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	HAL032109	A. BUILDING: _____ B. WING _____	R 09/03/2026

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THE PEARL AT SOUTH POINT	1002 EAST HIGHWAY 54 DURHAM, NC 27713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up and annual survey on 09/02/26-09/03/26.	D 000		
D 254	10A NCAC 13F .0801 (c) Resident Assessment 10A NCAC 13F .0801 Resident Assessment (c) When a facility identifies a change in a resident's baseline condition based upon the factors listed in Parts (1)(A) through (M) of this Paragraph, the facility shall monitor the resident's condition for no more than 10 days to determine if a significant change in the resident's condition has occurred. The facility shall conduct an assessment of a resident within three days after the facility identifies that a significant change in the resident's baseline condition has occurred. The facility shall use the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows: (1) Significant change is one or more of the following: (A) deterioration in two or more activities of daily living including bathing, dressing, personal hygiene, toileting, or eating; (B) change in ability to walk or transfer, including falls if the resident experiences repeated falls, meaning more than one, on the same day, or multiple falls that occur over several days to weeks, new onset of falls not attributed to an identifiable cause, a fall with consequent change in neurological status, or physical injury; (C) pain worsening in severity, intensity, or duration, occurring in a new location, or new onset of pain associated with trauma; (D) change in the pattern of usual behavior, new	D 254		

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D 254	Continued From page 1	D 254		

onset of resistance to care, abrupt onset or progression of agitation or combative behavior, deterioration in affect or mood, or violent or destructive behaviors directed at self or others;
(E) no response by the resident to the intervention for an identified problem;
(F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period;
(G) when a resident has been enrolled in hospice;
(H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crater, or any pressure ulcer determined to be greater than Stage II;
(I) a new diagnosis of a condition which affects the resident's physical, mental, or psychosocial well-being;
(J) improved behavior, mood or functional health status to the extent that the established plan of care no longer meets the resident's needs;
(K) new onset of impaired decision-making;
(L) continence to incontinence or indwelling catheter; or
(M) the resident's condition indicates there may be a need to use a restraint in accordance with Rule .1501 of this Subchapter and there is no current restraint order for the resident.
(2) Significant change does not include the following:
(A) changes that resolve with or without intervention;
(B) an acute illness or episodic event. For the purposes of this Rule "acute illness" means symptoms or a condition that develops quickly and is not a part of the resident's baseline physical health or mental health status;

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D 254	Continued From page 2 (C) an established, predictable cyclical pattern; or (D) steady improvement under the current course of care.	D 254		

This Rule is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to ensure an assessment and care plan was updated within 3 days of identifying a significant change in condition for 1 of 4 sampled residents (#3).

The findings are:

Review of Resident #3's current FL2 dated 03/24/26 revealed:
-Diagnoses included diabetes, ketoacidosis, dementia, and hypertension.
-He was ambulatory.
-He had a history of wandering.
-He was constantly disoriented.

Review of Resident #3's current care plan dated 04/14/26 revealed:
-Resident #3 was independent with ambulation and transfers.
-He needed supervision from staff with eating.
-He needed limited assistance from staff with toileting and dressing.
-He needed extensive assistance from staff with

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D 254	Continued From page 3 bathing. Review of Resident's #3's record revealed: -He had 4 falls from 07/17/26-08/27/26. -He had a closed fracture of the nasal bone from a fall on 07/17/26. -He had the need for physical therapy (PT) and occupational therapy (OT). -He had physician orders to wear nonskid socks when up walking. Observation of Resident #3 on 09/02/26 and 09/03/26 at various times revealed: -He used a rollator walker to ambulate. -He ambulated with the assistance of the personal care aides (PCA). -He ambulated with rapid and shuffling steps. Interview with a PCA on 09/03/26 at 9:12am revealed: -Resident #3 needed to be reminded to use his rollator. -He required monitoring to prevent falls. -He walked down the hall with handheld assistance. Interview with a medication aide (MA) on 09/03/26 at 2:45pm revealed: -Resident #3 needed to be monitored to prevent falls. -He was encouraged to stay in the common room so he could be monitored closely. Interview with Resident #3's occupational therapist on 09/03/26 at 12:26pm revealed: -Resident #3 was working with OT to improve strength, functional mobility, and enhance quality of life. -He had generalized muscle weakness. -He had a lack of coordination.	D 254		

