/08/26, leaving a balance of 0. -There were 7 doses (14 tablets) documented as administered from 04/09/26 - 04/15/26 but none were declined from the count and the balance remained 0. -On 04/16/26 at 5:21am, there was a medication check-in with 56 tablets (60 tablets received on 04/14/26) added to the count for a balance of 56. Observation of Resident #15's medications on hand on 07/07/26 at 9:45am revealed: -There was a supply of Alprazolam 0.5mg tablets dispensed on 06/04/26 with instructions to take 2 tablets at bedtime. -There were 9 of 60 Alprazolam 0.5mg tablets remaining. Review of Resident #15's facility progress notes dated March 2026 - July 2026 revealed: -On 03/04/26 at 8:55pm, there was communication with the pharmacy and the resident's Alprazolam was refilled. -On 04/10/26 at 4:14pm, there was communication with the pharmacy about the resident's Alprazolam; pharmacy staff indicated they would fax the doctor about the resident's Alprazolam because there were no refills and a new prescription was needed. -On 04/12/26 at 9:48pm, there was communication with the resident's primary care	D 372		

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provider (PCP) that the resident needed a new prescription for Alprazolam.
-There was no other documentation related to the resident's Alprazolam.

Review of Resident #15's eMARs, eCSRs, and pharmacy dispensing information for Alprazolam revealed:
-Resident #15 had a balance of 46 Alprazolam 0.5mg tablets on 03/17/26.
-Those 23 doses were documented as administered from 03/17/26 - 04/08/26, leaving a balance of 0.
-The next supply of Alprazolam 0.5mg for Resident #15 was dispensed on 04/13/26 and delivered to the facility on 04/14/26 at 5:30am.
-The MAs documented Resident #15 was administered Alprazolam on the eMAR and eCSR from 04/09/26 - 04/13/26 when none would have been available to administer until the new supply arrived on 04/14/26.

Review of the April 2026 eCSRs for Alprazolam 0.5mg tablets for a resident living on the assisted living (AL) side of the facility revealed:
-There was a medication check-in on 04/16/26 at 5:17am when 2 tablets were deducted from the balance with no reason noted.
-There was a medication quantity change on 04/27/26 at 7:16am when 7 tablets were deducted from the count with no reason noted.
-There was a medication quantity change on 04/28/26 at 7:04am with 2 tablets deducted from the count with no reason noted.

Review of the April 2026 eCSRs for Alprazolam 0.5mg tablets for a second resident living on the AL side of the facility revealed there was a medication check-in on 04/16/26 at 5:18am when 5 tablets were deducted from the balance with no

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D 372	Continued From page 81 reason noted. Interview with Resident #15 on 07/10/26 at 2:31pm revealed: -She usually received medications at about the same time every day. -The facility had not run out of any of her medications, and she had not missed any doses. -She took a medication for anxiety at bedtime and she had not missed any doses. -She would know if she did not receive the medication for anxiety because it helped her sleep. Interview with a medication aide (MA) on 07/09/26 at 8:51am revealed: -She did not currently borrow medications, including controlled substances. -The MAs used to borrow medications when the facility was under previous management about a year ago. -There was a previous MA who borrowed medications, but she no longer worked at the facility and she was not sure when the MA last borrowed medications. -If medications were unavailable, the MAs should get medications from the back-up pharmacy. Telephone interview with a second MA on 07/15/26 at 8:41am revealed: -Resident #15 was "on top of her game" with her medications. -Resident #15 would know if she missed any medications. -She did not borrow medications, and she did not know if other MAs borrowed medications. -She did not recall Resident #15 being out of Alprazolam. -If Resident #15 had not been administered Alprazolam, it would be noted on the eMAR and	D 372		

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D 372	Continued From page 82 the reason not administered would also be noted. Interview with the Special Care Coordinator (SCC) on 07/09/26 at 8:28am revealed: -The MAs were not allowed to borrow any medications, including controlled substances. -He was not aware of any medications being borrowed since he started in February 2026. Interview with the Resident Care Coordinator (RCC) on 07/09/26 at 9:06am revealed: -She did not like borrowing medications and she did not think it was allowed but she was not sure. -No MAs had reported borrowing any medications to her. -She assumed the MAs would document it and replace any borrowed medications. -She had not dealt with borrowed medications, so she was not sure of the process. -If medication was not available, the MAs should get it from the back-up pharmacy. Second interview with the RCC on 07/15/26 at 2:38pm revealed: -She did not recall if Resident #15 had run out of Alprazolam. -Resident #15 "definitely" received Alprazolam because the resident would have told the RCC if she had not received her Alprazolam. -There were a couple of other residents on the AL side of the facility who received the same strength of Alprazolam. -The MAs were not supposed to borrow medications, but the MAs probably would not have told her if they borrowed medication because the MAs knew they were not supposed to borrow. Interview with the Administrator on 07/09/26 at 4:24pm revealed:	D 372		

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D 372	Continued From page 83 -The MAs were not supposed to borrow any medications. -She was not aware of any medications being borrowed. Interview with the Regional Clinical Director (RCD) on 07/10/26 at 3:23pm revealed: -Medications could only be borrowed in an emergency. -She was not aware of any medications being borrowed for any residents. -The MAs should check with their supervisor before borrowing any medications. -If a controlled substance was borrowed, it should be documented on the controlled substance records. -If medications were borrowed, it should be documented and replaced. Telephone interview with Resident #15's PCP on 07/15/26 at 1:26pm revealed: -She did not recall when the facility contacted her about needing a prescription for Resident #15's Alprazolam but she sent the prescription on 04/13/26. -All controlled substances had to be electronically prescribed and the on-call provider did not usually send prescriptions for controlled substances on the weekend. -It was not good practice to borrow medications for the safety of the residents. -Resident #15 was alert and oriented and if she had missed any doses of Alprazolam, the resident would have known and the resident would have been very upset. -The resident would have told the PCP during their visits if she had missed any doses of Alprazolam. -If Resident #15 had missed doses of Alprazolam, the resident could have withdrawal symptoms	D 372		

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D 372	Continued From page 84 including seizures. -There had been no reported withdrawal symptoms for Resident #15. Attempted telephone interview with a third MA on 07/15/26 at 2:13pm was unsuccessful.	D 372		
D 392	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure readily retrievable records that accurately reconciled the receipt, administration, and disposition of controlled substances for 7 of 7 residents (#1, #3, #5, #10, #15, #16, #22) sampled with orders for controlled substances used to treat moderate to severe pain (#1, #3, #5, #16) and used to treat anxiety (#3, #10, #15, #22), including a resident who had missing pain medication (#16). The findings are: Review of the facility's Controlled Substance / Medication Diversion Policy dated September 2021 revealed: -The facility would ensure that all Federal and State regulations relevant to the control of	D 392		

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D 392	Continued From page 85 controlled substances were followed. -All missing and unaccounted for controlled substance medications must be reported, as listed below. -All medication would be audited upon receipt from the pharmacy and compared to the order receipt. -The 'pharmacy packing slip' must be completed. -There was a separate packing slip for controlled substances. -It was extremely important that the controlled substance packing slip was signed at the time of delivery and given to the delivery personnel for return to the pharmacy. -If there was no staff present to sign for the controlled substances at the time of delivery, the controlled substances would be returned to the pharmacy by the delivery personnel. -Staff would document the reporting and the resolution of the discrepancy on an incident reporting form. -A copy of the packing slip in question should be attached to the incident reporting form. -Each controlled substance medication received should be maintained on electronic medication administration record (eMAR). -Staff must follow accurate documentation practices when charting the use of controlled substances. -If a controlled substance medication was prepared for administration, but contaminated or not given, staff should dispose of the controlled substance at the facility. -Only single dose destruction/disposal could be done at the facility. -Another staff member must witness the disposition of the controlled substance and initial the count sheet. -Any spill of a controlled substance medication must be reported to supervisory staff	D 392		

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D 392	Continued From page 86	D 392		

immediately.
-Any controlled substance medication that was expired, discontinued, or no longer required, should be removed from the cart and written up on the Medication Destruction Form.
-A controlled substance medication count must be completed at the end of each shift, or anytime controlled substance keys were exchanged.
-If a medication aide (MA) must leave the shift prior to the end of the shift, a count must be completed before the MA left the facility.
-The off-going staff must be logged into eMAR, the oncoming staff would sign as verifier/witness.
-Oncoming staff should count the controlled substance medication and the off-going staff should enter the number counted into the eMAR.
-Controlled substance bubble pack cards should be removed from the med cart drawer and counted so that each dose on the card could be seen.
-Staff should check the back of the card to assure there had been no tampering with the card.
-The use of tape or any other sealant to reseal or secure medication in the bubble pack was strictly forbidden.
-If the controlled substance count was incorrect, medication had been tampered with in any way, or a discrepancy was found, both the supervisor and the Administrator must be notified immediately.
-Involved staff must remain at the facility until released by the Administrator.
-Supervisory staff would direct and participate in the preliminary investigation to rule out any documentation or misfiling error that might account for the missing medication.
-If the medication was not found or accounted for, either the Care Coordinator or the Administrator would direct staff to notify and report the situation to: local Law Enforcement, Nurse Aide (NA) or

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D 392	Continued From page 87 Health Care Personnel Registry (HCPR), Department of Social Services (DSS), the dispensing pharmacy, and the resident's physician. -The Administrator would be responsible for the completion of any necessary NA/HCPR twenty-four-hour report and five-day report. -This reporting was mandatory. -Staff implicated in diversion would be suspended until completion of an investigation. 1. Review of Resident #16's current FL-2 dated 02/18/26 revealed: -Diagnoses included vascular dementia, type 2 diabetes with hyperglycemia, chronic kidney disease, cardiac pacemaker, pneumonia, hypertensive heart disease, atherosclerotic heart disease, acute respiratory failure, osteoarthritis of the left knee, and effusion of the left knee. -There was an order for Hydrocodone/Acetaminophen (APAP) 10-325mg 1 tablet every 12 hours. (Hydrocodone/APAP is a controlled substance used to treat moderate to severe pain. Hydrocodone is an opioid, which is a class of medication with the potential for abuse and dependence.) Review of Resident #16's previous physician's order dated 10/29/25 revealed an order for Hydrocodone/APAP 10-325mg 1 tablet twice a day. Review of Resident #16's Health Care Personnel Registry (HCPR) Initial Allegation and Investigation Reports dated 12/24/25 revealed: -There were 3 medication aides (MAs) listed as accused employees. -Each accused employee was a MA on duty during the window of time that Resident #16's controlled substance came to be missing.	D 392		

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D 392	Continued From page 88 -The facility became aware of the incident on 12/24/25 at 1:30pm. -A MA reported to the Administrator that there were 4 Hydrocodone/APAP 10-325mg tablets missing for Resident #16. -The incident was reported to the local police department on 12/24/25 at 2:00pm. -The HCPR report was signed by the Administrator. -There were attachments with urine drug testing results for all 3 MAs and one MA tested positive for opioids. -The facility unsubstantiated the allegation of drug diversion for 2 of 3 MAs. -The facility substantiated the allegation of drug diversion for the MA who tested positive for opioids and the MA was terminated. Review of Resident #16's December 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Hydrocodone/APAP 10-325mg 1 tablet twice daily scheduled at 8:00am and 8:00pm. -There was no documentation that Hydrocodone/APAP 10-325mg was administered from 12/05/25 - 12/08/25 (8:00am) with no reasons documented. -Hydrocodone/APAP 10-325mg was documented as not administered on 12/24/25 at 8:00pm - 12/25/26 at 8:00am and from 12/27/25 (8:00pm) - 12/31/25 due to the resident being out of the facility and on a leave of absence. -There were 44 total doses of Hydrocodone/APAP 10-325mg documented as administered from 12/01/25 - 12/31/25. Review of Resident #16's December 2025 electronic controlled substance record (eCSR) for Hydrocodone/APAP 10-325mg revealed:	D 392		

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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 392	Continued From page 89 -There were 43 doses of Hydrocodone/APAP 10-325mg documented and declined from the count as administered from 12/01/25 - 12/31/25 but 44 doses were documented as administered on the December 2025 eMAR. -The first entry was a medication check-in with 56 in the Quantity column, 28 in the Administered column, and 28 in the Balance column. -There were no Hydrocodone/APAP 10-325mg tablets documented as administered from 12/04/25 (8:00pm) - 12/07/25 (8:00pm) -On 12/08/25 at 7:09am, there was a medication quantity change with 1 tablet deducted with no explanation leaving a balance of 20 tablets. -On 12/08/25 at 7:43pm, there was a "Medication Disposal, Other - Describe - transferred to new prescription" with 20 in the Quantity column and 20 declined in the Administered column, leaving a balance of 0. -On 12/08/26 at 7:43pm, there was a check in with 160 in the Quantity column, 80 in the Administered column, and 80 in the Balance column. -On 12/22/25 at 8:44pm, there was a medication quantity change with 1 tablet deducted, leaving a balance of 50 tablets. -On 12/24/26 at 8:21pm there was a "Medication Disposal, Other - Describe - missing 4 tablets under investigation" with 47 in the Quantity column and 4 declined in the Administered column, leaving a balance of 43. -On 12/24/25 at 11:17pm, one Hydrocodone/APAP 10-325mg tablet was documented as administered but it was declined from the count and the balance remained 43. -On 12/26/26 at 7:24am there was a "Medication Disposal, Other - Describe - resident left with family and 2 tablets were deducted, leaving a balance of 40 tablets. -The last dose documented was 12/27/25 at	D 392		

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8:13am with a balance of 36 tablets.
-The eCSR did not accurately reflect the administration, receipt, and disposition of Hydrocodone/APAP for Resident #16.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/10/26 at 2:40pm revealed:
-There were 60 Hydrocodone/APAP 10-325mg tablets dispensed on 11/01/25 for Resident #16.
-There were 60 Hydrocodone/APAP 10-325mg tablets dispensed on 12/04/25 for Resident #16.

Telephone interview with a medication aide (MA) on 07/10/26 at 10:31am revealed:
-When she came to work on the morning of 12/24/25, she counted the controlled substances with the night shift MA.
-The night shift MA told her that another MA (now a former MA) had prepared Resident #16's medications, including Hydrocodone/APAP for a 2-day leave of absence.
-The former MA had supposedly opened Resident #16's multi-dose packs (MDPs) and added Hydrocodone/APAP tablets from the bubble card to each MDP.
-She did not give the medication to the resident that morning because she could tell the extra tablets in the MDPs did not look like Hydrocodone/APAP.
-There were 4 extra tablets because the resident received Hydrocodone/APAP twice a day.
-She removed the extra tablets and sent the bubble card with Hydrocodone/APAP and the MDPs with the resident and his family member.
-She did not recall how Resident #16's doses of Hydrocodone/APAP were documented for the missing tablets or the medications sent on the leave of absence.
-She went to the Administrator, and they identified

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the extra tablets as Tylenol 650mg. (Tylenol is an over-the-counter medication used for mild to moderate pain.)
-She had to write a statement and give a urine sample for a drug screening test that day, 12/24/25.
-The police also came to the facility and asked her some questions.
-The four Hydrocodone/APAP tablets for Resident #16 were never found.
-There were sometimes discrepancies with the eCSR and the controlled substance count for residents when the MAs did shift counts.
-She thought the discrepancies were caused by the electronic system not working correctly.
-She was not sure why Resident #16's December 2025 eCSR was not accurate.
-She was not aware of any other controlled substances missing.

Interview with the Administrator on 07/09/26 at 9:57am revealed:
-On 12/24/25, a MA came to her and reported something was not right with Resident #16's Hydrocodone/APAP.
-A former MA had pulled Resident #16's medications to send home with the resident who was going home with his family for the holidays.
-Another MA noticed the former MA had opened Resident #16's sealed MDPs and added another tablet in each MDP that was supposed to be the resident's Hydrocodone/APAP removed from the bubble card.
-The MA noticed the extra tablets added to the MDP were a different size than Resident #16's Hydrocodone/APAP tablets.
-They investigated and discovered the extra tablets the former MA added to the MDP were Tylenol instead of Hydrocodone/APAP.
-The Tylenol were removed and the resident's

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Hydrocodone/APAP bubble card was sent with the resident when he went home for a visit with his family.
-The resident did not miss any doses of the Hydrocodone/APAP tablets.
-She conducted urine drug testing on the 3 MAs that had been on duty around the time of the incident and the former MA tested positive for opioids while the other MAs tested negative.
-The former MA did not answer on 12/24/25 when she called him but he came in on 12/25/25 for duty but she stopped him, did the urine drug test, got a written statement from him, and he was suspended pending her investigation.
-She reported it to the HCPR, local law enforcement, and the resident's primary care provider (PCP).
-They never found Resident #16's missing Hydrocodone/APAP tablets.
-After her 5-day HCPR investigation, she tried to contact the former MA to let him know he had been terminated but he never returned her call or came back to the facility.
-The resident was later moved to the special care unit (SCU), placed on hospice services and passed away on 03/07/26.

Attempted telephone interview with the night MA on 07/15/26 at 4:45pm was unsuccessful.

Attempted telephone interview with the former MA on 07/10/26 at 10:21am was unsuccessful.

Refer to interviews with a MA on 07/09/26 at 8:51am and 2:10pm.

Refer to interview with a second MA on 07/09/26 at 2:25pm.

Refer to interview with the Regional Clinical

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D 392	Continued From page 93 Director (RCD) on 07/09/26 at 2:47pm. Refer to interview with the Special Care Coordinator (SCC) on 07/09/26 at 8:28am. Refer to interview with the Resident Care Coordinator (RCC) on 07/09/26 at 9:06am. Refer to interview with the Administrator on 07/13/26 at 2:30pm. 2. Review of Resident #15's current FL-2 dated 07/16/25 revealed: -Diagnoses included anxiety, hypertension, intervertebral disc degeneration, sciatica, and flushing. -There was an order for Alprazolam 0.5mg 2 tablets at bedtime. (Alprazolam is a controlled substance used to treat anxiety.) Review of Resident #15's April 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Alprazolam 0.5mg 2 tablets (1mg) at bedtime scheduled at 8:30pm. -There were 30 doses (60 tablets) of Alprazolam 0.5mg documented as administered from 04/01/26 - 04/30/26. Review of Resident #15's April 2026 electronic controlled substance record (eCSR) for Alprazolam revealed: -There were 46 tablets (23 doses) Alprazolam 0.5mg tablets documented and declined from the count as administered from 04/01/26 - 04/30/26 but 60 tablets (30 doses) were documented as administered on the April 2026 eMAR. -On 04/08/26 at 8:56pm, there was one dose (2 tablets) documented as administered, leaving a balance of 0.	D 392		

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D 392	Continued From page 94 -The next 6 entries on 04/09/26 at 8:19pm - 04/15/26 at 10:24pm, one dose (2 tablets) at each time was documented as administered but 0 was documented as declined and there was a 0 balance for each entry. -On 04/16/26 at 5:21am, there was a medication check-in documented with 112 in the Quantity column, 56 in the Administered column, and 56 in the Balance column. -On 04/21/26 at 3:33pm, there was a medication quantity change with 5 tablets deducted from the balance with no explanation leaving a balance of 41. -On 04/23/26 at 8:32pm, there was a "Medication Disposal, Other - Describe - entry Pharmacy drug error, take back facility" with 35 in the Quantity column and 2 declined in the Administered column, leaving a balance of 33 tablets. -The last entry documented was a dose administered on 04/30/26 at 10:24pm, leaving a balance of 19 tablets. -The eCSR did not accurately reflect the administration, receipt, and disposition of Alprazolam for Resident #15. Review of Resident #15's May 2026 eMAR revealed: -There was an entry for Alprazolam 0.5mg 2 tablets (1mg) at bedtime scheduled at 8:30pm. -Alprazolam 0.5mg was documented as not administered on 05/30/26 due to the medication being unavailable. -There were 30 doses (60 tablets) of Alprazolam 0.5mg documented as administered from 05/01/26 - 05/31/26. Review of Resident #15's May 2026 eCSR for Alprazolam revealed: -There were 60 tablets (30 doses) Alprazolam 0.5mg tablets documented and declined from the	D 392		

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count as administered from 05/01/26 - 05/31/26.
-On 05/08/26 at 11:27am, there was a medication check-in documented with 125 in the Quantity column, 60 in the Administered column, and 65 in the Balance column.
-On 05/11/26 at 7:33am, there was a medication quantity change with 26 tablets deducted from the balance with no explanation leaving a balance of 33.
-On 05/12/26 at 7:29am, there was a medication quantity change with 83 in the Quantity column, 26 added in the Administered column, and 57 in the Balance column.
-On 05/30/26 at 8:48pm, Alprazolam was documented as being administered but no tablets were deducted from the count.
-The last entry documented was a dose administered on 05/31/26 at 9:00pm, leaving a balance of 19 tablets.
-The eCSR did not accurately reflect the administration, receipt, and disposition of Alprazolam for Resident #15.

Review of Resident #15's June 2026 eMAR revealed:
-There was an entry for Alprazolam 0.5mg 2 tablets (1mg) at bedtime scheduled at 8:30pm.
-There were 30 doses (60 tablets) of Alprazolam 0.5mg documented as administered from 06/01/26 - 06/30/26.

Review of Resident #15's June 2026 eCSR for Alprazolam revealed:
-There were 60 tablets (30 doses) Alprazolam 0.5mg tablets documented and declined from the count as administered from 06/01/26 - 06/30/26.
-On 06/05/26 at 5:10pm, there was a medication check-in documented with 131 in the Quantity column, 60 in the Administered column, and 71 in the Balance column.