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D 254	Continued From page 4 -He required moderate assistance from staff for lower body dressing due to fatigue and poor safety awareness. -His blood pressure (BP) dropped to 97/61 from 117/78 with functional activity. -It took 5 minutes for his systolic BP to return greater than 100. Interview with the Health and Wellness Director (HWD) on 09/03/26 at 5:15pm revealed: -She was aware that the care plan needed to be updated with significant changes in condition. -She was not aware of the timeframe to update the care plan. -She had requested PT obtain a wheelchair for safety purposes for Resident #3. -She had communicated in daily huddle meetings with the staff that Resident #3 needed to be monitored during ambulation because of recent falls. Interview with the Administrator on 09/03/26 at 6:00pm revealed: -The HWD was responsible for updating the care plans. -She was aware that there had been significant changes with Resident #3 and the frequency of his falls. -She was aware of the timeframe required for updating the care plan. Attempted telephone interview with Resident 3's primary care provider (PCP) on 09/03/26 at 3:00pm was unsuccessful.	D 254		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up	D 273		

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D 273	Continued From page 5 to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up to meet the acute health care needs of 1 of 3 sampled residents (#1) related to failure to notify the primary care provider (PCP) of finger stick blood sugars (FSBS) outside of the parameters (#1). The findings are: Review of Resident #1's current FL2 dated 02/27/26 revealed: -Diagnoses that included type 1 diabetes mellitus (DM) and dementia. -There was an order to notify the PCP if the FSBS was greater than 450. Review of Resident #1's physician's order dated 06/27/26 revealed an order to check the FSBS twice a day with lunch and dinner and notify the PCP if the FSBS was less than 50 or greater than 400. Review of Resident #1's physician's order dated 07/24/26 revealed an order to discontinue Lantus 13 units and start Lantus 14 units; there were no FSBS parameters. Review of Resident #1's July 2026 electronic medication administration record (eMAR) revealed: -There was an entry to inject 13 units of Lantus (used to control FSBS) twice a day with lunch and dinner and call the PCP if the FSBS was less than 50 or greater than 400. -Documented FSBS values ranged from 82-600.	D 273		

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-At 12:00pm, examples of Resident #1's FSBS documented included 456, 489, 567, 535, 582, and 599; on 12 out of 23 days, the FSBS was greater than 400.
-At 5:00pm, examples of Resident #1's FSBS documented included 425, 433, 512, 589, 566, 578, and 567; on 12 out of 23 days, the FSBS was greater than 400.
-There was no documentation that the PCP had been notified of the FSBS greater than 400.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/03/26 at 10:15am revealed long-term uncontrolled FSBS increased the risk of overall health issues, including heart disease, kidney disease, loss of limbs, and other organ failures.

Telephone interview with Resident #1's hospice nurse on 09/03/26 at 1:48pm revealed:
-Resident #1 had type 1 DM, and the management of her diabetes was ongoing.
-The hospice team did not have anything to do with Resident #1's insulin; it was managed by her PCP.
-Resident #1 was in hospice primarily due to her progressive dementia.
-Resident #1's family member reported the resident had "crippling" diabetes.

Interview with a medication aide (MA) on 09/03/26 at 2:16pm revealed:
-Resident #1's FSBS had been greater than 400 before, but she did not call the PCP.
-Resident #1's order to call the PCP for a FSBS greater than 400 was not an order that "popped up," so she had not called the PCP.