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D 392	Continued From page 96 -There was no Alprazolam documented as administered and declined from the count on 06/07/26 but it was documented as administered on the eMAR. -On 06/08/26 at 7:09am, there was a medication quantity change with 2 tablets deducted with no explanation, leaving a balance of 65. -On 06/10/26 at 10:13pm, one dose (2 tablets) was documented as administered and declined, leaving a balance of 59. -On 06/10/26 at 10:13pm (14 seconds later), another dose (2 tablets) was documented as administered and declined, leaving a balance of 57. -On 06/11/26 at 7:29am, there was a medication quantity change with 2 tablets added with no explanation, leaving a balance of 59. -There was no Alprazolam documented as administered and declined from the count on 06/14/26 but it was documented as administered on the eMAR. -On 06/16/26 at 7:06am, there was a medication quantity change with 2 tablets deducted with no explanation, leaving a balance of 49. -On 06/16/26 at 2:11pm and 9:33am, there were 2 tablets documented as administered and deducted each time, but no dose was due at 2:11pm. -On 06/17/26 at 7:03am, there was a medication quantity change with 2 tablets added with no explanation, leaving a balance of 47. -There was no Alprazolam documented as administered and declined from the count on 06/25/26 but it was documented as administered on the eMAR. -On 06/26/26 at 7:07am, there was a medication quantity change with 2 tablets deducted with no explanation, leaving a balance of 29. -On 06/16/26 at 7:10pm and 8:14pm, there were 2 tablets documented as administered and	D 392		

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D 392	Continued From page 97 deducted each time (4 tablets total, but only one dose (2 tablets) was due at bedtime. -On 06/26/26 at 7:21pm, there was a medication quantity change with 2 tablets added with no explanation, leaving a balance of 29. -On 06/29/26 at 7:35am, there was a medication quantity change with 2 tablets deducted with no explanation, leaving a balance of 25. -The last entry documented was a dose administered on 06/30/26 at 10:56pm, leaving a balance of 21 tablets. -The eCSR did not accurately reflect the administration, receipt, and disposition of Alprazolam for Resident #15. Review of Resident #15's July 2026 eMAR dated 07/01/26 - 07/07/26 (8:30am) revealed: -There was an entry for Alprazolam 0.5mg 2 tablets (1mg) at bedtime scheduled at 8:30pm. -There were 6 doses (12 tablets) of Alprazolam 0.5mg documented as administered from 07/01/26 - 07/06/26. Review of Resident #15's July 2026 eCSR for Alprazolam dated 07/01/26 - 07/06/26 revealed: -There were 12 tablets (6 doses) Alprazolam 0.5mg tablets documented and declined from the count as administered from 07/01/26 - 07/06/26. -The last entry documented was a dose administered on 07/06/26 at 9:00pm, leaving a balance of 9 tablets. Observation of Resident #15's medications on hand on 07/07/26 at 9:45am revealed: -There was a supply of Alprazolam 0.5mg tablets dispensed on 06/04/26 with instructions to take 2 tablets at bedtime. -There were 9 of 60 Alprazolam 0.5mg tablets remaining.	D 392		

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D 392	Continued From page 98 Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/10/26 at 2:40pm revealed: -There were 60 (30-day supply) Alprazolam 0.5mg tablets dispensed on 03/05/26 for Resident #15. -There were 60 (30-day supply) Alprazolam 0.5mg tablets dispensed on 04/13/26 for Resident #15. -There were 60 (30-day supply) Alprazolam 0.5mg tablets dispensed on 05/07/26 for Resident #15. -There were 60 (30-day supply) Alprazolam 0.5mg tablets dispensed on 06/04/26 for Resident #15. Refer to interviews with a medication aide (MA) on 07/09/26 at 8:51am and 2:10pm. Refer to interview with a second MA on 07/09/26 at 2:25pm. Refer to interview with the Regional Clinical Director (RCD) on 07/09/26 at 2:47pm. Refer to interview with the Special Care Coordinator (SCC) on 07/09/26 at 8:28am. Refer to interview with the Resident Care Coordinator (RCC) on 07/09/26 at 9:06am. Refer to interview with the Administrator on 07/13/26 at 2:30pm. 3. Review of Resident #10's current FL-2 dated 01/27/26 revealed diagnoses included dementia without behaviors, type 2 diabetes, hypothyroidism, hyperlipidemia, peripheral vascular disease, effusion of right knee, weakness, and pneumonia.	D 392		

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D 392	Continued From page 99 Review of Resident #10's physician's order dated 02/19/26 revealed an order for Alprazolam 0.5mg every 12 hours. (Alprazolam is a controlled substance used to treat anxiety.) Review of Resident #10's April 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Alprazolam 0.5mg 1 tablet twice daily scheduled at 8:30am and 8:30pm. -Alprazolam 0.5mg was documented as administered on 44 occasions at 8:30am and 8:30pm from 04/01/26 - 04/23/26 (8:30am). -There was a second entry for Alprazolam 0.5mg 1 tablet every 12 hours for anxiety scheduled at 10:00am and 10:00pm. -Alprazolam 0.5mg was documented as administered on 15 occasions at 10:00am and 10:00pm from 04/23/26 (10:00pm) - 04/30/26. -There were 59 doses of Alprazolam 0.5mg documented as administered from 04/01/26 - 04/30/26. Review of Resident #10's April 2026 electronic controlled substance record (eCSR) for Alprazolam revealed: -There were 42 Alprazolam 0.5mg tablets documented and declined from the count as administered from 04/01/26 - 04/30/26 but 59 doses were documented as administered on the April 2026 eMAR. -On 04/08/26 at 7:03am, there was a medication check-in documented and one tablet was added back to the count with no explanation. -On 04/19/26 at 7:38pm, one dose was documented as administered leaving a balance of 0. -The next 3 entries on 04/20/26 at 10:54am,	D 392		

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D 392	Continued From page 100 04/20/26 at 9:48pm, and 04/21/26 at 10:15am, one dose at each time was documented as administered but 0 was documented as declined and there was a 0 balance for each entry. -On 04/21/26 at 3:33pm, there was a medication quantity change with 118 in the Quantity column, 59 in the Administered column, and 59 in the Balance column with no explanations documented. -On 04/22/26 at 6:45am, there was a medication check-in documented with 178 in the Quantity column, 60 in the Administered column, and 118 in the Balance column. -On 04/23/26 at 8:32pm, there was a "Medication Disposal, Other - Describe - entry Pharmacy drug error, take back facility" with 115 in the Quantity column and 58 declined in the Administered column, leaving a balance of 57 tablets. -On 04/27/26 at 7:16am, there was a medication quantity change with 7 tablets deducted, leaving a balance of 50 tablets. -For the last entry on 04/28/26 at 7:04am, there was a medication quantity change and 2 tablets were deducted leaving a balance of 48 tablets. -There were no entries that doses were administered on 04/23/26 at 8:30am and any doses from 04/24/26 - 04/30/26, a total of 15 doses but those doses were documented as administered on the eMAR. -The eCSR did not accurately reflect the administration, receipt, and disposition of Alprazolam for Resident #10. Review of Resident #10's May 2026 eMAR revealed: -There was an entry for Alprazolam 0.5mg 1 tablet every 12 hours for anxiety scheduled at 10:00am and 10:00pm. -There were 62 doses of Alprazolam 0.5mg documented as administered from 05/01/26 -	D 392		

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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 392	Continued From page 101 05/31/26. Review of Resident #10's May 2026 eCSR for Alprazolam revealed: -There were 46 Alprazolam 0.5mg tablets documented and declined from the count as administered from 05/01/26 - 05/31/26 but 62 doses were documented as administered on the May 2026 eMAR. -The first entry dated 05/01/26 at 7:30am was a medication quantity change with 48 in the Quantity column and 6 tablets declined from the Administered column, leaving a balance of 42 tablets. -On 05/02/26 at 7:16pm, there was a "Medication Disposal, Other - Describe - entry Pharmacy drug error, take back facility" with 42 in the Quantity column and 3 tablets deducted from the Administered column, leaving a balance of 39 tablets. -On 05/05/26 at 7:14am, there was a medication quantity changed with no explanation and 5 tablets were deducted leaving a balance of 34 tablets. -From 05/05/26 at 7:03pm - 05/11/26 at 7:33am, there were 6 consecutive entries with a medication quantity changed with a total of 34 tablets declined from the count leaving a balance of 0 with no explanation. -The eCSR then started over with an entry for 05/01/26 at 9:51pm and 05/02/26 at 9:59am with both occasions documented as medication administered but there was a 0 in all 3 columns (Quantity, Administered, Balance) for both entries. -On 05/02/26 at 7:28pm, there was a medication check-in with 78 in the Quantity column, 39 in the Administered column, and 39 in the Balance column. -On 05/02/26 at 7:28pm (59 seconds later), there	D 392		

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 392	Continued From page 102 was an entry with "Medication Disposal, Other - Describe - entry Pharmacy drug error, take back facility" with 39 in the Quantity column and 39 tablets deducted from the Administered column, leaving a balance of 0. -The next 9 entries dated 05/03/26 at 12:10am - 05/06/26 at 11:43am documented the medication was administered but 0 was documented in all 3 columns for Quantity, Administered, and Balance with no explanations. -On 05/06/26 at 7:26pm, there was a medication quantity change with 62 in the Quantity column, 31 in the Administered column, and 31 in the Balance column. -On 05/09/26 at 7:20pm, there was a medication quantity change with 26 in the Quantity column and 26 were declined from the Administered column, leaving a balance of 0. -The next 5 entries dated 05/09/26 at 10:14pm - 05/11/26 at 9:10pm documented the medication was administered but 0 was documented in all 3 columns for Quantity, Administered, and Balance with no explanations. -On 05/12/26 at 7:29am, there was a medication quantity change with 40 in the Quantity column, 20 in the Administered column, and 20 in the Balance column. -On 05/14/26 at 7:14pm, 05/18/26 at 10:51pm, 05/19/26 at 7:16am, 05/19/26 at 7:21pm, 05/24/26 at 7:39am, 05/26/26 at 7:31pm, and 05/27/26 at 7:21am, there were medication quantity changes with a deduction of 1 tablet each time with no explanations. -On 05/25/26 at 7:06pm, there was a medication check-in with 1 tablet deducted with no explanation leaving a balance of 23 tablets. -The balance on 05/31/26 at 11:44pm was 10 tablets. -There were no entries for doses to be administered at 10:00pm on 05/01/26, 05/02/26,	D 392		

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D 392	Continued From page 103 05/06/26, and 05/07/26, a total of 4 doses that were documented as administered on the eMAR. -The eCSR did not accurately reflect the administration, receipt, and disposition of Alprazolam for Resident #10. Review of Resident #10's June 2026 eMAR revealed: -There was an entry for Alprazolam 0.5mg 1 tablet every 12 hours for anxiety scheduled at 10:00am and 10:00pm. -There were 60 doses of Alprazolam 0.5mg documented as administered from 06/01/26 - 06/30/26. Review of Resident #10's June 2026 eCSR for Alprazolam revealed: -There were 60 Alprazolam 0.5mg tablets documented and declined from the count as administered from 06/01/26 - 06/30/26. -The beginning balance for 06/01/26 was 10 tablets. -On 06/03/26 at 7:26pm, 06/05/26 at 7:14pm, and 06/10/26 at 7:13pm, there were medication quantity changes with 1 tablet deducted from the balance each time with no explanations. -On 06/05/26 at 5:11pm, there was a medication check-in with 63 in the Quantity column, 30 in the Administered column, and 33 in the Balance column. -On 06/19/26 at 6:43pm, there was a medication check-in with 65 in the Quantity column, 30 in the Administered column, and 35 in the Balance column. -The last documented dose on 06/30/26 at 10:34pm left a balance of 12 tablets. -The eCSR did not accurately reflect the administration, receipt, and disposition of Alprazolam for Resident #10.	D 392		

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D 392	Continued From page 104 Review of Resident #10's July 2026 eMAR dated 07/01/26 - 07/07/26 revealed: -There was an entry for Alprazolam 0.5mg 1 tablet every 12 hours for anxiety scheduled at 10:00am and 10:00pm. -There were 13 doses of Alprazolam 0.5mg documented as administered from 07/01/26 - 07/07/26 (10:00am). Review of Resident #10's July 2026 eCSR for Alprazolam dated 07/01/26 - 07/07/26 revealed: -There were 13 Alprazolam 0.5mg tablets documented and declined from the count as administered from 07/01/26 - 07/07/26. -The beginning balance for 07/01/26 was 12 tablets. -On 07/03/26 at 7:06am, there was a medication quantity change with 100 in the Quantity column, 46 in the Administered column, and 54 in the Balance column. -On 07/03/26 at 7:29pm, 07/05/26 at 9:40pm, and 07/06/26 at 6:48am, there were medication quantity changes declining 1 tablet each time with no explanations. -On 07/04/26 at 6:58am, there was a medication quantity change with 51 in the Quantity column and 45 declined in the Administered column, leaving a balance of 6 tablets. -On 07/05/26 at 4:24am, there was a medication quantity change with 64 in the Quantity column and 30 in the Administered column, leaving 34 in the Balance column with no explanation. -The balance on 07/07/26 after documentation of the scheduled morning dose was 29 tablets. Observation of Resident #10's medications on hand on 07/07/26 at 9:44am revealed: -There was a supply of Alprazolam 0.5mg tablets dispensed on 07/04/26 with instructions to take 1 tablet every 12 hours for anxiety.	D 392		

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D 392	Continued From page 105 -There were 29 of 30 Alprazolam 0.5mg tablets remaining. Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/10/26 at 2:40pm revealed: -There were 60 Alprazolam 0.5mg tablets dispensed on 03/19/26 for Resident #10. -There were 60 Alprazolam 0.5mg tablets dispensed on 04/20/26 for Resident #10. -There were 30 Alprazolam 0.5mg tablets dispensed on 05/18/26 for Resident #10. -There were 30 Alprazolam 0.5mg tablets dispensed on 06/04/26 for Resident #10. -There were 30 Alprazolam 0.5mg tablets dispensed on 06/18/26 for Resident #10. -There were 30 Alprazolam 0.5mg tablets dispensed on 07/04/26 for Resident #10. Refer to interviews with a medication aide (MA) on 07/09/26 at 8:51am and 2:10pm. Refer to interview with a second MA on 07/09/26 at 2:25pm. Refer to interview with the Regional Clinical Director (RCD) on 07/09/26 at 2:47pm. Refer to interview with the Special Care Coordinator (SCC) on 07/09/26 at 8:28am. Refer to interview with the Resident Care Coordinator (RCC) on 07/09/26 at 9:06am. Refer to interview with the Administrator on 07/13/26 at 2:30pm. 4. Review of Resident #22's current FL-2 dated 01/28/26 revealed: -Diagnoses included anxiety disorder,	D 392		

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polyneuropathy, cerebral infarct, muscle weakness, and difficulty in walking.
-There was an order for Alprazolam 0.5mg 1 tablet 3 times a day. (Alprazolam is a controlled substance used to treat anxiety.)

Review of Resident #22's April 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for Alprazolam 0.5mg 1 tablet 3 times daily scheduled at 8:30am, 2:30pm, and 8:30pm.
-Alprazolam 0.5mg was not documented as administered on 04/05/26 at 2:30pm due to being on a leave of absence; 04/05/26 at 8:30pm with no reason documented; and 04/30/26 at 2:30pm due to being out of the facility.
-There were 87 doses of Alprazolam 0.5mg documented as administered from 04/01/26 - 04/30/26.

Review of Resident #22's April 2026 electronic controlled substance record (eCSR) for Alprazolam revealed:
-There were 82 Alprazolam 0.5mg tablets documented and declined from the count as administered from 04/01/26 - 04/30/26 but 87 doses were documented as administered on the April 2026 eMAR.
-On 04/08/26 at 7:03am, there was a medication quantity change with 2 tablets deducted from the balance with no explanation leaving a balance of 40.
-On 04/16/26 at 5:18am, there was a medication quantity change with 5 tablets deducted from the balance with no explanation leaving a balance of 11.
-On 04/19/26 at 6:51pm, one dose was documented as administered leaving a balance of 0.

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D 392	Continued From page 107 -The next 6 entries on 04/19/26 at 7:39pm, 04/20/26 at 10:55am, 04/20/26 at 6:59pm, 04/20/26 at 9:48pm, 04/21/26 at 10:16am, and 04/21/26 at 2:49pm, one dose at each time was documented as administered but 0 was documented as declined and there was a 0 balance for each entry. -On 04/21/26 at 3:33pm, there was a medication quantity change documenting 176 in the Quantity column, 88 in the Administered column, and 88 in the Balance column with no explanations documented. -On 04/22/26 at 6:46am, there was a medication check-in documented with 267 in the Quantity column, 90 in the Administered column, and 177 in the Balance column. -On 04/23/26 at 8:32pm, there was a "Medication Disposal, Other - Describe - entry Pharmacy drug error, take back facility" with 172 in the Quantity column and 90 declined in the Administered column, leaving a balance of 82 tablets. -On 04/27/26 at 7:16am, there was a medication quantity change documented and 1 tablet was deducted leaving a balance of 73 tablets. -The last entry documented was a dose administered on 04/30/26 at 10:09pm, leaving a balance of 62 tablets. -The eCSR did not accurately reflect the administration, receipt, and disposition of Alprazolam for Resident #22. Review of Resident #22's May 2026 eMAR revealed: -There was an entry for Alprazolam 0.5mg 1 tablet 3 times daily scheduled at 8:30am, 2:30pm, and 8:30pm. -There were 93 doses of Alprazolam 0.5mg documented as administered from 05/01/26 - 05/31/26.	D 392		

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D 392	Continued From page 108 Review of Resident #22's May 2026 eCSR for Alprazolam revealed: -There were 93 Alprazolam 0.5mg tablets documented and declined from the count as administered from 05/01/26 - 05/31/26. -The first entry dated 05/01/26 at 7:31am was a medication quantity change with 64 in the Quantity column and 1 tablet declined from the Administered column, leaving a balance of 63 tablets. -On 05/02/26 at 7:16pm, there was a "Medication Disposal, Other - Describe - entry Pharmacy drug error, take back facility" with 60 in the Quantity column and 2 tablets deducted from the Administered column, leaving a balance of 58 tablets. -On 05/03/26 at 1:37am, one dose was documented as administered and declined, leaving a balance of 56 but it was not due to be administered at that time. -On 05/03/26 at 1:37am (14 seconds later), another dose was documented as administered and declined, leaving a balance of 55 but it was not due to be administered at that time. -On 05/05/26 at 7:14am, there was a medication quantity change with no explanation, and 2 tablets were deducted leaving a balance of 51 tablets. -On 05/09/26 at 7:20pm, there was a medication quantity change with one tablet declined, leaving a balance of 37. -On 05/11/26 at 7:33am, there was a medication quantity change with 85 in the Quantity column, 26 in the Administered column, and 59 in the Balance column. -On 05/12/26 at 7:29am, there was a medication quantity change with 56 in the Quantity column, 26 in the Administered column, and 30 in the Balance column. -On 05/14/26 at 1:31am, one dose was	D 392		

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documented as administered and declined from the count, but none was due to be administered at that time.
-On 05/14/26 at 7:14pm, there was a medication quantity change with 2 tablets deducted with no explanation, leaving a balance of 23.
-On 05/18/26 at 10:51pm, 05/19/26 at 7:16am, 05/23/26 at 7:32pm, and 05/26/26 at 7:31pm, there were medication quantity changes with a deduction of 1 tablet each time with no explanation.
-On 05/22/26 at 3:24pm, there was a medication check-in with 180 in the Quantity column, 90 in the Administered column, and 90 in the Balance column.
-On 05/25/26 at 7:06pm, there was a medication check-in and 1 tablet was deducted with no explanation, leaving a balance of 82.
-The balance on 05/31/26 at 9:10pm was 62 tablets.
-There were no entries that doses were administered on 05/01/26 at 8:30am and 2:30pm, 05/07/26 at 8:30am, and 05/18/26 at 8:30am, a total of 4 doses that were documented as administered on the eMAR.
-The eCSR did not accurately reflect the administration, receipt, and disposition of Alprazolam for Resident #10.

Review of Resident #22's June 2026 eMAR revealed:
-There was an entry for Alprazolam 0.5mg 1 tablet 3 times daily scheduled at 8:30am, 2:30pm, and 8:30pm.
-Alprazolam 0.5mg was documented as refused on 06/06/26 at 8:30am.
-There were 89 doses of Alprazolam 0.5mg documented as administered from 06/01/26 - 06/30/26.

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D 392	Continued From page 110 Review of Resident #22's June 2026 eCSR for Alprazolam revealed: -There were 90 Alprazolam 0.5mg tablets documented and declined from the count as administered from 06/01/26 - 06/30/26 but 89 doses were documented as administered on the eMAR. -The beginning balance for 06/01/26 was 61 tablets. -On 06/08/26 at 7:09am, 06/11/26 at 7:29am, 06/16/26 at 7:06am, 06/17/26 at 7:03am, 06/26/26 at 7:07am, and 06/26/26 at 7:21pm, there were medication quantity changes with 1 tablet deducted from the balance each time with no explanations. -On 06/08/26 at 2:06pm, one dose was documented as administered and declined, leaving a balance of 40. -On 06/08/26 at 2:06pm (5 seconds later), another dose was documented as administered and declined, leaving a balance of 39. -On 06/10/26 at 10:10pm, one dose was documented as administered and declined, leaving a balance of 32. -On 06/10/26 at 10:10pm (25 seconds later), another dose was documented as administered and declined, leaving a balance of 31. -On 06/16/26 at 2:17pm, one dose was documented as administered and declined, leaving a balance of 15. -On 06/16/26 at 2:25pm (8 minutes later), another dose was documented as administered and declined, leaving a balance of 14. -On 06/19/26 at 6:45pm, there was a medication check-in with 186 in the Quantity column, 90 in the Administered column, and 96 in the Balance column. -On 06/29/26 at 7:35am, there was a medication quantity change with 2 tablets deducted with no explanation, leaving a balance of 66.	D 392		

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D 392	Continued From page 111 -The last documented dose on 06/30/26 at 10:37pm left a balance of 60 tablets. -There were no entries that doses were administered at 8:30pm on 06/07/26, 06/14/26, and 06/25/26 but these 3 doses were documented as administered on the eMAR. -The eCSR did not accurately reflect the administration, receipt, and disposition of Alprazolam for Resident #22. Review of Resident #22's July 2026 eMAR dated 07/01/26 - 07/09/26 (8:30am) revealed: -There was an entry for Alprazolam 0.5mg 1 tablet 3 times daily scheduled at 8:30am, 2:30pm, and 8:30pm. -There were 25 doses of Alprazolam 0.5mg documented as administered from 07/01/26 - 07/09/26 (8:30am). Review of Resident #22's July 2026 eCSR for Alprazolam dated 07/01/26 - 07/09/26 revealed: -There were 25 Alprazolam 0.5mg tablets documented and declined from the count as administered from 07/01/26 - 07/09/26. -The beginning balance for 07/01/26 was 60 tablets. -On 07/03/26 at 7:06am, there was a medication quantity change with 54 in the Quantity column with 37 declined in the Administered column, and 17 in the Balance column. -On 07/03/26 at 7:29pm, there was a medication quantity change and 2 tablets were deducted with no explanation, leaving a balance of 17. -On 07/04/26 at 6:58am, there was a medication quantity change with 86 in the Quantity column and 35 were declined in the Administered column, leaving a balance of 51 tablets. -The balance on 07/09/26 after documentation of the scheduled morning dose was 35 tablets. -The eCSR did not accurately reflect the	D 392		

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administration, receipt, and disposition of Alprazolam for Resident #22.

Observation of Resident #22's medications on hand on 07/09/26 at 3:52pm revealed:
-There was a supply of Alprazolam 0.5mg tablets dispensed on 06/18/26 with instructions to take 1 tablet 3 times daily.
-There were 35 of 90 Alprazolam 0.5mg tablets remaining.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/10/26 at 2:40pm revealed:
-There were 90 Alprazolam 0.5mg tablets dispensed on 02/19/26 for Resident #22.
-There were 90 Alprazolam 0.5mg tablets dispensed on 03/17/26 for Resident #22.
-There were 90 Alprazolam 0.5mg tablets dispensed on 04/20/26 for Resident #22.
-There were 90 Alprazolam 0.5mg tablets dispensed on 05/20/26 for Resident #22.
-There were 90 Alprazolam 0.5mg tablets dispensed on 06/18/26 for Resident #22.

Refer to interviews with a medication aide (MA) on 07/09/26 at 8:51am and 2:10pm.

Refer to interview with a second MA on 07/09/26 at 2:25pm.

Refer to interview with the Regional Clinical Director (RCD) on 07/09/26 at 2:47pm.

Refer to interview with the Special Care Coordinator (SCC) on 07/09/26 at 8:28am.

Refer to interview with the Resident Care Coordinator (RCC) on 07/09/26 at 9:06am.

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THE LANDINGS OF SWANSBORO	280 SWANSBORO LOOP ROAD SWANSBORO, NC 28584

(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 392	Continued From page 113 Refer to interview with the Administrator on 07/13/26 at 2:30pm. 5. Review of Resident #3's current FL-2 dated 07/17/25 revealed diagnoses included hypertension, atrial fibrillation, sick sinus syndrome, heart disease, and diabetes. a. Review of the primary care provider (PCP) order sheet dated 03/15/26 revealed there was an order for Alprazolam 0.5mg at bedtime (Alprazolam is a controlled substance used to treat anxiety). Review of Resident #3's May 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Alprazolam 0.5mg one tablet at bedtime for anxiety or sleep scheduled at 8:00pm. -Alprazolam 0.5mg was documented as administered from 05/01/26-05/31/26 at 8:00pm. Review of Resident #3's May 2026 electronic controlled substance record (eCSR) for Alprazolam 0.5mg revealed: -There was a quantity of 9 tablets on 05/01/26, 8 tablets were documented as administered from 05/01/26 to 05/08/26, leaving a balance of 1. -On 05/09/26 at 10:21pm, there was a medication check in documented with 61 tablets was added and 30 administered, leaving a balance of 31. -Eight tablets were documented as administered from 05/09/26 to 05/16/26, leaving a balance of 23. -On 05/17/26 at 6:49am, there was a medication quantity change and 1 tablet was added. which changed the balance from 23 to 24, with no reason documented. -Fourteen tablets were documented as	D 392		

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administered from 05/17/26 to 05/27/26, leaving a balance of 10.
-On 05/28/26 at 7:08am, there was a medication quantity change and 1 tablet was added, which changed the balance from 10 to 11, with no reason was documented,
-Four tablets were documented and administered from 05/28/26 to 05/31/26, leaving a balance of 7.

Review of Resident #3's June 2026 eMAR revealed:
-There was an entry for Alprazolam 0.5mg one tablet at bedtime for anxiety or sleep scheduled at 8:00pm.
-Alprazolam 0.5mg was documented as administered from 06/01/26-06/30/26 at 8:00pm.

Review of Resident #3's June 2026 eCSR for Alprazolam 0.5mg revealed:
-There was a quantity of 7 tablets on 06/01/26, 4 tablets were documented as administered from 06/01/26 to 06/04/26, leaving a balance of 3.
-On 06/05/26 at 5:13pm, there was a medication check in documented and 63 tablets was added and 30 administered, with no documentation about the 30 tablets, leaving a balance of 33.
-Sixteen tablets were documented as administered from 06/05/26 to 06/20/26 leaving a balance of 17.
-On 06/21/26 at 8:09pm, there was a medication quantity change from balance of 17 tablets to 47 tablets, with 15 administered, leaving a balance of 32, with no reason documented.
-One tablet was documented as administered on 06/21/26 leaving a balance of 31.
-On 06/22/26 at 7:18am, there was a medication quantity change from a balance of 31 tablets with 15 administered, leaving a balance of 16, with no reason was documented.
-Nine tablets were documented as administered

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from 06/22/26 to 06/29/26, leaving a balance of 7.
-On 06/30/26 at 7:13pm, there was a medication quantity change from a balance of 7 tablets to a quantity of 9, with no reason was documented.
-Two tablets were administered from 06/30/26, leaving a balance of 7.

Review of Resident #3's July 2026 eMAR revealed:
-There was an entry for Alprazolam 0.5mg one tablet at bedtime for anxiety or sleep scheduled at 8:00pm.
-Alprazolam 0.5mg was documented as administered from 07/01/26-07/07/26 at 8:00pm.

Review of Resident #3's July 2026 eCSR for Alprazolam 0.5mg revealed:
-There was a quantity of 7 tablets on 07/01/26, 1 administered on 07/01/26 leaving a balance of 6.
-On 07/02/26 at 10:26am, there was a medication check in documented and 66 tablets was added and 30 administered, with no reason documented for the 30 tablets, leaving a balance of 36.
-Six tablets were documented as administered from 07/01/26 to 07/07/26 leaving a balance of 30.

Observation of Resident #3's medications on hand on 07/08/26 at 12:36pm revealed:
-There was a supply of Alprazolam 0.5mg tablets dispensed on 03/09/26 with instructions to take 1 tablet at bedtime.
-There was 1 of 30 tablets remaining.
-There was a supply of Alprazolam 0.5mg tablets dispensed on 05/08/26 with instructions to take 1 tablet at bedtime.
-There were 29 of 30 tablets remaining.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/10/26 at

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D 392	Continued From page 116 2:43pm revealed: -There were 30 Alprazolam 0.5mg tablets dispensed on 04/04/26 for Resident #3. -There were 30 Alprazolam 0.5mg tablets dispensed on 05/08/26 for Resident #3. -There were 30 Alprazolam 0.5mg tablets dispensed on 06/04/26 for Resident #3. -There were 30 Alprazolam 0.5mg tablets dispensed on 07/01/26 for Resident #3. Interview with the Regional Vice President of Operations (RVPO) on 07/13/26 at 9:45am revealed: -There were not any controlled substance destruction logs for Resident #3. -There were not any controlled substances waiting to be destroyed for Resident #3. -The pharmacy came to the facility to destroy controlled substances. Refer to interviews with a medication aide (MA) on 07/09/26 at 8:51am and 2:10pm. Refer to interview with a second MA on 07/09/26 at 2:25pm. Refer to interview with the Regional Clinical Director (RCD) on 07/09/26 at 2:47pm. Refer to interview with the Special Care Coordinator (SCC) on 07/09/26 at 8:28am. Refer to interview with the Resident Care Coordinator (RCC) on 07/09/26 at 9:06am. Refer to interview with the Administrator on 07/13/26 at 2:30pm. b. Review of Resident #3's primary care provider (PCP) order sheet dated 03/15/26 revealed there	D 392		

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D 392	Continued From page 117 was an order for Tramadol 50mg every 8 hours as needed (prn) (Tramadol is a controlled substance used to treat moderate to severe pain.) Review of Resident #3's May 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Tramadol 50mg 1 tablet every 8 hours as needed for moderate or severe pain. -Tramadol was documented as administered on 05/09/26 at 10:56pm, 05/19/26 at 12:04am, 05/26/26 at 6:31pm, 05/28/26 at 9:30pm, and 05/31/26 at 1:59am. Review of Resident #3's May 2026 electronic controlled substance record (eCSR) for Tramadol 50mg revealed: -On 05/09/26 at 10:24am, there was a medication check in documented and 77 tablets was added and 30 administered, with no reason documented on what happened to the 30 tablets, leaving a balance of 47. -Five tablets were documented as administered from 05/09/26 to 05/31/26, leaving a balance of 42. Review of Resident #3's June 2026 eMAR revealed: -There was an entry for Tramadol 50mg 1 tablet every 8 hours as needed for moderate or severe pain. -Tramadol was documented as administered on 06/02/26 at 7:59pm, 06/05/26 at 8:31pm, 06/08/26 at 7:38pm, 06/10/26 at 4:11pm, 06/13/26 at 8:19pm, 06/17/26 at 10:53pm, 06/19/26 at 8:05pm, 06/21/26 at 7:35pm, and 06/26/26 at 6:28pm.	D 392		

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D 392	Continued From page 118 Review of Resident #3's June 2026 eCSR for Tramadol 50mg revealed: -There was a quantity of 42 tablets on 06/02/26, 5 tablets were documented as administered from 06/02/26 to 06/13/26, leaving a balance of 37. -On 06/16/26 at 7:06am, there was a medication quantity change from a balance of 37 tablets to a quantity of 35 tablets, with no reason documented for the 2 tablets. -Three tablets were documented as administered from 06/17/26 to 06/21/26, leaving a balance of 32. -On 06/21/26 at 8:09pm, there was a medication quantity change from a quantity of 32 tablets to a balance of 17 tablets, with no reason documented. -On 06/22/26 at 7:18am, there was a medication quantity change from a quantity 47 tablets to a balance of 32 tablets, with no reason documented. -One tablet was documented as administered on 06/26/26, leaving a balance of 31. Review of Resident #3's July 2026 eMAR revealed: -There was an entry for Tramadol 50mg 1 tablet every 8 hours as needed for moderate or severe pain. -Tramadol was documented as administered on 07/01/26 at 6:44am, 07/02/26 at 8:11pm, and 07/05/26 at 9:28pm. Review of Resident #3's July 2026 eCSR for Tramadol 50mg revealed: -There was a quantity of 31 tablets on 07/01/26, 3 tablets were documented as administered from 07/01/26 to 07/05/26. -On 07/05/26 there was a balance of 28. Observation of Resident #3's medications on	D 392		

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hand on 07/08/26 at 12:36pm revealed:
-There was a supply of Tramadol 50mg dispensed on 05/08/26 with instructions to take 1 tablet every 8 hours prn moderate to severe pain.
-There were 28 of 30 tablets remaining.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/10/26 at 2:43pm revealed:
-There were 30 Tramadol tablets dispensed on 01/22/26 for Resident #3.
-There were 30 Tramadol tablets dispensed on 03/18/26 for Resident #3.
-There were 30 Tramadol tablets dispensed on 05/08/26 for Resident #3.

Interview with the Regional Vice President of Operations (RVPO) on 07/13/26 at 9:45am revealed:
-There were not any controlled substance destruction logs for Resident #3.
-There were not any controlled substances waiting to be destroyed for Resident #3.
-The pharmacy came to the facility to destroy controlled substances.

Refer to interviews with a medication aide (MA) on 07/09/26 at 8:51am and 2:10pm.

Refer to interview with a second MA on 07/09/26 at 2:25pm.

Refer to interview with the Regional Clinical Director (RCD) on 07/09/26 at 2:47pm.

Refer to interview with the Special Care Coordinator (SCC) on 07/09/26 at 8:28am.

Refer to interview with the Resident Care Coordinator (RCC) on 07/09/26 at 9:06am.

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D 392	Continued From page 120 6. Review of Resident #5's current FL2 dated 02/08/26 revealed: -Diagnoses included dementia, acute metabolic encephalopathy, and hypertension. -Resident #5 was intermittently disoriented. Review of Resident #5's Resident Register revealed he was admitted to the facility on 02/15/26. Review of Resident #5's physician's orders dated 05/27/26 revealed an order for Tramadol HCL 50mg twice daily for pain. (Tramadol is a controlled substance used to treat moderate to severe pain.) Review of Resident #5's physician order revealed a discontinue order for Tramadol HCL 50mg dated 07/07/26. Review of Resident #5's May 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Tramadol HCL 50mg scheduled twice daily for pain. -Tramadol HCL 50mg was documented as administered at 9:00am and 9:00pm on 05/01/26 to 05/31/26. Review of Resident #5's May 2026 electronic Controlled Substance Record (eCSR) for Tramadol 50mg tablets revealed on 05/15/26 at 7:17am there was a medication quantity changed documented and one tablet was added back to the count with no explanation. Review of Resident #5's June 2026 eMAR revealed: -There was an entry for Tramadol HCL 50mg	D 392		

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scheduled twice daily for pain.
-Tramadol HCL 50mg was documented as administered at 9:00am and 9:00pm on 06/01/26 to 06/30/26.

Review of Resident #5's June 2026 electronic Controlled Substance Record (eCSR) for Tramadol 50mg tablets revealed on 06/15/26 at 7:22am there was a medication check-in documented and one tablet was added back to the count with no explanation.

Review of Resident #5's July 2026 eMAR revealed:
-There was an entry for Tramadol HCL 50mg scheduled twice daily for pain.
-Tramadol HCL 50mg was documented as administered at 9:00am and 9:00pm on 07/01/26 to 07/06/26.

Review of Resident #5's July 2026 eCSR for Tramadol 50mg tablets revealed:
-On 07/02/26 there was no documented Tramadol HCL 50mg administered but on the eMAR it was documented that two Tramadol HCL 50mg was administered at 9:00am and 9:00pm.
-On 07/03/26 there was documentation of one Tramadol HCL 50mg was administered but on the eMAR it was documented that two Tramadol HCL 50mg were administered at 9:00am and 9:00pm.
-On 07/05/26 at 9:32am there was a medication check-in documented and two tablets were added back to the count with no explanation.

Observation of Resident #5's medications on hand on 07/08/26 at 1:00pm revealed Tramadol HCL 50mg were stored off of the cart with a paper attached stating that the order was discontinued.

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D 392	Continued From page 122 Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/10/26 at 2:43pm revealed: -Tramadol HCL 50mg was discontinued for Resident #5 on 07/07/26. -On 03/24/26 60 Tramadol HCL 50mg was dispensed for Resident #5. -On 04/21/26 30 Tramadol HCL 50mg was dispensed for Resident #5. -On 05/07/26 30 Tramadol HCL 50mg was dispensed for Resident #5. -On 05/19/26 60 Tramadol HCL 50mg was dispensed for Resident #5. -On 06/16/26 30 Tramadol HCL 50mg was dispensed for Resident #5. Refer to interviews with a medication aide (MA) on 07/09/26 at 8:51am and 2:10pm. Refer to interview with a second MA on 07/09/26 at 2:25pm. Refer to interview with the Regional Clinical Director (RCD) on 07/09/26 at 2:47pm. Refer to interview with the Special Care Coordinator (SCC) on 07/09/26 at 8:28am. Refer to interview with the Resident Care Coordinator (RCC) on 07/09/26 at 9:06am. Refer to interview with the Administrator on 07/13/26 at 2:30pm. 7. Review of Resident #1's current FL2 dated 06/24/26 revealed: -Diagnoses included dorsalgia, dementia, hypertension, and diabetes mellitus type 2. -There was an order for Tramadol HCL 50mg scheduled every 6 hours for pain. (Tramadol is a	D 392		

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D 392	Continued From page 123 controlled substance used to treat moderate to severe pain.) Review of Resident #1's physician orders dated 12/22/25 revealed there was an order for Tramadol HCL 50mg one every 6 hours for pain. Review of Resident #1's physician's orders dated 06/10/26 revealed a diagnosis of right breast cancer. Review of Resident #1's Resident Register revealed she was admitted to the facility on 07/15/21. Review of Resident #1's March 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Tramadol HCL 50mg scheduled every 6 hours for pain. -Tramadol HCL 50mg was documented as administered every 6 hours at 6:00am, 12:00pm, 6:00pm, and 12:00am from 03/01/26 to 03/31/26. Review of Resident #1's March 2026 electronic Controlled Substance Record (eCSR) for Tramadol 50mg tablets revealed: -There were 11 doses of Tramadol 50mg tablets documented as administered from 03/01/26 - 03/03/26. -The first dose documented was 1 tablet administered on 03/01/26 at 5:15am and left 10 tablets as the balance. -The next entry was on 03/01/26 at 12:07pm with 1 tablet documented as administered and left 9 tablets as the balance. -The next entry was on 03/01/26 at 7:54pm with 1 tablet administered and left a balance of 8 tablets. -The next entry was on 03/03/26 at 6:16pm with 1 tablet administered and left a balance of 1 tablet.	D 392		

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D 392	Continued From page 124 -The next entry was on 03/03/26 at 9:24pm with 1 tablet administered and left a balance of 0 tablets. -From 03/04/26 to 03/17/26 there were 55 entries of medication administered with a quantity of zero in column 8, zero administered in column 9, and balance of zero for each entry. -On 03/17/26 at 11:54am entered as Medication Check-In with 162 tablets listed as the quantity ,81 tablets administered, and left a balance of 81 tablets. -On 03/17/26 at 5:55pm there was an entry with 1 tablet administered and left a balance of 80 tablets. -On 03/17/26 at 11:59pm there was an entry with 1 tablet administered and left a balance of 79 tablets. -From 03/18/26 to 03/31/26 there were 55 entries listed as medication administered with 1 tablet administered each time and left a balance of 24 tablets. -The eCSR did not accurately reflect the administration, receipt, and disposition of Tramadol 50mg tablets. Review of Resident #1's April 2026 eMAR revealed: -There was an entry for Tramadol HCL 50mg scheduled every 6 hours for pain. -Tramadol HCL 50mg was documented as administered every 6 hours at 6:00am, 12:00pm, 6:00pm, and 12:00am from 04/01/26 to 04/30/26 except on 04/01/26 at 12:00pm, 04/11/26 at 6:00pm and 04/29/26 at 12:00pm. Review of Resident #1's April 2026 eCSR for Tramadol 50mg tablets revealed: -There was a balance of 24 doses of Tramadol 50mg tablets documented on 04/01/26. -The first dose documented as administered was on 04/01/26 at 12:18am, which left a balance of	D 392		

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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 392	Continued From page 125 23 tablets. -From 04/01/26 at 5:10am to 04/03/26 at 6:24am there were 8 entries of medication given with 1 tablet administered and left a balance of 15 tablets. -On 04/03/26 at 7:33am the action was Medication Quantity Changed with 1 tablet listed as administered and left a balance of 14 tablets. -From 04/03/26 at 12:29pm to 04/06/26 at 6:50pm there were 14 entries in as medication given with 1 tablet administered, leaving a balance of 0 tablets. -From 04/06/26 at 11:11pm to 04/08/26 at 5:39am there were 6 entries in the action column of medication given with 0 tablets administered and leaving a balance of 0 tablets. -On 04/08/26 at 7:03am entered as Medication Quantity Changed with a quantity of 206 with 103 tablets listed as administered leaving a balance of 103 tablets. -From 04/08/26 at 12:29pm to 04/15/26 at 11:27pm there were 30 entries of medication given with 1 tablet administered for each entry leaving a balance of 73 tablets. -On 04/16/26 at 5:01am he action was Medication Check-In with 99 tablets listed as the quantity, 13 tablets administered, and leaving a balance of 86 tablets. -From 04/16/26 at 6:58am to 04/21/26 at 11:37am there were 21 entries in with the action of medication given with 1 tablet administered leaving a balance of 65 tablets. -On 04/21/26 at 3:26pm the action was Medication Quantity Changed with a quantity of 69, with 2 tablets listed as administered leaving a balance of 67 tablets. -From 04/21/26 at 5:38pm to 04/30/26 at 5:07pm there were 37 entries with the action of medication given with 1 tablet administered leaving a balance of 30 tablets.	D 392		

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D 392	Continued From page 126 -The eCSR did not accurately reflect the administration, receipt, and disposition of Tramadol 50mg tablets. Review of Resident #1's May 2026 eMAR revealed: -There was an entry for Tramadol HCL 50mg scheduled every 6 hours for pain. -Tramadol HCL 50mg was documented as administered every 6 hours at 6:00am, 12:00pm, 6:00pm, and 12:00am from 05/01/26 and 05/31/26, except on 05/10/26 at 12:00pm, it was documented as "OOF" meaning resident was out of the facility. Review of Resident #1's May 2026 eCSR for Tramadol 50mg tablets revealed: -There was a balance of 30 doses of Tramadol 50mg tablets documented on 05/01/26. -The first dose documented as administered was on 05/01/26 at 12:51am, leaving a balance of 29 tablets. -On 05/01/26 at 6:15am 1 tablet was listed as administered leaving a balance of 28 tablets. -On 05/01/26 at 7:31am the action was Medication Quantity Changed with 28 tablets listed as the quantity, 1 tablet administered leaving a balance of 27 tablets. -From 05/01/26 at 2:11pm to 05/056 at 6:23am there were 16 entries entered as medication given with 1 tablet administered leaving a balance of 11 tablets. -On 05/05/26 at 7:05am the action was Medication Quantity Changed with 13 tablets listed as the quantity, 1 tablet administered leaving a balance of 12 tablets. -From 05/05/26 at 11:25am to 05/08/26 at 5:04am there were 11 entries listed as action was medication given with 1 tablet administered leaving a balance of 1 tablet.	D 392		