Interview with the Resident Care Coordinator (RCC) on 09/03/26 at 2:45pm revealed:

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D 273	Continued From page 7 -If Resident #1's FSBS was greater than 400, the MA should contact the PCP. -She had tried to contact the PCP through the facility's computer program, and the PCP did not respond, so the Health and Wellness Director (HWD) called the PCP for her, and she was advised to give the resident additional insulin. -The HWD audited residents' records to ensure the PCP was notified when a reading was outside the parameter. Interview with the Health and Wellness Director (HWD) on 09/03/26 at 3:12pm revealed: -She had noticed there were no parameters for Resident #1's FSBS readings, and she requested an order for parameters. -The PCP then discontinued the order because the resident was on hospice services and hospice monitored her care. -Elevated FSBS had a lot of risks, including ketoacidosis. -She did not know hospice was not monitoring Resident #1's FSBS. -She expected staff to have notified the PCP when the resident's FSBS was outside the ordered parameter when the order was active. Interview with the Administrator on 09/03/26 at 4:09pm revealed: -She expected the MAs to follow the order as written and call the PCP if the FSBS were outside the ordered parameter. -A high FSBS reading put the resident at risk of hyperglycemia. -There were a lot of health risks associated with uncontrolled diabetes. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable.	D 273		

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D 273	Continued From page 8 Attempted telephone interview with a second MA on 09/03/26 at 4:31pm was unsuccessful. Attempted telephone interview with a third MA on 09/03/26 at 4:32pm was unsuccessful. Attempted telephone interview with Resident #1's PCP on 09/03/26 at 10:06am and 5:26pm was unsuccessful.	D 273		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions set forth in 15A NCAC 18A .1300 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the kitchen was clean and free of contamination related to blood on the floor of the walk-in cooler, unlabeled food items, expired food items, and proteins stored above fresh vegetables. The findings are: Review of the environmental inspection report from the local county health department dated	D 283		

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D 283	Continued From page 9 11/19/24 revealed: -The facility received 4 demerits. -There was 1 repeat violation. -Ready-to-eat, time/temperature control for safety (TCS) food prepared and held in a food establishment, as well as ready-to-eat, time/temperature control for safety (TCS) food prepared and packaged by a food processing plant that had been opened and held for more than 24 hours, shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded. When held at a temperature of 41°F or less, the food may be kept for a maximum of 7 days and may not exceed the manufacturer's use-by date. -Observed mashed potatoes stored in the walk-in cooler date marked 070/7/26. -Observed turkey meat stored in the walk-in cooler date marked 07/20/26. The mashed potatoes and turkey meat were held beyond the required seven-day disposition date. -Observed opened buttermilk and almond milk stored in the walk-in cooler that were not date marked. -This was a repeat violation from 11/15/25 and 03/03/26. Review of the cleaning schedule dated 08/31/26-09/06/26 revealed: -There was a list of items with frequency and by whom, with the initial column labeled for each day of the week (7 columns). -There were initials under the column for Monday for blender/food processor, condiment/silverware, hand sink paper towels/soap, and knife rack. -There were no initials for walk-in sweep/mop or refrigerator freezer. -There was a weekly section, and there was no documentation that weekly cleaning had been completed for the refrigerator clean/organize.	D 283		

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D 283	Continued From page 10 Observation of the kitchen on 09/02/26 at 3:45pm revealed: -There was a container labeled as yogurt dated 08/24/26. -There was a second container with a white creamy substance that was not labeled or dated. -There was a third container with a reddish/brown creamy substance that was dated 08/28/26; it was not labeled as to the contents. -There were a carton of eggs and a protein shake sitting on the wire shelf directly above an opened bin of green peppers. -There was a manufacturer's container of sliced strawberries with a date of 08/15/26 written on the top. -There was a container of whipped topping that was not dated when opened. -There was a red liquid on the floor of the walk-in cooler. -There was a box of chicken; the bottom of the box was wet. Observation of the kitchen on 09/03/26 at 11:05am revealed: -The container labeled as yogurt dated 08/24/26 remained on the shelf. -The container with a white creamy substance that was not labeled or dated remained on the shelf. -The carton of eggs and a protein shake sitting on the wire shelf directly above an opened bin of green peppers remained on the shelf. -The container of whipped topping that was not dated when opened remained on the shelf. -The red liquid on the floor of the walk-in cooler had not been cleaned up. -The box of chicken, with the bottom of the box wet, remained on the shelf.	D 283		

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Interview with a cook on 09/03/26 at 11:05am revealed:
-The container with a creamy white substance was condensed milk.
-He had not noticed the red substance on the floor.
-The red substance on the floor was coming from the box of chicken.
-He knew items should be labeled and dated.
-All dietary staff were responsible for labeling food items.
-Food should be discarded within 7 days of being opened.
-The walk-in cooler was supposed to be cleaned twice weekly.
-He had not had time to clean the walk-in cooler that week.
-He had not noticed there were storage containers that were not dated and labeled and some that needed to be discarded.
-He knew proteins were not supposed to be stored over raw vegetables but had not noticed the items on the shelf above the green peppers.
-The Dietary Manager (DM) was not available.

Interview with the Administrator on 09/03/26 at 12:16pm revealed:
-She expected the dietary staff to label and date any food item placed in the walk-in cooler.
-She did not know there were food items in the walk-in cooler that were not labeled or dated.
-She expected spills in the walk-in cooler to be cleaned up immediately.

Attempted telephone interview with the Environmental Health Specialist at the local health department on 09/03/26 at 9:06am was unsuccessful.

Attempted interview with the DM on 09/03/26 at

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D 283	Continued From page 12 12:20pm was unsuccessful.	D 283		
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes: (1) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure mealtime table service included a non-disposable place setting when glasses were not provided for the residents' milk. The findings are: Review of the facility's current license, effective 01/01/26, revealed the facility was licensed for 51 Special Care Unit (SCU) beds. Review of the facility's census on 09/02/26 revealed 25 residents. Observations of the breakfast meal service on 09/02/26 from 8:56am-10:06am revealed:	D 286		

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D 286	Continued From page 13 -There were half-pint unopened cartons of 2% milk at all the place settings; there were no glasses to pour the milk into. -One resident attempted to open her carton of milk from 8:52am-9:00am. -A second resident could not open his carton of milk to drink from it, and a personal care aide (PCA) opened the entire top of the carton. -A resident asked a PCA to open her milk, and the PCA did so. -There were 6 cartons of milk that were not opened during the meal service. Observations of the lunch meal service on 09/02/26 from 12:09-12:46pm revealed there were unopened half-pint cartons of 2% milk at all the place settings; there were no glasses to pour the milk into. Observations of the breakfast meal service on 09/03/26 at 8:38am revealed there were unopened half-pint cartons of 2% milk at all the place settings; there were no glasses to pour the milk into. Observations of the lunch meal on 09/03/26 from 12:00pm-12:06pm revealed: -There were unopened half-pint cartons of 2% milk at all place settings; there were no glasses to pour the milk into. -One resident attempted for 2 minutes to open his carton of milk and was unsuccessful; he used his knife to jab a hole in the carton. Interview with a cook on 09/03/26 at 11:05am revealed: -Milk cartons were placed on the tray for each meal for the residents. -He did not know the residents could not be served milk in the carton.	D 286		

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D 286	Continued From page 14 Interview with a dietary aide on 09/03/26 at 12:48pm revealed milk was always served to the residents in cartons. Interview with the Resident Care Coordinator (RCC) on 09/03/26 at 2:45pm revealed the residents were served milk in cartons; it had been that way for at least four months. Interview with the Health and Wellness Director (HWD) on 09/03/26 at 3:12pm revealed: -Milk had been served in cartons for a while. -Milk used to be poured into glasses, but there was a lot of wasted milk. Interview with the Administrator on 09/03/26 at 12:48pm revealed: -Each resident was given a carton of milk with each meal. -The facility had been serving milk in glasses up until 3-4 weeks ago when the facility's food ordering system was changed.	D 286		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff.	D 296		