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D 392	Continued From page 127 -On 05/08/26 at 11:26am the action was Medication Check-In with 241 tablets listed as the quantity, 120 tablets administered leaving a balance of 121 tablets. -From 05/08/26 at 11:31am to 05/11/26 at 6:15am there were 12 entries listed as action was medication given with 1 tablet administered leaving a balance of 110 tablets. -On 05/11/26 at 7:33am the action was Medication Quantity Changed with 130 tablets listed as the quantity, 10 tablets administered leaving a balance of 120 tablets. -On 05/11/26 at 11:19am and 5:48pm the action was medication given with 1 tablet administered in column 9 leaving a balance of 118 tablets. -On 05/11/26 at 7:01pm the action was Medication Quantity Changed with 118 tablets listed as the quantity, 10 tablets administered leaving a balance of 108 tablets. -From 05/11/26 at 11:24pm to 05/13/26 at 6:02pm the actions were 7 entries of medication given with 1 tablet administered leaving a balance of 101 tablets. -On 05/13/26 at 7:18pm the action was Medication Quantity Changed with 101 tablets listed as the quantity, 1 tablet administered leaving a balance of 100 tablets. -From 05/13/26 at 11:11pm to 05/17/26 at 5:39am there were 15 entries listed as action was medication given with 1 tablet administered leaving a balance of 85 tablets. -On 05/17/26 at 6:49am the action was Medication Quantity Changed with 85 tablets listed as the quantity, 10 tablets administered leaving a balance of 75 tablets. -On 05/17/26 at 11:25am and 5:56pm the action was medication given with 1 tablet administered in leaving a balance of 73 tablets. -On 05/17/26 at 7:14pm the action was Medication Quantity Changed with 93 tablets	D 392		

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D 392	Continued From page 128 listed as the quantity, 10 tablets administered leaving a balance of 83 tablets. -From 05/17/26 at 11:33pm to 05/25/26 at 5:18am there were 31 entries listed as action was medication given with 1 tablet administered leaving a balance of 52 tablets. -On 05/1726 at 5:25am the action was Medication Disposal with 52 tablets listed as the quantity, 1 tablet administered leaving a balance of 51 tablets and included the disposal reason as medication dropped and disposal method as drug buster. -On 05/17/26 at 12:43pm and 5:10pm the action was medication given with 1 tablet administered leaving a balance of 49 tablets. -On 05/25/26 at 11:26am the action was Medication Check-In with 51 tablets listed as the quantity, 1 tablet administered leaving a balance of 50 tablets. -From 05/25/26 at 11:20pm to 05/31/26 at 11:43pm there were 26 entries listed as action was medication given with 1 tablet administered leaving a balance of 26 tablets. -The eCSR did not accurately reflect the administration, receipt, and disposition of Tramadol 50mg tablets. Review of Resident #1's June 2026 eMAR revealed: -There was an entry for Tramadol HCL 50mg scheduled every 6 hours for pain. -Tramadol HCL 50mg was documented as administered every 6 hours at 6:00am, 12:00pm, 6:00pm, and 12:00am from 06/01/26 and 06/30/26, except on 06/02/26 at 12:00pm and 06/03/26 at 12:00pm, it was documented as "OOF" meaning resident was out of the facility. Review of Resident #1's June 2026 eCSR for Tramadol 50mg tablets revealed:	D 392		

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D 392	Continued From page 129 -There was a balance of 26 doses of Tramadol 50mg tablets documented on 06/01/26. -The first dose documented as administered was on 06/01/26 at 6:09am, leaving a balance of 25 tablets. -On 06/01/26 at 7:01am the action was Medication Quantity Changed with 27 tablets listed as the quantity, 1 tablet administered leaving a balance of 26 tablets. -From 06/01/26 at 12:23pm to 06/05/26 at 12:25pm there were 15 entries listed as action was medication given with 1 tablet administered leaving a balance of 11 tablets. -On 06/05/26 at 5:12pm action was Medication Check-In with 251 tablets listed as the quantity, 120 tablets administered leaving a balance of 131 tablets. -From 06/05/26 at 5:17pm to 06/12/26 at 6:17pm there were 28 entries listed as action was medication given with 1 tablet administered leaving a balance of 103 tablets. -On 06/12/26 at 7:20pm in the action was Medication Quantity Changed with 103 tablets listed as the quantity, 1 tablet administered in column 9 leaving a balance of 102 tablets. -From 06/13/26 at 12:22am to 06/17/26 at 6:12am there were 19 entries listed as action was medication given with 1 tablet administered leaving a balance of 83 tablets. -On 06/17/26 at 7:03am the action was Medication Quantity Changed with 85 tablets listed as the quantity, 1 tablet administered leaving a balance of 84 tablets. -From 06/17/26 at 11:48am to 06/30/26 at 5:33pm there were 54 entries listed as action was medication given with 1 tablet administered leaving a balance of 30 tablets. -The eCSR did not accurately reflect the administration, receipt, and disposition of Tramadol 50mg tablets.	D 392		

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D 392	Continued From page 130 Review of Resident #1's July 2026 eMAR revealed: -There was an entry for Tramadol HCL 50mg scheduled every 6 hours for pain. -Tramadol HCL 50mg was documented as administered every 6 hours at 6:00am, 12:00pm, 6:00pm, and 12:00am from 07/01/26 and 07/13/26. Review of Resident #1's July 2026 eCSR for Tramadol 50mg tablets revealed: -There was a balance of 30 doses of Tramadol 50mg tablets documented on 07/01/26. -From 07/01/26 at 1:04am to 07/03/26 at 5:12am there were 10 entries listed as action was medication given with 1 tablet administered leaving a balance of 20 tablets. -On 07/03/26 at 7:06am the action was Medication Quantity Changed with 24 tablets listed as the quantity, 2 tablets administered leaving a balance of 22 tablets. -From 07/03/26 at 11:15am to 07/03/26 at 5:01pm there were 2 entries listed as action was medication given with 1 tablet administered leaving a balance of 20 tablets. -On 07/03/26 at 7:29am the action was Medication Quantity Changed with 20 tablets listed as the quantity, 2 tablets administered leaving a balance of 18 tablets. -From 07/03/26 at 11:47am to 07/07/26 at 5:28pm there were 18 entries listed as action was medication given with 1 tablet administered leaving a balance of 0 tablets. -On 07/07/26 at 7:04pm the action was Medication Quantity Changed with 2 tablets listed as the quantity, 1 tablet administered leaving a balance of 1 tablet. -On 07/07/26 at 11:30pm the action was medication given with 1 tablet listed as the	D 392		

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quantity, 1 tablet administered leaving a balance of 0 tablets.
-n 07/08/26 at 5:13am the action was medication given with 0 tablet listed as the quantity, 0 tablet administered leaving a balance of 0 tablets.
-On 07/08/26 at 6:43am the action was Medication Check-In with 120 tablets listed as the quantity, 60 tablets administered leaving a balance of 60 tablets.
-On 07/08/26 at 7:04am the action was Medication Quantity Changed with 61 tablets listed as the quantity, 1 tablet administered leaving a balance of 60 tablets.
-From 07/08/26 at 12:01pm to 07/09/26 at 5:21pm there were 7 entries listed as action was medication given with 1 tablet administered leaving a balance of 53 tablets.
-The eCSR did not accurately reflect the administration, receipt, and disposition of Tramadol 50mg tablets.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/10/26 at 2:43pm:
-The pharmacy dispensed 120 tablets of Tramadol 50mg for Resident #1 on 03/05/26.
-The pharmacy dispensed 120 tablets of Tramadol 50mg for Resident #1 on 04/04/26.
-The pharmacy dispensed 120 tablets of Tramadol 50mg for Resident #1 on 05/07/26.
-The pharmacy dispensed 120 tablets of Tramadol 50mg for Resident #1 on 06/04/26.
-The pharmacy dispensed 60 tablets of Tramadol 50mg for Resident #1 on 07/07/26.

Interview with the Resident Care Coordinator (RCC) on 07/14/26 at 4:15pm revealed:
-The pharmacy delivered medications between 5:00am and 7:00am.
-The 3rd shift medication aide (MA) normally

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checked the medications in and placed them into the appropriate carts and the controlled substances into the locked box in the medication carts.
-If needed, the MA on 1st shift, the Special Care Coordinator (SCC) or the RCC would check the medications delivered from the pharmacy if the third shift MA did not have time to do so.
-The eCSRs in the computer "are crazy".
-No one knew how the computer system worked.
-There was not a way to add the new medications into the eCSRs.
-Paper logs were easier to follow and understand.
-Resident #1 had not been out of her Tramadol that she was aware.
-She thought Resident #1 would have had withdrawal symptoms if she had run out.
-She was not sure why there were zero amounts on Resident #1's eCSRs, yet the MAs still documented that Resident #1 was administered a tablet.

Interview with the Administrator on 07/13/26 at 9:45am revealed:
-She was not sure how the MAs were administering medications if there was a zero balance on the eCSR.
-She had worked as a MA from time to time and did not recall Resident #1 being out of her Tramadol.
-She had reached out to the support team for the facility's computer system for clarification of the eCSRs; she had not received anything back from them.
-She did not know how the MAs could administer a controlled substance if the count was zero which meant there was no medication available to give.

Refer to interviews with a medication aide (MA)

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D 392	Continued From page 133 on 07/09/26 at 8:51am and 2:10pm. Refer to interview with a second MA on 07/09/26 at 2:25pm. Refer to interview with the Regional Clinical Director (RCD) on 07/09/26 at 2:47pm. Refer to interview with the Special Care Coordinator (SCC) on 07/09/26 at 8:28am. Refer to interview with the Resident Care Coordinator (RCC) on 07/09/26 at 9:06am. Refer to interview with the Administrator on 07/13/26 at 2:30pm. _____ Interviews with a medication aide (MA) on 07/09/26 at 8:51am and 2:10pm revealed: -The MAs were supposed to document the administration of controlled substances in the electronic medication administration record (eMAR) system at the time the medication was administered. -Once they "clicked" the administration of the controlled substance on the eMAR, it was supposed to automatically deduct it on the electronic controlled substance records (eCSRs). -She could not make any adjustments to the eCSRs. -When there was a problem with the count the Resident Care Coordinator (RCC), Special Care Coordinator (SCC), or the Administrator had to correct the count. -She had not had any control substance counts that were off that she could remember. -The night shift MA checked all medications in and added them to the medication cart. Interview with a second MA on 07/09/26 at	D 392		

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D 392	Continued From page 134 2:25pm revealed: -When a control substance count was off she notified the RCC, SCC, or Administrator. -MAs could not make any corrections on the CSRs. -There had been times when corrections had to be made but she could not remember any details. -The MA on night shift checked in all of the medications that arrived and added them to the medication cart. -She had never had to add controlled substances to the medication cart. Interview with the Regional Clinical Director (RCD) on 07/09/26 at 2:47pm revealed: -The facility did not use paper CSRs for documentation. -All controlled substances are documented in the computer in the eCSR system. -The correct count of the controlled substance should be entered and when a medication was administered the MA subtracted the number administered. -The MAs did not have access to make any corrections on the eCSRs. -The RCC, SCC, and the Administrator had the ability to make changes to the eCSRs. Interview with the SCC on 07/09/26 at 8:28am revealed: -They used eCSRs for the controlled substances. -When the MAs documented a controlled substance was administered in the eMAR system, it automatically adjusted the count on the eCSR. -The MAs conducted controlled substance shift counts at each shift change. -The MAs counted the controlled substances and entered the amount in the eCSR system. -If the count did not match after 3 attempts, the	D 392		

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D 392	Continued From page 135 MA had to contact him or the Resident Care Coordinator (RCC). -He or the RCC then had to check the discrepancy and correct the count in the eCSR system. -Corrected counts had to be entered by him, the RCC, or the Administrator. -They sometimes had issues with controlled substance when half tablets were ordered because the system may count the half tablet as a whole tablet instead of a dosage. -He did not know why controlled substances were documented as administered on the eCSRs but not deducted from the count. -He did not know where there were large quantities added and then removed on some eCSRs but thought it may all be cause by "glitches" in the eCSR system. -He and the RCC compared eCSRs to the eMARs weekly and had found issues with documentation for the administration of half tablets, but he had not noticed the other discrepancies. Interview with the RCC on 07/09/26 at 9:06am revealed: -When the MAs documented administration of controlled substances on the eMARs, it was supposed to automatically deduct it from the eCSRs. -The MAs did controlled substance shift counts at each shift change. -If the count did not match, the MAs had to notify her, the SCC, or the Administrator. -Discrepancies were usually problems with the electronic system not working properly. -She or the SCC or the Administrator had access to correct the controlled substance counts in the eCSR system. -She sometimes added or deducted so the	D 392		

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D 392	Continued From page 136 eCSRs system would match the count on hand. -She did not know why there were times when large quantities were added or deducted if it was not associated with a new supply being received. -She did not know why there were sometimes multiple entries of controlled substances documented as administered but none declined from the count. -She and the SCC compared eCSRs to eMARs during cart audits weekly. -She did not know why she had not noticed the discrepancies. Interview with the Administrator on 07/13/26 at 2:30pm revealed: -The RCC, SCC, and she had the ability to make any needed corrections to the eCSRs, for example, if the wrong number of medications had been entered. -It was the RCC and the SCC's responsibility to ensure the eCSR counts were correct. -She was ultimately responsible to ensure the eCSR counts were correct. -She did not have a process to review the eCSRs for accuracy. _____ The facility failed to maintain accurate electronic controlled substance records (eCSRs) for 7 of 7 residents sampled (#1, #3, #5, #10, #15, #16, #22) in order to reconcile the receipt, administration, and disposition of controlled substances. Resident #16's eCSR for a controlled substance used to treat moderate to severe pain was not accurate and 4 tablets were diverted and missing in December 2025 that were never found. The eCSRs for controlled substances used to treat moderate to severe pain were also inaccurate for Residents #1, #3, and #5. The eCSRs for a controlled substance used to treat anxiety was inaccurate for Residents #3, #10,	D 392		

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D 392	Continued From page 137 #15, and #22. Failure to maintain accurate records of controlled substances prevented accurate tracking of the controlled substances to ensure the medications were accounted for and administered as ordered. This failure of the facility was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/10/26 and amended on 07/13/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 29, 2026.	D 392		
D 399	10A NCAC 13F .1008 (h) Controlled Substance 10A NCAC 13F .1008 Controlled Substance (h) The facility shall ensure that all known drug diversions are reported to the pharmacy, local law enforcement agency and Health Care Personnel Registry as required by state law, and that all suspected drug diversions are reported to the pharmacy. There shall be documentation of the contact and action taken. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report drug diversion of a controlled substance to the pharmacy for a resident (#16) for a medication used to treat moderate to severe pain. The findings are: Review of the facility's Controlled Substance /	D 399		

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D 399	Continued From page 138 Medication Diversion Policy dated September 2021 revealed: -The facility would ensure that all Federal and State regulations relevant to the control of controlled substances were followed. -All missing and unaccounted for controlled substance medications must be reported, as listed below. -If the controlled substance count was incorrect, medication had been tampered with in any way, or a discrepancy was found, both the supervisor and the Administrator must be notified immediately. -If the medication was not found or accounted for, either the Care Coordinator or the Administrator would direct staff to notify and report the situation to: local Law Enforcement, Nurse Aide (NA) or Health Care Personnel Registry (HCPR), Department of Social Services (DSS), the dispensing pharmacy, and the resident's physician. Review of Resident #16's current FL-2 dated 02/18/26 revealed: -Diagnoses included vascular dementia, type 2 diabetes with hyperglycemia, chronic kidney disease, cardiac pacemaker, pneumonia, hypertensive heart disease, atherosclerotic heart disease, acute respiratory failure, osteoarthritis of the left knee, and effusion of the left knee. -There was an order for Hydrocodone/Acetaminophen (APAP) 10-325mg 1 tablet every 12 hours. (Hydrocodone/APAP is a controlled substance used to treat moderate to severe pain. Hydrocodone is an opioid, which is a class of medications with the potential for abuse and dependence.) Review of Resident #16's previous physician's order dated 10/29/25 revealed an order for	D 399		

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D 399	Continued From page 139 Hydrocodone/APAP 10-325mg 1 tablet twice a day. Review of Resident #16's HCPR Initial Allegation and Investigation Reports dated 12/24/25 revealed: -There were 3 medication aides (MAs) listed as accused employees. -Each accused employee was a MA on duty during the window of time that Resident #16's controlled substance came to be missing. -The facility became aware of the incident on 12/24/25 at 1:30pm. -A MA reported to the Administrator that there were 4 Hydrocodone/APAP 10-325mg tablets missing for Resident #16. -The incident was reported to the local police department on 12/24/25 at 2:00pm. -The HCPR report was signed by the Administrator. -There were attachments with urine drug testing results for all 3 MAs and one MA tested positive for opioids. -The facility unsubstantiated the allegation of drug diversion for 2 of 3 MAs. -The facility substantiated the allegation of drug diversion for the MA who tested positive for opioids and the MA was terminated. Telephone interview with a MA on 07/10/26 at 10:31am revealed: -When she came to work on the morning of 12/24/25, she counted the controlled substances with the night shift MA. -The night shift MA told her that another MA (now a former MA) had prepared Resident #16's medications, including Hydrocodone/APAP for a 2-day leave of absence. -The former MA had supposedly opened Resident #16's multi-dose packs (MDPs) and added	D 399		

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D 399	Continued From page 140 Hydrocodone/APAP tablets from the bubble card to each MDP. -She did not give the medication to the resident that morning because she could tell the extra tablets in Resident #16's multi-dose packs (MDPs) did not look like Hydrocodone/APAP. -There were 4 extra tablets because the resident received Hydrocodone/APAP twice a day. -She removed the extra tablets and sent the bubble card with Hydrocodone/APAP and the MDPs with the resident and his family member. -She did not recall how Resident #16's doses of Hydrocodone/APAP were documented for the missing tablets or the medications sent on the leave of absence. -She went to the Administrator, and they identified the extra tablets as Tylenol 650mg. (Tylenol is an over-the-counter medication used for mild to moderate pain.) -She had to write a statement and give a urine sample for a drug screening test that day, 12/24/25. -The police also came to the facility and asked her some questions. -The four Hydrocodone/APAP tablets for Resident #16 were never found. -She did not report it to the pharmacy, and she did not know if anyone else notified the pharmacy of the missing tablets. Interview with the Administrator on 07/09/26 at 9:57am revealed: -On 12/24/25, a MA came to her and reported something was not right with Resident #16's Hydrocodone/APAP. -A former MA had pulled Resident #16's medications to send home with the resident who was going home with his family for the holidays. -Another MA noticed the former MA had opened Resident #16's sealed MDPs and added another	D 399		

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tablet in each MDP that was supposed to be the resident's Hydrocodone/APAP removed from the bubble card.
-The MA noticed the extra tablets added to the MDP were a different size than Resident #16's Hydrocodone/APAP tablets.
-They investigated and discovered the extra tablets the former MA added to the MDP were Tylenol instead of Hydrocodone/APAP.
-The Tylenol tablets were removed and the resident's Hydrocodone/APAP bubble card was sent with the resident when he went home for a visit with his family.
-The resident did not miss any doses of the Hydrocodone/APAP tablets.
-She conducted urine drug testing on the 3 MAs that had been on duty around the time of the incident and the former MA tested positive for opioids while the other MAs tested negative.
-The former MA did not answer on 12/24/25 when she called him, but he came in on 12/25/25 for duty but she stopped him, did the urine drug test, got a written statement from him, and he was suspended pending her investigation.
-She reported it to the HCPR, local law enforcement, and the resident's primary care provider (PCP).
-They never found Resident #16's missing Hydrocodone/APAP tablets.
-She did not report the drug diversion to the facility's contracted pharmacy because she did not know there was a rule that required it be reported to the pharmacy.

Telephone interview with the Pharmacist-in-Charge at the facility's contracted pharmacy on 07/10/26 at 2:40pm revealed there was no documentation in their records of the facility reporting drug diversion regarding Resident #16's Hydrocodone/APAP tablets.

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D 411	10A NCAC 13F .1010 (d) Pharmaceutical Services 10A NCAC 13F .1010 Pharmaceutical Services (d) The facility shall assure the provision of medication for residents on temporary leave from the facility or involved in day activities out of the facility. The facility shall have written policies and procedures for a resident's temporary leave of absence. The policies and procedures shall facilitate safe administration by assuring that upon receipt of the medication for a leave of absence the resident or the person accompanying the resident is able to identify the medication, dosage, and administration time for each medication provided for the temporary leave of absence. The policies and procedures shall include the following provisions: (1) The amount of resident's medications provided shall be sufficient and necessary to cover the duration of the resident's absence. For the purposes of this Rule, sufficient and necessary means the amount of medication to be administered during the leave of absence or only a current dose pack, card, or container if the current dose pack, card, or container has enough medication for the planned absence; (2) written and verbal instructions for each medication to be released for the resident's absence shall be provided to the resident or the person accompanying the resident upon the medication's release from the facility and shall include: (A) the name and strength of the medication; (B) the directions for administration as prescribed by the resident's physician; and (C) any cautionary information from the original prescription package if the information is not on the container released for the leave of absence; (3) the resident's medication shall be provided in	D 411		

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a capped or closed container that will protect the medications from contamination and spillage; and (4) labeling of each of the resident's individual medication containers for the leave of absence shall be legible, include at least the name of the resident and the name and strength of the medication, and be affixed to each container. The facility shall maintain documentation in the resident's record of medications provided for the resident's leave of absence, including the quantity released from the facility and the quantity returned to the facility. The documentation of the quantities of medications released from and returned to the facility for a resident's leave of absence shall be verified by signature of the facility staff and resident or the person accompanying the resident upon the medications' release from and return to the facility.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure the provision of medication for a resident (#16) who went on temporary leaves from the facility related to documenting the quantities released and returned for all medications provided for the resident's leaves of absence.