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D 296	Continued From page 15 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to have matching therapeutic diet menus for food service staff guidance for 1 of 3 sampled residents (#1) who had a physician's order for a consistent carbohydrate (CCHO) diet. The findings are: Review of Resident #1's current FL2 dated 02/27/26 revealed: -Diagnoses that included type 1 diabetes mellitus (DM) and dementia. -Resident #1 resided in the Special Care Unit (SCU). -There was an order for a CCHO diet. Review of Resident #1's diet order dated 03/26/26 revealed Resident #1 was ordered a CCHO diet. Review of the facility's therapeutic diet menus for 09/02/26-09/03/26 revealed there was no CCHO diet on the therapeutic menu. Observation of the breakfast meal on 09/02/26 from 8:38am-9:30am revealed: -Resident #1 was served scrambled eggs, a sausage link, a biscuit, and jelly. -She ate 100 percent of her meal. Observation of the lunch meal on 09/02/26 from 12:15pm-12:52pm revealed: -Resident #1 was served fried chicken, green beans, creamed potatoes, fruit punch, 2% milk, water, and pudding. -She ate 100% of her pudding and drank her fruit juice.	D 296		

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D 296	Continued From page 16 -She ate 25% of her chicken, 75% of her creamed potatoes, and 50% of her green beans. Observation of the breakfast meal on 09/03/26 from 8:21am-9:26am revealed: -Resident #1 was served a sausage link, a bowl of oatmeal, a fourth of a waffle with regular syrup, orange juice, 2% milk, and water. -She ate 100 percent of her meal. Interview with a cook on 09/03/26 at 12:35pm revealed: -He did not have a menu for a CCHO diet. -For the diabetics, he used sugar-free items. -Sugar-free pudding was used for the banana pudding. -They usually had sugar-free syrup to give the residents. Interview with a dietary aide on 09/03/26 at 12:41pm revealed there was no sugar-free syrup to provide to the residents today, 09/03/26. Interview with the Resident Care Coordinator (RCC) on 09/03/26 at 2:45pm revealed: -She knew Resident #1 was on a CCHO diet. -Diet orders were given to the dietary staff for guidance on meal preparation. Interview with the Health and Wellness Director on 09/03/26 at 3:12pm revealed the order she had on file for Resident #1 was a CCHO diet. Interview with the Administrator on 09/03/26 at 12:48pm revealed the Dietary Manager was out of the facility, and she could not locate a CCHO diet menu.	D 296		

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D 310	Continued From page 17	D 310		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure that therapeutic diets were served as ordered for 1 of 3 sampled residents (#1), who had an order for chopped meats. The findings are: Review of Resident #1's current FL2 dated 02/27/26 revealed: -Diagnoses that included type 1 diabetes mellitus (DM) and dementia. -Resident #1 resided in the Special Care Unit (SCU). -There was an order for a CCHO diet. Review of Resident #1's diet order dated 03/26/26 revealed Resident #1 was ordered a CCHO diet. Review of Resident #1's primary care provider's (PCP) order dated 07/24/26 revealed an order for chopped meats. Review of the facility's therapeutic diet menu for 09/02/26-09/03/26 revealed there was no menu specifically for chopped meats.	D 310		

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D 310	Continued From page 18 Observation of the breakfast meal on 09/02/26 from 8:38am-9:30am revealed: -Resident #1 was served scrambled eggs, a sausage link, a biscuit, and jelly. -She ate 100 percent of her meal. Observation of the lunch meal on 09/02/26 from 12:15pm-12:52pm revealed: -Resident #1 was served fried chicken, green beans, creamed potatoes, fruit punch, 2% milk, water, and pudding. -She ate 100% of her pudding and drank her fruit juice. -She ate 25% of her chicken, 75% of her creamed potatoes, and 50% of her green beans. Observation of the breakfast meal on 09/03/26 from 8:21am-9:26am revealed: -Resident #1 was served a sausage link, a bowl of oatmeal, a fourth of a waffle with regular syrup, orange juice, 2% milk, and water. -She ate 100 percent of her meal. Interview with a cook on 09/03/26 at 12:35pm revealed Resident #1 did not have an order for chopped meats. Interview with the Resident Care Coordinator (RCC) on 09/03/26 at 2:45pm revealed: -She knew Resident #1 was on a CCHO diet. -Diet orders were given to the dietary staff for guidance on meal preparation. -She did not know the consistency of Resident #1's diet. -She was not aware of Resident #1 having any problems with chewing. Interview with the Health and Wellness Director on 09/03/26 at 3:12pm revealed:	D 310		

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D 310	Continued From page 19 -Resident #1 ate well. -She did not know why Resident #1 had an order for chopped meats. -Resident #1 did not have dentures, but she had not seen her have any problems with eating. -She processed the PCP's order dated 07/24/26, but she was not sure what happened that resulted in the dietary department not having the order in place. Interview with the Administrator on 09/03/26 at 4:09pm revealed if Resident #1 had an order for chopped meat, she expected the order to be followed. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable. Attempted telephone interview with Resident #1's family member on 09/03/26 at 10:00am was unsuccessful. Attempted telephone interview with Resident #1's PCP on 09/03/26 at 10:06am and 5:26pm was unsuccessful.	D 310		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.	D 358		

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D 358	Continued From page 20 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 6 residents (#4) observed during the morning medication pass, and 1 of 5 sampled residents (#1) for medication used to treat diabetes. The findings are: 1. Review of Resident #1's current FL2 dated 02/27/26 revealed: -Diagnoses included type 1 diabetes mellitus (DM) and dementia. -Level of care was special care unit (SCU). Review of Resident #1's physician's order dated 02/27/26 revealed: -There was an order for Novolog (a fast acting insulin used to treat high blood pressure) 100 unit/mL FlexPen, inject 7 units with each meal with sliding scale insulin (SSI) correction. -There was an order for Novolog 100 unit/mL FlexPen, per SSI, inject subcutaneously (SQ) three times daily and at bedtime as directed, with the following sliding scale: less than 150, give no additional insulin; 151-200 = 1 unit; 201-250 = 2 units; 251-300 = 3 units; 301-350 = 5 units; 351-400 = 6 units; greater than 400 = 7 units. Review of Resident #1's record revealed an admission date of 02/27/26. Review of Resident #1's hospital discharge summary dated 02/27/26 revealed: -Resident #1 was admitted to the hospital from another SCU on 02/01/26 with diabetic	D 358		

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ketoacidosis (DKA) and altered mental status.
-Her hemoglobin A1C (HbA1c) was 12.7. (The HbA1c determines the average level of blood sugar over the past 2 to 3 months. According to the American Diabetes Association, a HbA1c value less than 7.0 is a goal for diabetic residents, with the normal range for HbA1c being 4 to 5.9 for someone who is not diabetic.)

Review of Resident #1's hospital discharge summary dated 06/01/26 revealed:
-Resident #1 was seen secondary to altered mental status and hyperglycemia (high blood sugar).
-She was diagnosed with DKA.
-Her HbA1c was 12.%.

Review of Resident #1's laboratory report dated 06/15/26 revealed she had a HbA1c of 11.9%.

Review of Resident #1's physician's order dated 06/29/26 revealed:
-There was an order for Novolog 100 unit/mL FlexPen, inject 11 units with breakfast and 13 units with lunch and dinner with SSI correction.
-There was no documentation that the SSI coverage changed.

Review of Resident #1's electronic progress notes dated 07/12/26 revealed:
-Resident #1 was very weak, unable to walk without assistance, and was slurring her speech.
-Emergency Medical Services (EMS) were called, and Resident #1 was transported to the hospital.