The findings are:

Review of the facility's Medication Leaving/Returning Policy Dated September 2021 revealed:
-When a resident went on leave from the facility and would need his or her medication before returning, the following procedure should be followed.
-When more than one dosage was required for the temporary leave of a resident, the medications would be packaged and released in

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their entirety by medication staff.
-Staff would document all medications leaving the facility using the Medication Release Form.
-Multi-dose packs (MDPs), individual pill bottles and single dose blister packs were prepared according to the specific time the resident would be out of the facility.
-The original container and directions for administration must be provided to the resident or responsible party.
-The resident and/or responsible party would sign a Medication Release Form with acknowledgment of receipt and return of medications.
-Staff would print a Resident Flowsheet to send with the Medication Release Form.
-Documentation would be kept in the facility, readily available, and would include: medication name, quantity released, and quantity returned.
-If a resident temporarily left the facility with all their medications, upon return to the facility, the medication aide (MA) or Care Coordinator must do an immediate medication count with a family member to ensure the correct number of medications have been returned.
-If a resident temporarily left with all their medication and upon return to the facility did not bring back the correct number of medications (especially controlled substances), staff would: have the family sign with a staff witness that they did not return the correct number of medications and notify the pharmacy and the prescribing doctor.
-If this occurred more than once with the same resident/family member, staff would notify the police.
-In the case of controlled substance medications, staff would notify the police on the first occurrence.
-Staff would ensure the family was aware that the resident's insurance will not cover replacement

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medication.
-However, the facility must order medications at the resident's expense.
-The facility may request drug screens and appropriate lab work to determine appropriate therapeutic medication levels.

Review of Resident #16's current FL-2 dated 02/18/26 revealed:
-Diagnoses included vascular dementia, type 2 diabetes with hyperglycemia, chronic kidney disease, cardiac pacemaker, pneumonia, hypertensive heart disease, atherosclerotic heart disease, acute respiratory failure, osteoarthritis of the left knee, and effusion of the left knee.
-There was an order for Hydrocodone/Acetaminophen (APAP) 10-325mg 1 tablet every 12 hours. (Hydrocodone/APAP is a controlled substance used to treat moderate to severe pain. Hydrocodone is an opioid, which is a class of medication with the potential for abuse and dependence.)
-There was an order for Bumetanide 1mg ½ tablet on Monday, Wednesday, and Friday. (Bumetanide is a diuretic used to treat excess fluid and swelling.)
-There was an order for Folic Acid 1mg 1 tablet once daily. (Folic acid is a vitamin supplement.)
-There was an order for Gabapentin 300mg 1 once daily. (Gabapentin is used to treat nerve pain.)
-There was an order for Invokana 100mg 1 tablet once daily. (Invokana is used to lower blood sugar.)
-There was an order for Metamucil 4 grams once daily. (Metamucil is a fiber supplement used for constipation.)
-There was an order for Miralax 17 grams in water once daily. (Miralax is a laxative used to treat and prevent constipation.)

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D 411	Continued From page 146 -There was an order for Preservision AREDS 2 Take 1 capsule every 12 hours. (Preservision AREDS 2 is a vitamin supplement for eye health.) -There was an order for Crestor 40mg 1 tablet once daily. (Crestor is used to lower cholesterol.) Review of Resident #16's FL-2 Medication Clarification orders dated 02/26/26 revealed an order for Gabapentin 300mg 1 capsule every 12 hours. Review of Resident #16's December 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Hydrocodone/APAP 10-325mg 1 tablet twice daily scheduled at 8:00am and 8:00pm. - Hydrocodone/APAP 10-325mg was documented as not administered on 12/24/25 at 8:00pm - 12/25/26 at 8:00am and from 12/27/25 (8:00pm) - 12/31/25 due to the resident being out of the facility and on a leave of absence. -There was an entry for Bumetanide 1mg ½ tablet on Monday, Wednesday, and Friday scheduled at 6:30am. -There was an entry for Folic Acid 1mg 1 tablet once daily scheduled at 8:30am. -There was an entry for Gabapentin 300mg 1 twice daily. -There was an entry for Invokana 100mg 1 tablet once daily scheduled at 8:30am. -There was an entry for Metamucil Oral Packet give contents of 1 packet mixed with fluid (8 ounce of water) once daily scheduled at 8:00am. -There was an entry for Miralax Oral Powder mix 17 grams in 8 ounces of liquid a give daily scheduled at 8:00am. -There was an entry for Preservision AREDS 2 Take 1 capsule twice daily scheduled at 8:30am and 8:30pm.	D 411		

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-There was an entry for Crestor 40mg 1 tablet once daily scheduled at 8:00pm.
-These medications were not documented as administered for the evening doses on 12/24/25 and the morning doses on 12/25/25 due to the resident being out of the facility on leave of absence.
-These medications were not documented as administered from the evening doses on 12/27/25 through 12/31/25 due to the resident being on leave of absence.

Review of Resident #16's December 2025 and January 2026 electronic controlled substance records (eCSRs) for Hydrocodone/APAP 10-325mg revealed:
-On 12/26/25 at 7:24am there was a "Medication Disposal, Other - Describe - resident left with family and 2 tablets were deducted, leaving a balance of 40 tablets.
-The last dose documented for December 2025 was 12/27/25 at 8:13am with a balance of 37 tablets.
-The first entry for January 2026 was one dose administered and declined on 01/01/26 at 11:07am, leaving a balance of 36 tablets.
-The next entry was "Other - Describe - left with family" and 9 tablets were deducted leaving a balance of 27 tablets.

Review of Resident #16's facility progress notes for December 2025 revealed:
-On 12/26/25 at 12:53pm: the resident was leaving on 12/27/25 to go with a family member for a week.
-There was no documentation of the leave of absence from 12/24/25 - 12/25/25.

Review of Resident #16's Medication Release Form dated 12/27/25 revealed:

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D 411	Continued From page 148 -The date of departure was documented as 12/27/25. -The expected date of return was documented as 01/03/26. -Hydrocodone/APAP 10-325mg with directions to take 1 tablet twice daily at 8:00am and 8:00pm was listed on the form. -There were 37 Hydrocodone/APAP 10-325mg tablets documented as the quantity leaving the facility. -There was no documentation of any other medications being released to the resident for the leave of absence. -A MA signed and dated as staff releasing the medication on 12/27/25. -A signature for the resident's responsible party receiving the medication was dated 12/27/25. -There was documentation that 28 Hydrocodone/APAP 10-325mg tablets were received back. -A second MA signed and dated as staff receiving the medication back on 01/01/26. Request for Resident #16's Medication Release Form for the resident's 12/24/25 - 12/25/25 leave of absence on 07/09/26 at 12:42pm was not provided by survey exit. Telephone interview with a MA on 07/10/26 at 10:31am revealed: -When she came to work on the morning of 12/24/25, she counted the controlled substances with the night shift MA. -The night shift MA told her that another MA (now a former MA) had prepared Resident #16's medications, including Hydrocodone/APAP for a 2-day leave of absence with his family. -The former MA had supposedly opened Resident #16's MDPs and added Hydrocodone/APAP tablets from the bubble card to each MDP.	D 411		

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D 411	Continued From page 149 -There were 4 extra tablets because the resident received Hydrocodone/APAP twice a day. -She removed the extra tablets and sent the whole bubble card with Hydrocodone/APAP and the resident's MDPs with the resident's other scheduled medications were sent with the resident and his family member. -The former MA should have prepared the whole bubble cards and the MDPs due for the 2-day period the resident was going to be on leave from the facility. -She filled out a form for the resident's leave of absence on 12/24/25 and listed the Hydrocodone/APAP on the form and had the resident's family member sign it. -She did not list the resident's medications in the MDPs on the form, because they were not controlled substances. -She was not on duty when Resident #16 returned to the facility, so she did not know if the quantity returned was documented. Interview with the Administrator on 07/09/26 at 9:57am revealed: -On 12/24/25, a MA came to her and reported something was not right with Resident #16's Hydrocodone/APAP. -A former MA had pulled Resident #16's medications to send with the resident who was going home with his family for the holidays. -Another MA noticed the former MA had opened Resident #16's sealed MDPs and added another tablet in each MDP that was supposed to be the resident's Hydrocodone/APAP removed from the bubble card. -The MA noticed the extra tablets added to the MDP were a different size than Resident #16's Hydrocodone/APAP tablets. -They investigated and discovered the extra tablets the former MA added to the MDP were	D 411		

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D 411	Continued From page 150	D 411		

Tylenol (an over-the-counter mild pain reliever) instead of Hydrocodone/APAP.
-The Tylenol were removed and the resident's Hydrocodone/APAP bubble card was sent with the resident when he left the facility for a visit with his family.

Second interview with the Administrator on 07/10/26 at 9:04am revealed:
-The MAs were responsible for preparing a resident's medications for any leave of absence.
-The MAs should send the whole bubble card for any medications packaged in bubble cards.
-The MAs were responsible for completing the Medication Release Form when a resident was taking a leave of absence from the facility.
-The MAs were supposed to document all medications sent out with a resident for any leave of absence.
-The MAs should give the Medication Release Form to the Resident Care Coordinator (RCC) or the Special Care Coordinator (SCC).
-The RCC and SCC were responsible for reviewing Medication Release Forms to ensure the forms were complete and included the required information.
-She was unable to locate any other Medication Release Forms for Resident #16.
-There should be a Medication Release Form for Resident #16's leave of absence on 12/24/25 and his Medication Release Form for 12/27/25 should have included all medications released to Resident #16.

Interview with the Regional Clinical Director (RCD) on 07/10/26 at 3:23pm revealed:
-There was a form that the MAs were supposed to complete when a resident went on a leave of absence from the facility.
-The MAs were supposed to send all of the

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D 411	Continued From page 151 resident's medications in the bubble cards and the MDPs when a resident went on a leave of absence. -The MAs were supposed to document all medications released and returned on the form. -If there were controlled substances, the MAs were supposed to count them and have the family to sign the form. Attempted telephone interview with the former MA on 07/10/26 at 10:21am was unsuccessful. Attempted telephone interview with Resident #16's family member on 07/14/26 at 10:43am was unsuccessful.	D 411		
D 424	10A NCAC 13F .1104 (f) Accounting For Resident's Personal Funds 10A NCAC 13F .1104 Accounting For Resident's Personal Funds (f) The resident's personal needs allowance shall be credited to the resident's account within one business day of the funds being available in the facility's resident personal funds account. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure resident's personal needs allowance was credited to the resident's account for 1 of 3 sampled residents (#9) within one business day of being received. The findings are: Review of Resident #9's current FL-2 dated 04/15/26 revealed: -Diagnoses included fronto-temperal dementia, hyperammonemia, acute metabolic	D 424		

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encephalopathy, type 2 diabetes mellitus with hyperglycemia, and hypertension.
-The resident was intermittently disoriented.
-The resident was ambulatory.

Review of the Resident Register for Resident #9 revealed:
-She was admitted to the facility on 03/03/26.
-Her guardian was a social worker with the Department of Social Services (DSS).

Interview with Resident #9 on 07/13/26 at 10:00am revealed:
-She was admitted to the facility in March of 2026.
-She was supposed to be getting $70.00 each month.
-She had not received any of her personal funds money since she had been at the facility.
-The Administrator told her approximately a week ago that she would be receiving her $70.00 soon.
-She needed her $70.00 in order to buy some items she wanted from the grocery store.

Interview with Resident #9's DSS guardian on 07/14/26 at 8:40am revealed:
-Resident #9 received state and special assistance funds.
-The facility should have been giving Resident #9 $70.00 personal funds each month.
-Resident #9 had been complaining to her that she was not receiving her $70.00 monthly personal funds.
-Resident #9 had not received her personal funds since she was admitted to the facility.

Telephone interview with the former Business Office Manager (BOM) on 07/13/26 at 1:05pm revealed:
-The facility had difficulties receiving funds for

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D 424	Continued From page 153 Resident #9. -The money the facility received for Resident #9 was applied to her room and board. -DSS was the guardian for Resident #9 and was responsible for her money. Interview with the Administrator on 07/13/26 at 9:30am revealed: -DSS was the guardian for Resident #9 and was responsible for her payments. -The facility had not had a BOM since 06/02/26. -She was not aware that the facility had received any payments for Resident #9 until the BOM left and she then found the checks in her office. -Resident #9 had been asking for her $70.00 personal funds since she was admitted to the facility. -She informed Resident #9 that she would receive her $70.00 personal funds on 07/13/26. -The BOM should have given Resident #9 her personal funds as soon as she received the checks from DSS. -The facility planned to give Resident #9 backpay for the $70.00 personal funds to make up for the months she did not receive her payments. -The BOM was responsible for ensuring that residents were paid their personal funds each month. -She was now responsible for ensuring that residents were paid personal funds because the facility did not have a BOM.	D 424		
D 427	10A NCAC 13F .1106 (a) Settlement Of Cost Of Care 10A NCAC 13F .1106 Settlement Of Cost Of Care (a) If a resident of an adult care home, has been notified by the facility of its intent to discharge in	D 427		

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D 427	Continued From page 154 accordance with Rule .0702 of this Subchapter, the facility shall refund the resident an amount equal to the cost of care for the remainder of the month minus the amount charged for any nights spent in the facility during the notice period. The refund shall be made within 14 days after the resident leaves the facility. For the purposes of this Rule, "cost of care" means any monies paid by the resident or the resident's legal representative in advance for room and board and services provided by the facility as agreed upon in the resident's contract. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure a refund of the amount equal to the cost of care for the remainder of the month was made within 14 days after the resident left the facility for 1 of 1 resident (#23). The findings are: Review of Resident #23's current FL-2 dated 07/16/26 revealed: -Diagnoses included Alzheimer's disease and dementia. -The resident was constantly disoriented. Review of the Resident Register for Resident #23 revealed she was admitted to the facility on 02/25/25. Review of Resident #23's financial agreement dated 02/25/25 revealed: -The financial agreement was signed by the Business Office Manager (BOM) and Resident #3's financial representative on 02/25/25. -The financial agreements stated that if a resident received assistance from the State or County, or was a special assistant (SA) resident, state	D 427		

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regulations permitted the community to hold the resident's bed for a maximum of 30 days.
-The financial agreement stated upon resident move-out, the community would refund the resident/financial representative any prepaid amounts for accommodations and services not rendered by the community after the expiration of the 14 day period.

Review of a bank statement for Resident #23's family member/financial representative on 07/08/26 at 9:08am revealed the facility withdrew $1627.00 from the account on 04/06/26.

Telephone interview with Resident #23 family member/financial representative on 07/07/26 at 9:45am revealed:
-Resident #23 was a resident in the facility for a year.
-Resident #23 went to the hospital after a fall on 03/13/26.
-She spoke with the BOM in person (date unknown) and explained to her that she did not know if Resident #23 would be able to return to the facility and that her condition required skilled nursing care.
-Resident #23 was admitted to a skilled nursing facility (SNF) on 03/19/26.
-On 03/19/26 she went to the facility to retrieve Resident #23's belongings, and she was told by the BOM that she did not have to pick them all up that day and that she could return for the remainder of her items later.
-She returned to the facility at the beginning of April to pick up the remainder of Resident #23's belongings and complained to the BOM about the $1627.00 being withdrawn from the account.
-She spoke with the BOM on numerous occasions requesting that the $1627.00 for the month of April be refunded to her account.

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-She reported that the BOM acknowledged the withdrawal from the account but did not refund the money and stopped responding to her messages.

Second telephone interview with Resident #23's family member/financial representative on 07/09/26 at 3:42pm revealed she was overnighted a refund check of $1,006.00 from the facility and received it on 07/09/26.

Telephone interview with the former BOM on 07/08/26 at 9:10am revealed:
-Resident #23 left the facility after a fall and was admitted to a SNF.
-Resident #23's family informed the Administrator and her that Resident #23 would not be returning to the facility because she needed a higher level of care.
-The resident was not discharged from the facility until sometime in April because they had not received confirmation that she was admitted to the SNF.
-Resident #23 was residing at the SNF for 30 days before she knew that she was not coming back to the facility.
-Resident #23's family should have been refunded a portion of the money back for the month of April.

Interview with the Administrator on 07/08/26 at 9:50am revealed:
-Resident #23 was discharged from the facility on 04/14/26.
-In April $1627.00 was withdrawn for Resident #23's account.
-Resident #23 should have been given a partial refund for the days of April after her discharge date of 04/14/26.
-Resident #23 was discharged 30 days after she

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D 427	Continued From page 157 left the facility due to a fall. -She was never given a notice by the family to inform the facility that she was not returning. -The facility corporate home office was responsible for sending refunds to residents and family members after they were discharged from the facility. -The BOM was responsible for sending the corporate home office resident discharge notices. -She was not aware if the former BOM sent Resident #23's discharge information to the home office. -She was now responsible for the BOM responsibilities because the facility currently did not have a BOM.	D 427		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the minimum number of staff were present at all times to meet the needs of residents residing in the special care unit (SCU) for 6 of 21 shifts sampled on 05/02/26, 06/26/26, and from 07/01/26 - 07/05/26. The findings are:	D 465		

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D 465	Continued From page 158 Review of the facility's current license effective 01/01/26 revealed the facility was licensed for a capacity of 80 including a special care unit (SCU) with a capacity of 24. Review of the facility's resident census reports dated 05/02/26, 06/26/26, and from 07/01/26 - 07/05/26 revealed there was a census of 21 residents on each of those dates, which required 21 staff hours on first and second shifts and 16.8 staff hours on third shift. Review of staff timecards dated 05/02/26 revealed there was a total of 16.43 staff hours provided on first shift with a shortage of 4.57 hours. Review of staff timecards dated 06/26/26 revealed there was a total of 20.15 staff hours provided on second shift with a shortage of 0.85 hours. Review of staff timecards dated 07/01/26 revealed there was a total of 15.47 staff hours provided on first shift with a shortage of 5.53 hours. Review of staff timecards dated 07/03/26 revealed there was a total of 20.20 staff hours provided on second shift with a shortage of 0.80 hours. Review of staff timecards dated 07/04/26 revealed there was a total of 19.72 staff hours provided on first shift with a shortage of 1.28 hours. Review of staff timecards dated 07/05/26 revealed there was a total of 11.50 staff hours	D 465		

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D 465	Continued From page 159 provided on third shift with a shortage of 5.30 hours. Interview with a medication aide (MA) on 07/07/26 at 10:05am revealed -The MAs usually worked 12-hour shifts from 7:00am - 7:00pm and 7:00pm - 7:00am. -The personal care aides (PCAs) usually worked 8-hour shifts from 7:00am - 3:00pm, 3:00pm - 11:00pm, and 11:00pm - 7:00am. Telephone interview with a second MA on 07/15/26 at 8:41am revealed: -The MAs usually worked 12-hour shifts and the PCAs worked 8-hour shifts. -For first and second shifts, there was usually 1 MA and 2 PCAs for the SCU. -For third shift, there were usually 2 PCAs on the SCU with 1 MA covering the SCU and the assisted living (AL) side of the facility. -In March 2026, the facility started being short staffed. -When she worked on night shift, she was usually the only MA in the facility after 11:00pm. -There was a problem with the facility retaining staff. Telephone interview with the Special Care Coordinator (SCC) on 07/15/26 at 2:51pm revealed: -He specifically remembered being short staffed on 05/02/26 because of call outs. -He and 1 PCA were the only staff working in the SCU on first shift on 05/02/26. -He administered medications in the SCU on 05/02/26. -He did not make the schedule. -If he was manager on duty, he sometimes adjusted the staff assignment sheet if needed for call outs.	D 465		

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D 465	Continued From page 160 -If there were call outs, he may call other staff to find coverage, or he would come in and work himself. -They had a problem with frequent call outs. -They were in the process of trying to hire new staff and had just added 2 new MAs last week. Telephone interview with the Resident Care Coordinator (RCC) on 07/15/26 at 2:38pm revealed: -She did not make the schedule, but she was responsible for completing the assignment sheets. -For the SCU, there was usually 1 MA and 2 PCAs assigned to first and second shifts. -There were 2 PCAs assigned to the SCU for third shift. -There was 1 MA that was shared between the SCU and the AL side of the facility for third shift. -They had issues with staff calling out. -When there was a call out, she called other staff to find replacements for that shift. -If she was unable to find coverage, either she or the SCC or the Administrator would fill in to help cover the shift. -They especially had a difficult time getting enough MAs to work on weekends. -She felt like staffing had improved recently. Interviews with the Administrator on 07/14/26 at 4:00pm and 5:04pm revealed: -On 05/02/26, they had some call outs, so she and the SCC had to cover some shifts. -She and the SCC administered medications on 05/02/26 when they were short staffed. -They tried to call in other staff to help cover the shifts, but they did not have any luck in getting other staff to come in. -She was not aware they were short staffed on second shift on 06/26/26.	D 465		

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D 465	Continued From page 161 -She was not sure why one of the staff member's lunch break was so long on that shift. -Lunch breaks were usually 30 minutes. -She created the schedule every two weeks. -The RCC maintained the schedule. -When staff members called out they were supposed to call the MA on shift to inform them they would not be working their shift. -The MAs were responsible for finding staff to cover shifts. -When the MAs could not find coverage, they would inform the RCC and SCC. -The SCC, RCC, or the Administrator were responsible for ensuring all shifts were covered. -She or the RCC or the SCC would fill in when needed to cover shifts for call outs.	D 465		
D 502	10A NCAC 13F .0309 (b) (c) Fire Safety and Emergency Preparedness Plans 10A NCAC 13F .0309 Fire Safety and Emergency Preparedness Plans (b) There shall be unannounced fire drills of the fire plan conducted quarterly on each shift in accordance with the requirement of the local fire prevention code enforcement official and the 2018 North Carolina Building Code: Fire Prevention Code, which is hereby incorporated by reference and includes all subsequent editions, available at https://codes.iccsafe.org/content/NCFC2018. (c) Documentation of fire drills shall be maintained by the administrator or their designee in the facility and be made available upon request to the Division of Health Service Regulation, county department of social services, and local officials. The records shall include the date and time of the drills, the shift, staff members present,	D 502		

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D 502	Continued From page 162 and a short description of the drill. 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 record reviews and interviews, the facility failed to conduct unannounced fire drills quarterly on each shift and failed to maintain documentation of the fire drills to include the staff members present and a short description of the drill. The findings are: Review of the facility fire drill report dated 12/07/25 revealed: -The fire drill took place on the first shift from 8:30am through 8:45am. -There was no documentation of staff that participated in the fire drill. -There was no description of the fire drill. -The document was not signed. Review of the facility fire drill report dated 01/08/26 revealed: -The fire drill took place on the second shift from 3:30pm through 4:00pm. -There was no documentation of staff that participated in the fire drill. -There was no description of the fire drill. -The document was signed by the Administrator. Review of the facility fire drill report dated 03/11/26 revealed: -The fire drill took place on the first shift from 8:30am through 9:00am. -There was no documentation of staff that participated in the fire drill. -There was no description of the fire drill.	D 502		

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D 502	Continued From page 163 -The document was signed by the Administrator. Review of the facility fire drill report dated 04/28/26 revealed: -The fire drill took place on the second shift from 3:30pm through 4:00pm. -There was no documentation of staff that participated in the fire drill. -There was no description of the fire drill. -The document was signed by the Administrator. Interview with a medication aide (MA) on 07/07/26 at 10:05am revealed -The MAs usually worked 12-hour shifts from 7:00am - 7:00pm and 7:00pm - 7:00am. -The personal care aides (PCA) usually worked 8-hour shifts from 7:00am - 3:00pm, 3:00pm - 11:00pm, and 11:00pm - 7:00am. Review of facility fire drill reports on 07/09/26 at 3:00pm revealed there were no fire drills conducted on 3rd shift (11:00pm - 7:00am). Interview with the Resident Care Coordinator (RCC) on 07/09/26 at 3:20pm revealed: -The facility conducted fire drills quarterly. -The Maintenance Director was responsible for conducting the fire drills. -She was not aware of what was supposed to be documented on the fire drill reports. -The staff that participated and a description of the fire drill were not documented on the fire drill reports. Interview with the Maintenance Director on 07/09/26 at 3:25pm revealed: -He was responsible for monitoring the door locks and assisted with the facility fire inspections. -He was responsible for maintaining the fire extinguishers throughout the facility.	D 502		

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D 502	Continued From page 164 -He and the Administrator were responsible for conducting fire drills. -The fire drills were conducted monthly. -The Administrator was responsible for completing the fire drill reports after each fire drill was completed. Interview with the Administrator on 07/09/26 at 3:35pm revealed: -Fire drills were conducted quarterly. -She was responsible for conducting the quarterly fire drills. -She was not aware of what needed to be documented on the fire drill reports. -The current fire drill report logs were in the fire safety binder when she became the Administrator. -She continued to document the fire drills as they were done prior to becoming the Administrator. -The staff members that were present and a short description of the fire drill were missing from the quarterly fire drill reports.	D 502		
D 610	10A NCAC 13F .1801(a) Infection Prevention & Control Policies & Pro 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL POLICIES AND PROCEDURES (a) In accordance with Rule .1211(a)(4) of this Subchapter and G.S. 131D-4.4A(b)(1), the facility shall establish and implement infection prevention and control policies and procedures consistent with the federal Centers for Disease Control and Prevention (CDC) published guidelines on infection prevention and control. The Department shall approve a set of policies and procedures for infection prevention and control consistent with the federal CDC published	D 610		

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D 610	Continued From page 165 guidelines on infection prevention and control that shall be made available on the Division of Health Service Regulation, Adult Care Licensure Section website at https://info.ncdhhs.gov/dhsr/acls/acforms.html at no cost. The facility shall either: (1) utilize the set of policies and procedures for infection prevention and control approved by the Department; (2) develop policies and procedures for infection prevention and control that are consistent with the set of Department approved policies and procedures; or (3) develop policies and procedures for infection prevention and control that are based on nationally recognized standards in infection prevention and control that are consistent with the federal CDC published guidelines on infection prevention and control. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to implement infection control procedures for glucometers used to obtain fingerstick blood sugar (FSBS) readings for 6 of 7 sampled residents (#4, #6, #7, #8, #9, #21) with orders for FSBS monitoring. The findings are: Review of the facility's Glucometer Care, Maintenance, Testing Policy dated September 2021 revealed: -It was the policy of the facility to maintain glucometers at optimal functioning based on manufacturer's guidelines and to adhere to strict infection control procedures based on Centers for Disease Control (CDC) guidelines.	D 610		

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D 610	Continued From page 166 -Glucometers were sanitized weekly as per manufacturer's guidelines and calibrated weekly with results of calibration maintained in a log. Review of the CDC Guidelines for Blood Glucose Monitoring dated 08/07/24 revealed: -Glucometers could easily become contaminated during use. -When used in healthcare or other group settings, germs and infections could spread if preventative measures were not in place. -Do not share glucometers. -If you must share them in a healthcare or congregate setting, select a device designed for use in professional settings, not an over-the-counter device. -Clean and disinfect glucometers after every use, per manufacturer instructions. -If glucometers must be shared, the device should be cleaned and disinfected after every use, per the manufacturer's instructions to prevent the spread of blood and infectious agents. -If the manufacturer did not specify how the device should be cleaned and disinfected, it should not be shared. Review of the manufacturer's manual for Brand A glucometers revealed: -This glucometer was intended to be used by a single person and should not be shared. -All parts of the system were considered biohazardous and could potentially transmit infectious diseases, even after performing pre-cleaning and disinfection. -This devices was not intended for use in healthcare or assisted-use settings such as hospitals, physician offices or long-term care facilities because it had not been cleared by the Food and Drug Administration (FDA) for use in	D 610		

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D 610	Continued From page 167 the settings. -Use of this device on multiple persons may lead to the transmission of Human Immunodeficiency Virus (HIV), Hepatitis C Virus (HCV), Hepatitis B Virus (HBV), or other bloodborne pathogens. -The pre-cleaning procedure was needed to clean dirt as well as blood and other body fluids on the exterior of the glucometer before performing the disinfection procedure. -The disinfection procedure was needed to prevent transmission of bloodborne pathogens. -The pre-cleaning and disinfection procedure should be performed once per week using a specific healthcare bleach germicidal wipe. -Other cleaners or disinfectants should not be used because other chemicals had not been validated and may damage the glucometer. Review of the manufacturer's manual for Brand B glucometers revealed: -This glucometer was intended to be used by a single person and not to be shared. -This glucometer was for one person use only. -Do not share the glucometer with anyone, including family members. -Do not use the glucometer on multiple people. -All parts of the glucometer system could carry bloodborne pathogens after use, even after cleaning and disinfecting. -Cleaning and disinfecting the glucometer destroys most, but not necessarily all bloodborne pathogens. -If the glucometer was operated by a second person who provided testing assistance, the glucometer should be cleaned and disinfected prior to use by the second person. -It was important to keep the glucometer clean and disinfected. -Cleaning removed blood and soil from the glucometer.	D 610		

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D 610	Continued From page 168 -Disinfecting removed most, but not all possible infections agents from the glucometer, including bloodborne pathogens. -Clean and disinfect the glucometer immediately after getting any blood on the glucometer or if the glucometer was dirty. -Clean and disinfect the glucometer at least once a week. -The glucometer should only be cleaned and disinfected with the specified sanitizing wipe. -Other disinfectants had not been tested and may damage the glucometer. Review of the manufacturer's manual for Brand C glucometers revealed: -This glucometer was for single person use only. -Do not share the glucometer with anyone, including family members. -Do not use the glucometer on multiple people. -All parts of the glucometer system were considered biohazardous and could potentially transmit infectious diseases, even after cleaning and disinfection. -The glucometer should not be used for more than one person as this posed a risk of transmitting bloodborne pathogens, such as Hepatitis B or HIV. -The glucometer should be cleaned whenever it was visibly dirty by wiping the outside of the glucometer using a cloth dampened with either mild detergent mixed with water or 70% isopropyl (rubbing) alcohol. -Do not use bleach or other harsh abrasives to clean the glucometer. -If the glucometer was being operated by a second person who was providing testing assistance to the user, the glucometer should be decontaminated prior to use by the second person. -There were no specific instructions for	D 610		

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D 610	Continued From page 169 decontaminating the glucometer. Review of the manufacturer's manual for Brand D glucometers revealed: -The glucometer was designed for use by a single individual and should not be shared. -To clean the glucometer, wipe the outside with a soft cloth dampened with water and mild detergent. -Do not use alcohol or another solvent to clean the glucometer. -To disinfect the glucometer, prepare a solution of one part household bleach to ten parts water. Review of the manufacturer's manual for Brand E glucometers revealed: -The glucometer was for individual use. -To ensure proper function and hygiene, the glucometer should be wiped with a soft cloth dampened with a mild detergent or 70% isopropyl (rubbing) alcohol. -To clean the glucometer, wipe the outside with a soft cloth dampened with water and mild detergent. -Do not use alcohol or another solvent to clean the glucometer. -To disinfect the glucometer, prepare a solution of one part household bleach to ten parts water. 1. Review of Resident #4's current FL-2 dated 07/16/26 revealed: -Diagnoses included dementia with behaviors, type 1 diabetes mellitus, hypertension, hallucinations, memory loss, and weight loss. -There was an order to check fingerstick blood sugar (FSBS) 3 times a day before meals. Observation of Resident #4's medications on hand on 07/07/26 at 10:51am in the special care unit (SCU) revealed:	D 610		

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D 610	Continued From page 170 -There was a Brand C glucometer in the back of the top drawer on the medication cart in the SCU with Resident #4's name written on the back of it. -Resident #4's glucometer would not turn on. -There was no glucometer with Resident #4's name stored at the front of the drawer of the medication cart with the other glucometers. -There was a red Brand A glucometer stored with the actively used glucometers with no resident's name. Interview with the medication aide (MA) on 07/07/26 at 10:51am revealed: -She did not use Resident #4's Brand C glucometer because it was broken and would not turn on. -She used the red Brand A glucometer for Resident #4 and another resident because both of their glucometers were broken. -Resident #4's Brand C glucometer had been broken for the last couple of months. -She did not know if anyone was trying to obtain a new glucometer for Resident #4. -She was not sure if the broken Brand C glucometer had been reported to anyone. -She thought it was okay to share glucometers because she cleaned the glucometers with alcohol wipes between each resident. Observation of the red Brand A glucometer history on 07/07/26 at 10:53am revealed: -The date and time on the screen when the glucometer was turned on was 07/07/26 at 8:49am. -There were multiple days with multiple consecutive blood sugar readings taken within a few minutes of the next FSBS reading, indicating the glucometer was used for multiple residents in a row on those days. -There was a blood sugar reading of 183 on	D 610		

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D 610	Continued From page 171 07/07/26 at 10:11am. -There was a blood sugar reading of "HI" (greater than 600) on 07/07/26 at 10:06am. -There was a blood sugar reading of 246 on 07/07/26 at 9:49am. -There was a blood sugar reading of "HI" on 07/07/26 at 6:53am. -There was a blood sugar reading of 171 on 07/02/26 at 5:04am. -There was a blood sugar reading of 96 on 07/01/26 at 4:09pm. -There was a blood sugar reading of 233 on 07/01/26 at 4:03pm. -There was a blood sugar reading of 401 on 07/01/26 at 9:49am. -There was a blood sugar reading of 466 on 07/01/26 at 9:35am. -There was a blood sugar reading of 197 on 07/01/26 at 9:28am. -There was a blood sugar reading of 366 on 07/01/26 at 6:34am. -There was a blood sugar reading of 337 on 06/30/26 at 8:08pm. -There was a blood sugar reading of 171 on 06/30/26 at 4:46pm. -There was a blood sugar reading of 179 on 06/30/26 at 3:47pm. -There was a blood sugar reading of 148 on 06/30/26 at 3:45pm. -There was a blood sugar reading of 462 on 06/30/26 at 10:01am. -There was a blood sugar reading of 232 on 06/30/26 at 9:44am. -There was a blood sugar reading of 337 on 06/30/26 at 9:38am. -There was a blood sugar reading of 331 on 06/30/26 at 6:52am. -There was a blood sugar reading of 96 on 06/30/26 at 6:27am. -There was a blood sugar reading of 225 on	D 610		

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D 610	Continued From page 172	D 610		

06/30/26 at 6:18am.
-There was a blood sugar reading of 313 on 06/29/26 at 7:15pm.
-There was a blood sugar reading of 350 on 06/29/26 at 3:41pm.
-There was a blood sugar reading of 259 on 06/29/26 at 3:26pm.
-There was a blood sugar reading of 186 on 06/29/26 at 3:06pm.
-There was a blood sugar reading of 259 on 06/29/26 at 9:55am.
-There was a blood sugar reading of 228 on 06/29/26 at 9:29am.
-There was a blood sugar reading of 344 on 06/29/26 at 9:12am.
-There was a blood sugar reading of 178 on 06/29/26 at 5:28am.
-There was a blood sugar reading of 393 on 06/29/26 at 5:16am.
-There was a blood sugar reading of 161 on 06/29/26 at 5:09am.
-There was a blood sugar reading of 169 on 06/29/26 at 4:53am.
-There was a blood sugar reading of 120 on 06/28/26 at 11:34pm.
-There was a blood sugar reading of 447 on 06/28/26 at 3:51pm.
-There was a blood sugar reading of 198 on 06/28/26 at 3:41pm.
-There was a blood sugar reading of 203 on 06/28/26 at 3:39pm.
-There was a blood sugar reading of 219 on 06/28/26 at 9:41am.
-There was a blood sugar reading of 351 on 06/28/26 at 6:07am.
-There was a blood sugar reading of 225 on 06/28/26 at 5:59am.
-There was a blood sugar reading of 299 on 06/27/26 at 3:34pm.
-There was a blood sugar reading of 154 on

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D 610	Continued From page 173	D 610		

06/27/26 at 3:32pm.
-There was a blood sugar reading of 228 on 06/27/26 at 6:02am.
-There was a blood sugar reading of 124 on 06/27/26 at 5:53am.
-There was a blood sugar reading of 156 on 06/27/26 at 5:51am.
-There were no further blood sugar readings in the glucometer history.

Review of Resident #4's June 2026 electronic medication administration record (eMAR) revealed:
-There was an entry to check FSBS 3 times a day before meals scheduled at 7:30am, 11:30am, and 5:30pm.
-The resident's FSBS was documented as being checked 3 times a day from 06/01/26 - 06/30/26.
-There were 6 FSBS documented on the eMAR for Resident #4 that matched the FSBS readings available for 06/27/26 - 06/30/26 in the red Brand A glucometer history.
-Matches for 7:30am included: 156 on 06/27/26 and 178 on 06/2926.
-Matches for 11:30am included: 120 on 06/28/26; 259 on 06/29/26; and 232 on 06/30/26.
-Matches for 5:30pm included 259 on 06/29/26.
-There were 6 FSBS readings documented on the eMAR from 06/27/26 - 06/30/26 that were not included in the red Brand A glucometer history.
-The resident's FSBS ranged from 97 - 363 from 06/01/26 - 06/30/26.

Review of Resident #4's July 2026 eMAR dated 07/01/26 - 07/07/26 revealed:
-There was an entry to check FSBS 3 times a day before meals scheduled at 7:30am, 11:30am, and 5:30pm.
-The resident's FSBS was documented as being checked 3 times a day from 07/01/26 - 07/07/26

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D 610	Continued From page 174 (11:30am). -The resident's FSBS was 183 on 07/02/26 at 11:30am and matched the FSBS reading in unlabeled red Brand A glucometer. -The other 18 FSBS documented on the July 2026 eMAR were not in the red Brand A glucometer history. -The resident's FSBS ranged from 110 - 433 from 07/01/26 - 07/07/26. Interview with the Special Care Coordinator (SCC) on 07/07/26 at 1:15pm revealed: -He was not aware Resident #4's glucometer was broken and a red glucometer was being shared until today, 07/07/26. -The MAs should contact the pharmacy to get a new glucometer for Resident #4 and notify him. Interview with the Administrator on 07/07/26 at 1:52pm revealed: -She was not aware Resident #4's glucometer was broken. -If the MAs had reported it, she would have ordered or bought a new glucometer for Resident #4. Telephone interview with Resident #4's PCP on 07/07/26 at 4:25pm revealed: -She completed face-to-face exams on all diabetic residents every 6 months for diabetic supplies. -The facility would need to contact her for a new prescription to obtain a glucometer so insurance would pay for it. -No one from the facility had notified her that Resident #4's glucometer was broken or that he needed a new prescription. -Glucometers should not be shared. -Each resident should have their own glucometer for better hygiene and better safety and to	D 610		

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D 610	Continued From page 175 prevent transmission of diseases. Based on observations, interviews, and record reviews, it was determined that Resident #4 was not interviewable. Refer to interview with the Special Care Coordinator (SCC) on 07/07/26 at 1:15pm. Refer to interview with the Resident Care Coordinator (RCC) on 07/07/26 at 1:37pm. Refer to interview with the Administrator on 07/07/26 at 1:52pm. Refer to interview with the Regional Clinical Director (RCD) on 07/10/26 at 3:23pm. 2. Review of Resident #21's current FL-2 dated 04/02/26 revealed: -Diagnoses included dementia with behavioral disturbances, anemia, type 2 diabetes mellitus, hypertension, breast cancer, and Vitamin D deficiency. -There was an order to check fingerstick blood sugar (FSBS) every morning. Observation of Resident #21's medications on hand on 07/07/26 at 10:52am in the special care unit (SCU) revealed: -There was an unlabeled Brand E glucometer identified by the medication aide (MA) as belonging to Resident #21. -Resident #21's Brand E glucometer would turn on but would turn off a few seconds later and would not stay turned on. -There was no glucometer in the medication cart with Resident #21's name. -There was a red Brand A glucometer stored with the actively used glucometers with no resident's	D 610		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SWANSBORO	280 SWANSBORO LOOP ROAD SWANSBORO, NC 28584

(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 610	Continued From page 176 name. Interview with the medication aide (MA) on 07/07/26 at 10:52am revealed: -She did not use Resident #21's Brand E glucometer because it was broken and would stay turned on. -She used the red Brand A glucometer for Resident #21 and another resident because both of their glucometers were broken. -Resident #21's Brand E glucometer had been broken for the last couple of months. -She did not know if anyone was trying to obtain a new glucometer for Resident #21. -She was not sure if the broken Brand E glucometer had been reported to anyone. -She thought it was okay to share glucometers because she cleaned the glucometers with alcohol wipes between each resident. Observation of the red Brand A glucometer history on 07/07/26 at 10:53am revealed: -The date and time on the screen when the glucometer was turned on was 07/07/26 at 8:49am. -There were multiple days with multiple consecutive blood sugar readings taken within a few minutes of the next FSBS reading, indicating the glucometer was used for multiple residents in a row on those days. -There was a blood sugar reading of 183 on 07/07/26 at 10:11am. -There was a blood sugar reading of "HI" (greater than 600) on 07/07/26 at 10:06am. -There was a blood sugar reading of 246 on 07/07/26 at 9:49am. -There was a blood sugar reading of "HI" on 07/07/26 at 6:53am. -There was a blood sugar reading of 171 on 07/02/26 at 5:04am.	D 610		

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 610	Continued From page 177 -There was a blood sugar reading of 96 on 07/01/26 at 4:09pm. -There was a blood sugar reading of 233 on 07/01/26 at 4:03pm. -There was a blood sugar reading of 401 on 07/01/26 at 9:49am. -There was a blood sugar reading of 466 on 07/01/26 at 9:35am. -There was a blood sugar reading of 197 on 07/01/26 at 9:28am. -There was a blood sugar reading of 366 on 07/01/26 at 6:34am. -There was a blood sugar reading of 337 on 06/30/26 at 8:08pm. -There was a blood sugar reading of 171 on 06/30/26 at 4:46pm. -There was a blood sugar reading of 179 on 06/30/26 at 3:47pm. -There was a blood sugar reading of 148 on 06/30/26 at 3:45pm. -There was a blood sugar reading of 462 on 06/30/26 at 10:01am. -There was a blood sugar reading of 232 on 06/30/26 at 9:44am. -There was a blood sugar reading of 337 on 06/30/26 at 9:38am. -There was a blood sugar reading of 331 on 06/30/26 at 6:52am. -There was a blood sugar reading of 96 on 06/30/26 at 6:27am. -There was a blood sugar reading of 225 on 06/30/26 at 6:18am. -There was a blood sugar reading of 313 on 06/29/26 at 7:15pm. -There was a blood sugar reading of 350 on 06/29/26 at 3:41pm. -There was a blood sugar reading of 259 on 06/29/26 at 3:26pm. -There was a blood sugar reading of 186 on 06/29/26 at 3:06pm.	D 610		

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D 610	Continued From page 178 -There was a blood sugar reading of 259 on 06/29/26 at 9:55am. -There was a blood sugar reading of 228 on 06/29/26 at 9:29am. -There was a blood sugar reading of 344 on 06/29/26 at 9:12am. -There was a blood sugar reading of 178 on 06/29/26 at 5:28am. -There was a blood sugar reading of 393 on 06/29/26 at 5:16am. -There was a blood sugar reading of 161 on 06/29/26 at 5:09am. -There was a blood sugar reading of 169 on 06/29/26 at 4:53am. -There was a blood sugar reading of 120 on 06/28/26 at 11:34pm. -There was a blood sugar reading of 447 on 06/28/26 at 3:51pm. -There was a blood sugar reading of 198 on 06/28/26 at 3:41pm. -There was a blood sugar reading of 203 on 06/28/26 at 3:39pm. -There was a blood sugar reading of 219 on 06/28/26 at 9:41am. -There was a blood sugar reading of 351 on 06/28/26 at 6:07am. -There was a blood sugar reading of 225 on 06/28/26 at 5:59am. -There was a blood sugar reading of 299 on 06/27/26 at 3:34pm. -There was a blood sugar reading of 154 on 06/27/26 at 3:32pm. -There was a blood sugar reading of 228 on 06/27/26 at 6:02am. -There was a blood sugar reading of 124 on 06/27/26 at 5:53am. -There was a blood sugar reading of 156 on 06/27/26 at 5:51am. -There were no further blood sugar readings in the glucometer history.	D 610		

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D 610	Continued From page 179 Review of Resident #21's June 2026 electronic medication administration record (eMAR) revealed: -There was an entry to check FSBS every morning scheduled at 6:00am. -The resident's FSBS was 169 on 06/29/26 at 6:00am and matched the FSBS in the red Brand A glucometer history. -There were 3 FSBS readings documented on the eMAR from 06/27/26 - 06/30/26 that were not included in the red Brand A glucometer history. -The resident FSBS ranged from 110 - 239 from 06/01/26 - 06/30/26. Review of Resident #21's July 2026 eMAR dated 07/01/26 - 07/07/26 revealed: -There was an entry to check FSBS every morning scheduled at 6:00am. -The resident's FSBS was 124 on 07/01/26 at 6:00am. -The resident's FSBS was 128 on 07/02/26 at 6:00am. -The resident's FSBS was 189 on 07/03/26 at 6:00am. -The resident's FSBS was 179 on 07/04/26 at 6:00am. -The resident's FSBS was 118 on 07/05/26 at 6:00am. -The resident's FSBS was 126 on 07/06/26 at 6:00am. -The resident's FSBS was 171 on 07/07/26 at 6:00am. -None of Resident #21's FSBS documented from 07/01/26 - 07/07/26 matched the FSBS readings in the red Brand A glucometer. -The resident FSBS ranged from 118 - 189 from 07/01/26 - 07/07/26. Interview with Resident #21 on 07/08/26 at	D 610		

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D 610	Continued From page 180 8:45am revealed: -Her FSBS was checked but she did not know how often. -She did not know if she had her own glucometer. Interview with the Special Care Coordinator (SCC) on 07/07/26 at 1:15pm revealed: -He was not aware Resident #21's glucometer was broken and a red glucometer was being shared until today, 07/07/26. -The MAs should notified him immediately about Resident #21's broken glucometer. Interview with the Administrator on 07/07/26 at 1:52pm revealed: -She was not aware of Resident #21's glucometer being broken. -If the MAs had reported it, she would have ordered or bought a new glucometer for Resident #21. Telephone interview with Resident #21's primary care provider (PCP) on 07/07/26 at 4:25pm revealed: -She completed face-to-face exams on all diabetic residents every 6 months for diabetic supplies. -The facility would need to contact her for a new prescription to obtain a glucometer so insurance would pay for it. -No one from the facility had notified her that Resident #21's glucometer was broken or that she needed a new prescription. -Glucometers should not be shared. -Each resident should have their own glucometer for better hygiene and better safety and to prevent transmission of diseases. Refer to interview with the Special Care Coordinator (SCC) on 07/07/26 at 1:15pm.	D 610		

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D 610	Continued From page 181 Refer to interview with the Resident Care Coordinator (RCC) on 07/07/26 at 1:37pm. Refer to interview with the Administrator on 07/07/26 at 1:52pm. Refer to interview with the Regional Clinical Director (RCD) on 07/10/26 at 3:23pm. 3. Review of Resident #7's current FL-2 dated 04/30/26 revealed: -Diagnoses included type 2 diabetes mellitus, hypertension, atrial fibrillation, chronic heart failure, respiratory failure, ulcerative pancolitis, muscle weakness, cardiac pacemaker, gastroesophageal reflux disease, pain, and anemia. -There was an order to check fingerstick blood sugar (FSBS) twice a day at 8:00am and 5:00pm for Novolog sliding scale insulin (SSI): if less than (<) 60 call primary care provider (PCP); 0 - 150 = 0 units; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; if greater than (>) 400 = 12 units and call PCP. (Novolog is rapid-acting insulin used to lower blood sugar.) Observation of Resident #7's medications on hand on 07/07/26 at 10:05am on the assisted living (AL) side revealed: -There was a black zipper pouch (used for storing a glucometer) in the medication cart with a piece of tape with Resident #7's first initial and last name written on the tape. -When unzipped, there was a Brand B glucometer inside with a piece of tape with "house" written on the tape. -There were no glucometers in the medication cart with Resident #7's name.	D 610		

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D 610	Continued From page 182 -There was a second unlabeled Brand C glucometer in the top drawer of the medication cart in a divided section beside Resident #7's insulin pens. Interview with the medication aide (MA) on 07/07/26 at 10:05am revealed: -She was not sure who the unlabeled Brand C glucometer in the top drawer of the 300 hall medication cart belonged to. -She did not know where Resident #7's glucometer was and she did not have another glucometer with Resident #7's name. -"House" meant the glucometer was house stock and it belonged to this particular medication cart to use if a resident did not have their own glucometer. -She did not know if the house stock Brand B glucometer stored in Resident #7's pouch had been used to check FSBSs for any other residents. -The MAs cleaned the glucometers with alcohol wipes and used disposable lancets. -She had not notified anyone that Resident #7 did not have a glucometer because she had not noticed the label on the back of the glucometer noted "house". Observation of the "house" Brand B glucometer history in Resident #7's black pouch on 07/07/26 at 10:05am revealed: -The date and time did not display on the screen when the glucometer was turned on. -The date and time of the first blood sugar reading stored in the memory was 07/07/26 at 8:03am. -There were multiple days with multiple consecutive blood sugar readings taken within a few minutes of the next FSBS reading, indicating the glucometer was used for multiple residents in	D 610		

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D 610	Continued From page 183 a row on those days. -There was a blood sugar reading of 142 on 07/07/26 at 8:03am. -There was a blood sugar reading of "HI" (greater than 600) on 07/01/26 at 6:22pm. -There was a blood sugar reading of 124 on 06/26/26 at 12:43pm. -There was a blood sugar reading of 363 on 06/25/26 at 6:33pm. -There was a blood sugar reading of 144 on 06/22/26 at 12:34pm. -There was a blood sugar reading of 96 on 06/20/26 at 5:00pm. -There was a blood sugar reading of 125 on 06/20/26 at 8:02am. -There was a blood sugar reading of 218 on 06/19/26 at 10:21pm. -There was a blood sugar reading of 130 on 06/19/26 at 6:01pm. -There was a blood sugar reading of 193 on 06/19/26 at 5:55pm. -There was a blood sugar reading of 465 on 06/19/26 at 1:48pm. -There was a blood sugar reading of 206 on 06/19/26 at 1:11pm. -There was a blood sugar reading of 399 on 06/19/26 at 8:20am. -There was a blood sugar reading of 425 on 06/18/26 at 7:10pm. -There was a blood sugar reading of 160 on 06/18/26 at 6:17pm. -There was a blood sugar reading of 170 on 06/18/26 at 6:14pm. -There was a blood sugar reading of 236 on 06/18/26 at 12:32pm. -There was a blood sugar reading of 298 on 06/18/26 at 12:22pm. -There was a blood sugar reading of 231 on 06/18/26 at 9:24am. -There was a blood sugar reading of 219 on	D 610		

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D 610	Continued From page 184	D 610		

06/13/26 at 10:53pm.
-There was a blood sugar reading of 154 on 06/13/26 at 7:11am.
-There was a blood sugar reading of 187 on 06/13/26 at 7:09am.
-There was a blood sugar reading of 317 on 06/12/26 at 6:13pm.
-There was a blood sugar reading of 268 on 06/10/26 at 9:13pm.
-There was a blood sugar reading of 277 on 06/10/26 at 6:08pm.
-There was a blood sugar reading of 261 on 06/09/26 at 6:41pm.
-There was a blood sugar reading of 99 on 06/09/26 at 6:11am.
-There was a blood sugar reading of 242 on 06/08/26 at 7:17pm.
-There was a blood sugar reading of 88 on 06/08/26 at 6:21pm.
-There was a blood sugar reading of 155 on 06/08/26 at 12:28pm.
-There was a blood sugar reading of 90 on 06/08/26 at 12:18pm.
-There was a blood sugar reading of 102 on 06/08/26 at 9:55am.
-There was a blood sugar reading of 183 on 06/08/26 at 9:00am.
-There was a blood sugar reading of 206 on 06/08/26 at 8:49am.
-There was a blood sugar reading of 144 on 06/07/26 at 10:28pm.
-There was a blood sugar reading of 278 on 06/07/26 at 8:32pm.
-There was a blood sugar reading of 166 on 06/07/26 at 6:25pm.
-There was a blood sugar reading of 318 on 06/07/26 at 6:22pm.
-There was a blood sugar reading of 93 on 06/07/26 at 6:00pm.
-There was a blood sugar reading of 101 on

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D 610	Continued From page 185 06/07/26 at 12:24pm. -There was a blood sugar reading of 224 on 06/07/26 at 12:06pm. -There was a blood sugar reading of 147 on 06/07/26 at 11:56am. -There was a blood sugar reading of 127 on 06/07/26 at 10:02am. -There was a blood sugar reading of 208 on 06/07/26 at 9:17am. -There was a blood sugar reading of 215 on 06/07/26 at 9:14am. -There was a blood sugar reading of 165 on 06/06/26 at 10:21pm. -There was a blood sugar reading of 437 on 06/06/26 at 5:15pm. -There was a blood sugar reading of 156 on 06/05/26 at 6:25pm. -There was a blood sugar reading of 219 on 06/04/26 at 6:29pm. -There was a blood sugar reading of 267 on 06/04/26 at 6:25pm. -There was a blood sugar reading of 87 on 06/04/26 at 6:06pm. -There was a blood sugar reading of 107 on 06/04/26 at 12:10pm. -There was a blood sugar reading of 176 on 06/04/26 at 9:14am. -There was a blood sugar reading of 232 on 06/04/26 at 8:48am. -There was a blood sugar reading of 160 on 06/03/26 at 9:19pm. -There was a blood sugar reading of 298 on 06/03/26 at 7:04pm. -There was a blood sugar reading of 132 on 06/03/26 at 6:28pm. -There was a blood sugar reading of 328 on 06/03/26 at 1:14pm. -There was a blood sugar reading of 242 on 06/03/26 at 9:56am. -There was a blood sugar reading of 384 on	D 610		

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D 610	Continued From page 186 06/03/26 at 9:40am. -There was a blood sugar reading of 145 on 06/02/26 at 10:23pm. -There was a blood sugar reading of 301 on 06/02/26 at 8:57pm. -There was a blood sugar reading of 246 on 06/02/26 at 6:52pm. -There was a blood sugar reading of 310 on 06/02/26 at 8:47am. -There was a blood sugar reading of 178 on 06/02/26 at 8:23am. -There was a blood sugar reading of 133 on 06/01/26 at 9:45pm. -There was a blood sugar reading of 279 on 06/01/26 at 8:50pm. -There was a blood sugar reading of 248 on 06/01/26 at 6:06pm. -There was a blood sugar reading of 250 on 06/01/26 at 6:02pm. -There was a blood sugar reading of 99 on 06/01/26 at 5:53pm. -There was a blood sugar reading of 301 on 06/01/26 at 12:10pm. -There was a blood sugar reading of 380 on 06/01/26 at 10:26am. -There was a blood sugar reading of 174 on 06/01/26 at 9:01am. Observation of an unlabeled Brand C glucometer in the medication cart with Resident #7's insulin pens on 07/07/26 at 10:03am revealed: -The date and time did not display on the screen when the glucometer was turned on. -The date and time of the first blood sugar reading stored in the memory was 05/16/26 at 8:53pm. -There were no blood sugar readings in the history for June or July 2026. Review of Resident #7's June 2026 electronic	D 610		

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D 610	Continued From page 187	D 610		

medication administration record (eMAR) revealed:
-There was an entry for Novolog SSI check FSBS twice daily: < 60 call PCP; 0 - 150 = 0 units; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; > 400 = 12 units and call PCP scheduled at 8:00am and 5:00pm from 06/01/26 - 06/30/26.
-The resident's FSBS was documented as being checked twice a day at 8:00am and 5:00pm.
-The resident's FSBS documented on the eMAR matched FSBS readings in the "house" Brand B glucometer on 13 occasions from 06/01/26 - 06/30/26.
-Matching FSBS scheduled at 7:30am included: 174 on 06/01/26; 242 on 06/03/26; 176 on 06/04/26; 208 on 06/07/26; and 154 on 06/13/26.
-Matching FSBS scheduled at 5:00pm included: 248 on 06/01/26; 246 on 06/02/26; 298 on 06/03/26; 219 on 06/04/26; 156 on 06/05/26, 166 on 06/07/26; 242 on 06/08/26, and 261 on 06/09/26.
-The resident FSBS ranged from 105 - 363 from 06/01/26 - 06/30/26.

Review of Resident #7's July 2026 eMAR dated 07/01/26 - 07/07/26 revealed:
-There was an entry for Novolog SSI check FSBS twice daily: < 60 call PCP; 0 - 150 = 0 units; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; > 400 = 12 units and call PCP scheduled at 8:00am and 5:00pm.
-The resident's FSBS was documented as being checked twice a day at 8:00am and 5:00pm from 07/01/26 - 07/07/26 (8:00am).
-The resident's FSBS was 142 on 07/07/26 and matched the FSBS reading in the "house" Brand B glucometer.
-There were 12 documented FSBS on the eMAR

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SWANSBORO	280 SWANSBORO LOOP ROAD SWANSBORO, NC 28584

(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 610	Continued From page 188 from 07/01/26 - 07/07/26 that were not included in the "house" Brand B glucometer in Resident #7's pouch. -The resident FSBS ranged from 90 - 357 from 07/01/26 - 07/07/26. Interview with Resident #7 on 07/08/26 at 4:10pm revealed: -She received FSBS checks in the morning and at bedtime. -The facility had a glucometer they used to check her FSBS. -She was not sure if she had her own glucometer. Interview with the Resident Care Coordinator (RCC) on 07/07/26 at 1:37pm revealed: -She was not aware the glucometer used for Resident #7 was labeled as a "house" glucometer. -"House" meant the facility had some extra glucometers in case a resident needed one. -The MAs should have notified her there was no glucometer with Resident #7's name. Interview with the Administrator on 07/07/26 at 1:52pm revealed: -She was not aware there was no labeled glucometer for Resident #7. -The facility did not have house stock glucometers, and she was not sure why there was glucometer labeled "house". -If the MAs had reported it, she would have ordered or bought a new glucometer for Resident #7. Telephone interview with Resident #7's PCP on 07/07/26 at 4:25pm revealed: -She completed face-to-face exams on all diabetic residents every 6 months for diabetic supplies.	D 610		

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D 610	Continued From page 189	D 610		

-The facility would need to contact her for a new prescription to obtain a glucometer so insurance would pay for it.
-No one from the facility had notified her that Resident #7's glucometer was broken or that she needed a new prescription.
-Glucometers should not be shared.
-Each resident should have their own glucometer for better hygiene and better safety and to prevent transmission of diseases.

Refer to interview with the Special Care Coordinator (SCC) on 07/07/26 at 1:15pm.

Refer to interview with the Resident Care Coordinator (RCC) on 07/07/26 at 1:37pm.

Refer to interview with the Administrator on 07/07/26 at 1:52pm.

Refer to interview with the Regional Clinical Director (RCD) on 07/10/26 at 3:23pm.

4. Review of Resident #8's current FL-2 dated 08/11/25 revealed diagnoses included type 2 diabetes mellitus, chronic kidney disease, atrial fibrillation, hyperlipidemia, gastroesophageal reflux disease, and anemia.

Review of Resident #8's physician's orders revealed no order in the record to check the resident's fingerstick blood sugar (FSBS).

Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/08/26 at 11:45am revealed there was an order on file for Resident #8 dated 12/01/25 for FSBS checks twice daily before breakfast and dinner.

Observation of Resident #8's medications on

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D 610	Continued From page 190 hand on 07/07/26 at 9:50am in the assisted living (AL) side revealed: -There was a black zipper pouch (used for storing a glucometer) in the medication cart with a piece of tape with Resident #8's first and last names written on the tape. -When unzipped, there was a Brand D glucometer and a bottle of test strips. Observation of Resident #8's Brand D glucometer history on 07/07/26 at 9:50am revealed: -The date and time did not display on the screen when the glucometer was turned on. -The date and time of the first blood sugar reading stored in the memory was 07/06/26 at 4:50pm. -There was a blood sugar reading of 259 on 07/06/26 at 4:50pm. -There was a blood sugar reading of 161 on 07/06/26 at 8:03am. -There was a blood sugar reading of 263 on 07/05/26 at 6:20pm. -There was a blood sugar reading of 123 on 07/05/26 at 7:05am. -There was a blood sugar reading of 90 on 07/04/26 at 6:48am. -There was a blood sugar reading of 357 on 07/03/26 at 4:32pm. -There was a blood sugar reading of 209 on 07/02/26 at 4:39pm. -There was a blood sugar reading of 104 on 07/02/26 at 7:45am. -There was a blood sugar reading of 282 on 07/01/26 at 5:56pm. -There was a blood sugar reading of 161 on 07/01/26 at 8:27am. -There was a blood sugar reading of 240 on 06/29/26 at 5:00pm. -There was a blood sugar reading of 116 on 06/29/26 at 7:59am.	D 610		

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D 610	Continued From page 191 -There was a blood sugar reading of 225 on 06/28/26 at 4:05pm. -There was a blood sugar reading of 187 on 06/27/26 at 3:51pm. -There was a blood sugar reading of 326 on 06/26/26 at 5:01pm. -There was a blood sugar reading of 194 on 06/24/26 at 5:04pm. -There was a blood sugar reading of 144 on 06/18/26 at 6:39am. -There was a blood sugar reading of 227 on 06/13/26 at 5:31am. -There was a blood sugar reading of 266 on 06/10/26 at 4:32pm. -There was a blood sugar reading of 231 on 06/09/26 at 5:16am. -There was a blood sugar reading of 252 on 06/08/26 at 4:52pm. -There was a blood sugar reading of 235 on 06/08/26 at 6:35am. -There was a blood sugar reading of 247 on 06/07/26 at 4:38pm. -There was a blood sugar reading of 187 on 06/07/26 at 6:38am. -There was a blood sugar reading of 442 on 06/04/26 at 4:46pm. -There was a blood sugar reading of 265 on 06/04/26 at 9:38am. -There was a blood sugar reading of 178 on 06/04/26 at 6:45am. -There was a blood sugar reading of 150 on 06/01/26 at 4:34pm. -There was a blood sugar reading of 108 on 06/01/26 at 11:17am. -There was a blood sugar reading of 163 on 06/01/26 at 5:20am. Review of Resident #8's June 2026 electronic medication administration record (eMAR) revealed:	D 610		

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D 610	Continued From page 192 -There was an entry to check FSBS twice daily every morning and evening before breakfast and dinner scheduled at 7:30am and 5:30pm. -The resident's FSBS was documented as being checked twice a day at 7:30am and 5:30pm except on 06/13/26 at 5:30pm when the resident was out of the facility and on 06/05/26 when no blood sugar result was documented with no reason noted. -The resident's FSBS matched the FSBS readings in the resident's Brand D glucometer for 15 of 58 FSBS readings from 06/01/26 - 06/30/26. -Matching FSBS scheduled at 7:30am included: 163 on 06/01/26; 111 on 06/05/26; 187 on 06/07/26; 232 on 06/08/26; 231 on 06/09/26, 227 on 06/13/26, and 144 on 06/18/26. -Matching FSBS scheduled at 5:30pm included: 150 on 06/01/26; 442 on 06/04/26; 247 on 06/07/26; 252 on 06/08/26; 266 on 06/10/26, 194 on 06/24/26; 187 on 06/27/26, and 225 on 06/28/26. -There were 43 FSBS readings documented on the June 2026 eMAR that were not in Resident #8's Brand D glucometer history. -The resident FSBS ranged from 111 - 442 from 06/01/26 - 06/30/26. Review of Resident #8's July 2026 eMAR dated 07/01/26 - 07/07/26 revealed: -There was an entry to check FSBS twice daily every morning and evening before breakfast and dinner scheduled at 7:30am and 5:30pm. -The resident's FSBS was documented as being checked twice a day at 7:30am and 5:30pm from 07/01/26 - 07/03/26 (7:30am) and the resident was documented as out of the facility from 07/04/26 - 07/07/26. -There were 5 FSBS readings in Resident #8's Brand D glucometer history when the resident	D 610		

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D 610	Continued From page 193	D 610		

was documented as being out the facility from 07/04/26 - 07/06/26.
-The resident's FSBS was 209 on 07/02/26 and matched the FSBS reading in the resident's Brand D glucometer history.
-The other 4 FSBS checked from 7/01/26 - 07/03/26 did not match any FSBS readings in Resident #8's Brand D glucometer history.
-The resident FSBS ranged from 174 - 211 from 07/01/26 - 07/03/26.

Interview with the Resident Care Coordinator (RCC) on 07/07/26 at 1:37pm revealed:
-Resident #8 was currently out of the facility in a skilled nursing rehabilitation facility.
-There was no other glucometer available for Resident #8 so her FSBS readings should be in glucometer labeled with the resident's name.

Attempted telephone interview with Resident #8's primary care provider (PCP) on 07/14/26 at 10:18am was unsuccessful.

Refer to interview with the Special Care Coordinator (SCC) on 07/07/26 at 1:15pm.

Refer to interview with the Resident Care Coordinator (RCC) on 07/07/26 at 1:37pm.

Refer to interview with the Administrator on 07/07/26 at 1:52pm.

Refer to interview with the Regional Clinical Director (RCD) on 07/10/26 at 3:23pm.

5. Review of Resident #6's current FL-2 dated 01/28/26 revealed:
-Diagnoses included type 2 diabetes mellitus, dementia, chronic obstructive pulmonary disease, cognitive impairment due to anoxic impairment,

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D 610	Continued From page 194 protein calorie malnutrition, and bipolar disorder. -There was an order to check fingerstick blood sugar (FSBS) before meals and inject Novolog sliding scale insulin (SSI): 141 - 180 = 4 units; 181 - 220 = 8 units; 221 - 260 = 8 units; 261 - 300 = 10 units; 301 - 350 = 12 units; 351 - 400 = 16 units; if greater than (>) 400 = 20 units and call primary care provider (PCP). (Novolog is rapid-acting insulin used to lower blood sugar.) -There was a second order to check FSBS at bedtime and inject Novolog SSI: 141 - 180 = 2 units; 181 - 220 = 4 units; 221 - 260 = 4 units; 261 - 300 = 5 units; 301 - 350 = 6 units; 351 - 400 = 8 units; > 400 = 10 units and call PCP. Observation of Resident #6's medications on hand on 07/07/26 at 10:45am in the special care unit (SCU) revealed: -There was a Brand B glucometer lying in the top drawer of the medication cart. -The Brand B glucometer was labeled with Resident #6's first name written on a piece of tape at the bottom of the glucometer. Observation of Resident #6's Brand B glucometer history on 07/07/26 at 10:45am revealed: -The date and time did not display on the screen when the glucometer was turned on. -The date and time of the first blood sugar reading stored in the memory was 07/07/26 at 7:40am. -There were multiple days with multiple consecutive blood sugar readings taken within a few minutes of the next FSBS reading, indicating the glucometer was used for multiple residents in a row on those days. -There was a blood sugar reading of 192 on 07/07/26 at 7:40am. -There was a blood sugar reading of 449 on 07/07/26 at 7:12am.	D 610		

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D 610	Continued From page 195 -There was a blood sugar reading of 114 on 07/07/26 at 7:07am. -There was a blood sugar reading of 397 on 06/26/26 at 11:31am. -There was a blood sugar reading of 225 on 06/26/26 at 7:14am. -There was a blood sugar reading of 93 on 06/26/26 at 6:49am. -There was a blood sugar reading of 123 on 06/26/26 at 6:46am. -There was a blood sugar reading of 112 on 06/25/26 at 6:30pm. -There was a blood sugar reading of 212 on 06/25/26 at 4:54pm. -There was a blood sugar reading of 166 on 06/25/26 at 10:37am. -There was a blood sugar reading of 192 on 06/25/26 at 10:35am. -There was a blood sugar reading of 101 on 06/25/26 at 6:52am. -There was a blood sugar reading of 161 on 06/24/26 at 5:00pm. -There was a blood sugar reading of 251 on 06/24/26 at 4:55pm. -There was a blood sugar reading of 141 on 06/22/26 at 4:41pm. -There was a blood sugar reading of 262 on 06/22/26 at 10:43am. -There was a blood sugar reading of 138 on 06/22/26 at 7:08am. -There was a blood sugar reading of 158 on 06/22/26 at 6:56am. -There was a blood sugar reading of 199 on 06/21/26 at 6:57pm. -There was a blood sugar reading of 231 on 06/21/26 at 6:17pm. -There was a blood sugar reading of 152 on 06/21/26 at 4:23pm. -There was a blood sugar reading of 131 on 06/21/26 at 4:18pm.	D 610		

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D 610	Continued From page 196 -There was a blood sugar reading of 64 on 06/21/26 at 4:06pm. -There was a blood sugar reading of 187 on 06/21/26 at 11:21am. -There was a blood sugar reading of 519 on 06/21/26 at 10:35am. -There was a blood sugar reading of 340 on 06/21/26 at 10:29am. -There was a blood sugar reading of 297 on 06/20/26 at 6:10pm. -There was a blood sugar reading of 266 on 06/20/26 at 10:30am. -There was a blood sugar reading of 110 on 06/19/26 at 11:43am. -There was a blood sugar reading of 36 on 06/19/26 at 11:16am. -There was a blood sugar reading of 182 on 06/11/26 at 6:11pm. -There was a blood sugar reading of 287 on 06/10/26 at 11:17am. -There was a blood sugar reading of 176 on 06/10/26 at 10:55am. -There was a blood sugar reading of 239 on 06/10/26 at 7:03am. -There was a blood sugar reading of 178 on 06/09/26 at 10:38am. -There was a blood sugar reading of 208 on 06/09/26 at 10:28am. -There was a blood sugar reading of 213 on 06/06/26 at 6:21pm. -There was a blood sugar reading of 86 on 06/06/26 at 4:42pm. -There was a blood sugar reading of 268 on 06/06/26 at 11:28am. -There was a blood sugar reading of 149 on 06/05/26 at 7:57pm. -There was a blood sugar reading of 451 on 06/05/26 at 6:12pm. -There was a blood sugar reading of 66 on 06/04/26 at 8:22pm.	D 610		

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D 610	Continued From page 197 -There was a blood sugar reading of 170 on 06/03/26 at 10:26am. -There was a blood sugar reading of 260 on 06/03/26 at 10:06am. -There was a blood sugar reading of 210 on 06/03/26 at 6:35am. -There was a blood sugar reading of 401 on 06/03/26 at 6:19am. -There was a blood sugar reading of 124 on 06/03/26 at 6:12am. -There was a blood sugar reading of 126 on 06/02/26 at 11:13am. -There was a blood sugar reading of 135 on 06/01/26 at 4:45pm. -There was a blood sugar reading of 265 on 06/01/26 at 10:51am. -There was a blood sugar reading of 227 on 06/01/26 at 10:41am. -There was a blood sugar reading of 110 on 06/01/26 at 7:19am. -There was a blood sugar reading of 97 on 06/01/26 at 7:05am. -There was a blood sugar reading of 146 on 06/01/26 at 5:39am. Review of Resident #6's June 2026 electronic medication administration record (eMAR) revealed: -There was an order to check FSBS before meals and inject Novolog SSI: 141 - 180 = 4 units; 181 - 220 = 8 units; 221 - 260 = 8 units; 261 - 300 = 10 units; 301 - 350 = 12 units; 351 - 400 = 16 units; > 400 = 20 units and call PCP. -There was a second entry to check FSBS at bedtime and inject Novolog SSI: 141 - 180 = 2 units; 181 - 220 = 4 units; 221 - 260 = 4 units; 261 - 300 = 5 units; 301 - 350 = 6 units; 351 - 400 = 8 units; > 400 = 10 units and call PCP. -The resident's FSBS checks were scheduled at 7:30am, 11:30am, 5:30pm, and 8:00pm.	D 610		

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D 610	Continued From page 198 -There were 20 FSBS readings documented on the eMAR from 06/01/26 - 06/30/26 that matched FSBS readings in the history of Resident #6's Brand B glucometer. -Matches for 7:30am included: 110 on 06/01/26; 155 on 06/19/26; 138 on 06/22/26; and 93 on 06/26/26. -Matches for 11:30am included: 265 on 06/01/26; 126 on 06/02/26; 268 on 06/06/26; 178 on 06/09/26; 176 on 06/10/26; 110 on 06/19/26; 266 on 06/20/26; 262 on 06/22/26; 166 on 06/25/26; and 397 on 06/26/26. -Matches for 5:30pm included: 135 on 06/01/26; 64 on 06/21/26; and 161 on 06/24/26. -Matches for 8:00pm included: 297 on 06/20/26; 231 on 06/21/26; and 112 on 06/25/26. -There were 94 FSBS documented for Resident #6 on the June 2026 eMAR that were not in the resident's Brand B glucometer history. -The resident FSBS ranged from 47 - 397 from 06/01/26 - 06/30/26. Review of Resident #6's July 2026 eMAR dated 07/01/26 - 07/07/26 revealed: -There was an order to check FSBS before meals and inject Novolog SSI: 141 - 180 = 4 units; 181 - 220 = 8 units; 221 - 260 = 8 units; 261 - 300 = 10 units; 301 - 350 = 12 units; 351 - 400 = 16 units; > 400 = 20 units and call PCP. -There was a second entry to check FSBS at bedtime and inject Novolog SSI: 141 - 180 = 2 units; 181 - 220 = 4 units; 221 - 260 = 4 units; 261 - 300 = 5 units; 301 - 350 = 6 units; 351 - 400 = 8 units; > 400 = 10 units and call PCP. -The resident's FSBS checks were scheduled at 7:30am, 11:30am, 5:30pm, and 8:00pm. -The resident's FSBS was documented as being checked 4 times a day from 07/01/26 - 07/07/26 (7:30am). -The resident's FSBS was 114 on 07/07/26 at	D 610		

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D 610	Continued From page 199	D 610		

7:30am and matched the FSBS reading in Resident #6's Brand B glucometer history.
-The other 24 FSBS checked from 7/01/26 - 07/06/26 did not match any FSBS readings in Resident #6's Brand B glucometer history.
-The resident FSBS ranged from 65 - 311 from 07/01/26 - 07/07/26 (7:30am).

Interview with the medication aide (MA) on 07/07/26 at 10:51am revealed:
-Resident #6 had her own labeled glucometer.
-Some residents' glucometers were broken so they had to share glucometers.
-She thought it was okay to share glucometers because she cleaned the glucometers with alcohol wipes between each resident.

Interview with the Special Care Coordinator (SCC) on 07/07/26 at 1:15pm revealed:
-Resident #6 had her own glucometer.
-The MAs should only use Resident #6's glucometer to check Resident #6's FSBS.

Telephone interview with Resident #6's PCP on 07/07/26 at 4:25pm revealed:
-Glucometers should not be shared.
-Each resident should have their own glucometer for better hygiene and better safety and to prevent transmission of diseases.

Based on observations, interviews, and record review, it was determined that Resident #6 was not interviewable.

Refer to interview with the Special Care Coordinator (SCC) on 07/07/26 at 1:15pm.

Refer to interview with the Resident Care Coordinator (RCC) on 07/07/26 at 1:37pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL067025	A. BUILDING: _____ B. WING _____	R-C 07/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SWANSBORO	280 SWANSBORO LOOP ROAD SWANSBORO, NC 28584

(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 610	Continued From page 200 Refer to interview with the Administrator on 07/07/26 at 1:52pm. Refer to interview with the Regional Clinical Director (RCD) on 07/10/26 at 3:23pm. 6. Review of Resident #9's current FL-2 dated 04/15/26 revealed: -Diagnoses included type 2 diabetes mellitus with hyperglycemia, fronto-temporal dementia, acute metabolic encephalopathy, essential hypertension, hyperammonemia, acute hypernatremia, and urinary tract infection. -There was an order to check fingerstick blood sugar (FSBS) 3 times daily (before breakfast, lunch, and dinner) and inject Novolog sliding scale insulin (SSI): 250 - 300 = 5 units; 301 - 350 = 8 units; 351 - 400 = 12 units; 401 - 450 = 15 units; 451 - 500 = 17 units; call primary care provider (PCP) for FSBS greater than (>) 500; hold insulin for FSBS less than (<) 80 and call PCP. (Novolog is rapid-acting insulin used to lower blood sugar.) -There was an order to check FSBS before meals and at bedtime, hold insulin for FSBS < 80, call PCP for FSBS > 450. Observation of Resident #9's medications on hand on 07/07/26 at 10:42am in the special care unit (SCU) revealed: -There was a Brand B glucometer lying in the top drawer of the medication cart. -The Brand B glucometer was labeled with Resident #9's nickname written on a piece of tape at the bottom of the glucometer. Observation of Resident #9's Brand B glucometer history on 07/07/26 at 10:42am revealed: -The date and time did not display on the screen when the glucometer was turned on.	D 610		

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D 610	Continued From page 201 -The date and time of the first blood sugar reading stored in the memory was 06/26/26 at 10:58am. -There were multiple days with multiple consecutive blood sugar readings taken within a few minutes of the next FSBS reading, indicating the glucometer was used for multiple residents in a row on those days. -There was a blood sugar reading of 466 on 06/26/26 at 10:58am. -There was a blood sugar reading of 239 on 06/25/26 at 7:06pm. -There was a blood sugar reading of 193 on 06/25/26 at 4:58pm. -There was a blood sugar reading of 194 on 06/25/26 at 10:41am. -There was a blood sugar reading of 423 on 06/25/26 at 9:29am. -There was a blood sugar reading of "Hi" (greater than 600) on 06/25/26 at 8:22am. -There was a blood sugar reading of 600 on 06/25/26 at 5:09pm. -There was a blood sugar reading of 133 on 06/24/26 at 5:09pm. -There was a blood sugar reading of 332 on 06/22/26 at 11:09am. -There was a blood sugar reading of 195 on 06/22/26 at 6:46am. -There was a blood sugar reading of 252 on 06/21/26 at 7:41pm. -There was a blood sugar reading of 297 on 06/21/26 at 6:38am. -There was a blood sugar reading of 292 on 06/20/26 at 6:58pm. -There was a blood sugar reading of 171 on 06/20/26 at 4:47pm. -There was a blood sugar reading of 453 on 06/20/26 at 11:03am. -There was a blood sugar reading of 123 on 06/20/26 at 7:12am.	D 610		

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D 610	Continued From page 202 -There was a blood sugar reading of 519 on 06/19/26 at 11:27am. -There was a blood sugar reading of 348 on 06/11/26 at 9:42pm. -There was a blood sugar reading of 510 on 06/11/26 at 5:13pm. -There was a blood sugar reading of 135 on 06/11/26 at 7:13am. -There was a blood sugar reading of 127 on 06/11/26 at 7:00am. -There was a blood sugar reading of 362 on 06/10/26 at 9:30pm. -There was a blood sugar reading of 270 on 06/10/26 at 4:46pm. -There was a blood sugar reading of 332 on 06/10/26 at 4:42pm. -There was a blood sugar reading of 212 on 06/10/26 at 11:09am. -There was a blood sugar reading of 175 on 06/10/26 at 9:17am. -There was a blood sugar reading of 104 on 06/10/26 at 7:16am. -There was a blood sugar reading of 387 on 06/09/26 at 11:04am. -There was a blood sugar reading of 181 on 06/09/26 at 7:08am. -There was a blood sugar reading of 191 on 06/08/26 at 7:53pm. -There was a blood sugar reading of 266 on 06/08/26 at 4:59pm. -There was a blood sugar reading of 339 on 06/08/26 at 4:57pm. -There was a blood sugar reading of 260 on 06/08/26 at 4:55pm. -There was a blood sugar reading of 290 on 06/08/26 at 11:37am. -There was a blood sugar reading of 141 on 06/08/26 at 7:15am. -There was a blood sugar reading of 290 on 06/08/26 at 6:43am.	D 610		

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D 610	Continued From page 203 -There was a blood sugar reading of 378 on 06/07/26 at 9:24pm. -There was a blood sugar reading of 167 on 06/07/26 at 5:11am. -There was a blood sugar reading of 195 on 06/07/26 at 4:53pm. -There was a blood sugar reading of 138 on 06/07/26 at 4:46pm. -There was a blood sugar reading of 183 on 06/07/26 at 10:54am. -There was a blood sugar reading of 144 on 06/07/26 at 10:35am. Review of Resident #9's June 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Novolog SSI based on FSBS 3 times daily: 250 - 300 = 5 units; 301 - 350 = 8 units; 351 - 400 = 12 units; 401 - 450 = 15 units; 451 - 500 = 17 units; call primary care provider (PCP) for FSBS > 500; hold insulin for FSBS < 80 and call PCP. -The resident's FSBS checks for Novolog SSI were scheduled at 7:30am, 11:30am, and 5:30pm. -There was a second entry for the resident's FSBS to be checked at 8:30pm. -The resident's FSBS was documented as being checked 4 times a day from 06/01/26 - 06/30/26. -There were 18 FSBS readings documented on the eMAR from 06/01/26 - 06/30/26 that matched FSBS readings in the history of Resident #9's Brand B glucometer. -Matches for 7:30am included: 290 on 06/08/26; 181 on 06/09/26; 195 on 06/22/26; and 600 on 06/25/26. -Matches for 11:30am included: 290 on 06/08/26; 387 on 06/09/26; 212 on 06/10/26; 332 on 06/22/26; 194 on 06/25/26; and 466 on 06/26/26. -Matches for 5:30pm included: 260 on 06/08/26;	D 610		

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D 610	Continued From page 204 332 on 06/10/26; 171 on 06/20/26; 133 on 06/24/26; and 193 on 06/25/26. -Matches for 8:30pm included: 292 on 06/20/26; 252 on 06/21/26; and 239 on 06/25/26. -There were 96 FSBS documented for Resident #9 on the June 2026 eMAR that were not in the resident's Brand B glucometer history. -The resident's FSBS ranged from 86 - 600 from 06/01/26 - 06/30/26. Review of Resident #9's July 2026 eMAR dated 07/01/26 - 07/07/26 revealed: -There was an entry for Novolog SSI based on FSBS 3 times daily: 250 - 300 = 5 units; 301 - 350 = 8 units; 351 - 400 = 12 units; 401 - 450 = 15 units; 451 - 500 = 17 units; call PCP for FSBS > 500; hold insulin for FSBS < 80 and call PCP. -The resident's FSBS checks for Novolog SSI were scheduled at 7:30am, 11:30am, and 5:30pm. -There was a second entry for the resident's FSBS to be checked at 8:30pm. -The resident's FSBS was documented as being checked 4 times a day from 07/01/26 - 07/07/26 (7:30am). -There were 25 of 25 FSBS documented on the July eMAR and none of the FSBS readings were in Resident #9's Brand B glucometer history. -The resident FSBS ranged from 198 - 550 from 07/01/26 - 07/07/26 (7:30am). Interview with the medication aide (MA) on 07/07/26 at 10:51am revealed: -Resident #9 had her own labeled glucometer. -Some residents' glucometers were broken so they had to share glucometers. -She thought it was okay to share glucometers because she cleaned the glucometers with alcohol wipes between each resident.	D 610		

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D 610	Continued From page 205 Interview with the Special Care Coordinator (SCC) on 07/07/26 at 1:15pm revealed: -Resident #9 had her own glucometer. -The MAs should only use Resident #9's glucometer to check Resident #9's FSBS. Telephone interview with Resident #9's PCP on 07/07/26 at 4:25pm revealed: -Glucometers should not be shared. -Each resident should have their own glucometer for better hygiene and better safety and to prevent transmission of diseases. Based on observations, interviews, and record review, it was determined that Resident #6 was not interviewable. Refer to interview with the Special Care Coordinator (SCC) on 07/07/26 at 1:15pm. Refer to interview with the Resident Care Coordinator (RCC) on 07/07/26 at 1:37pm. Refer to interview with the Administrator on 07/07/26 at 1:52pm. Refer to interview with the Regional Clinical Director (RCD) on 07/10/26 at 3:23pm. _____ Interview with the Special Care Coordinator (SCC) on 07/07/26 at 1:15pm revealed: -Each resident was supposed to have their own glucometer. -The facility did not share glucometers to prevent cross-contamination and for insurance purposes. -If glucometers were shared it could cause transmission of diseases to the residents. -The medication aides (MAs) should contact the pharmacy to get a new glucometer if one was broken.	D 610		

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D 610	Continued From page 206 -He should be the first person notified by the MAs when a resident's glucometer was broken. -He was supposed to check glucometers when he did weekly cart audits, but he was new in this position and had not done that yet. Interview with the Resident Care Coordinator (RCC) on 07/07/26 at 1:37pm revealed: -When she started working as the RCC in February or March 2026, all diabetic residents had their own labeled glucometers. -The facility's policy was for all diabetic residents to have their own glucometer labeled with their names on the pouch and the glucometer. -If glucometers were shared, she would be concerned about cross-contamination or transmission of diseases. -They did not keep any new replacement glucometers at the facility. -If she was notified a resident did not have or had a broken glucometer, she would have contacted the primary care provider (PCP) and pharmacy to get a new one. -There was no system to check the glucometers. Interview with the Administrator on 07/07/26 at 1:52pm revealed: -Each diabetic resident had their own glucometer. -In the event a glucometer had to be shared, the MAs should clean the glucometer between each resident with alcohol swabs. -She was not sure what the facility's policy was for sharing glucometers, but she thought it was okay as long as they cleaned the glucometer but that may have been information when she worked in a skilled nursing facility in the past. -She was not aware of Centers for Disease Control (CDC) guidelines that glucometers should not be shared and were for single patient use only.	D 610		

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D 610	Continued From page 207 -There were concerns with sharing glucometers including transmitting diseases, contamination, and not knowing which resident's FSBS reading was in the glucometer history. -The MAs should notify her, the RCC or the SCC if a resident's glucometer was not working. -She was not aware of a system to check the glucometers. Interview with the Regional Clinical Director (RCD) on 07/10/26 at 3:23pm revealed: -Each resident should have their own glucometer and should be labeled with the resident's name on the storage pouch and on the glucometer. -Each resident's glucometer should only be used for that resident. -If a resident's glucometer was broken, the MAs should notify the RCC or SCC and get a new one. -If needed the facility could purchase a glucometer from a local retail store until a new one arrived for a resident. -Sharing glucometers caused concerns for infection control. -If not cleaned properly, a shared glucometer could cause cross-contamination and could cause transmission of an infectious disease. The facility failed to implement infection control procedures for glucometers used to obtain finger stick blood sugar (FSBS) readings for 6 of 7 sampled residents (#4, #6, #7, #8, #9, #21) with orders for FSBS monitoring. The medication aides (MAs) shared glucometers between residents, putting the residents at risk of cross-contamination which could result in transmission of bloodborne pathogens. The failure of the facility put the residents at substantial risk for serious physical harm and constitutes a Type A2 Violation.	D 610		

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D 610	Continued From page 208 The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/07/26 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 14, 2026.	D 610		