Review of Resident #1's EMS report dated 07/12/26 revealed:
-EMS was dispatched to the facility at 8:02am for an unconscious resident.
-The primary impression was generalized

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weakness.
-The secondary impression was diabetic hyperglycemia.
-Her vital signs included a blood pressure of 100/50, a pulse of 80, and a finger-stick blood sugar (FSBS) of 311.
-She could not walk without assistance and was transferred to a stretcher for transport to the hospital.

Review of Resident #1's hospital discharge summary dated 07/12/26 revealed she was seen for weakness, abnormal gait, and hyperglycemia.

Review of Resident #1's physician's order dated 07/24/26 revealed an order for Novolog 100 unit/mL FlexPen, inject 15 units SQ with breakfast and 14 units SQ with lunch and dinner with SSI correction.

Review of Resident #1's primary care provider (PCP) after-visit summary dated 08/21/26 revealed:
-Resident #1 had a history of type 1 DM complicated by previous episodes of DKA.
-She had stage 2 mild kidney disease.
-She had a history of various circulatory diseases, including atherosclerosis and cerebrovascular disease (CVA).

Review of Resident #1's July 2026 electronic medication administration record (eMAR) from revealed:
-There was an entry for Novolog 100 unit/ml FlexPen, per inject SSI SQ three times daily and at bedtime as directed per SSI: less than 150, give no additional insulin; 151-200 = 1 unit; 201-250 = 2 units; 251-300 = 3 units; 301-350 = 5 units; 351-400 = 6 units; greater than 400 = 7 units.

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D 358	Continued From page 23 -There was documentation that Resident #1's FSBS was checked at 8:00am, 12:00pm, 5:00pm and 8:00pm. -Documented FSBS values ranged from 82-600. -There were 5 opportunities when Novolog should have been held for FSBS values less than 150; however, 1 unit of Novolog was documented as administered. Examples included: -At 8:00am on 07/20/26, the FSBS was documented as 127; however, 1 unit of Novolog was documented as administered. -At 8:00am on 07/25/26, the FSBS was documented as 128; however, 1 unit of Novolog was documented as administered. -At 8:00am on 07/26/26, the FSBS was documented as 125; however, 1 unit of Novolog was documented as administered. -At 5:00pm on 07/28/26, the FSBS was documented as 120; however, 1 unit of Novolog was documented as administered. -There were 8 opportunities when the amount of Novolog administered did not correspond with the ordered SSI. Examples included: -At 8:00am on 07/07/26, the FSBS was documented as 213 and 3 units of Novolog were documented as administered; however, the SSI indicated that 2 units should have been administered. -At 5:00pm on 07/18/26, the FSBS was documented as 368 and 5 units of Novolog were documented as administered and 6 units should have been administered. -At 8:00pm on 07/18/26, Resident #1's FSBS remained high with a reading of 370 requiring 6 units of Novolog. -At 12:00pm on 07/25/26, the FSBS was documented as 390 and 5 units of Novolog were documented as administered; however, the SSI indicated that 6 units should have been administered.	D 358		

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D 358	Continued From page 24 -At 8:00am on 07/27/26, the FSBS was documented as 302 and 3 units of Novolog were documented as administered; however, the SSI indicated that 5 units should have been administered. Review of Resident #1's August 2026 eMAR revealed: -There was an entry for Novolog 100 unit/ml FlexPen, per SSI inject SQ three times daily at bedtime as directed per SSI: less than 150, give no additional insulin; 151-200 = 1 unit; 201-250 = 2 units; 251-300 = 3 units; 301-350 = 5 units; 351-400 = 6 units; greater than 400 = 7 units. -There was documentation that Resident #1's FSBS was checked at 8:00am, 12:00pm, 5:00pm and 8:00pm. -Documented FSBS values ranged from 59-588. -There were 3 opportunities when Novolog should have been held for FSBS values less than 150; however, 1 unit of Novolog was documented as administered. Examples included: -At 8:00am on 08/03/26, the FSBS was documented as 59; however, 1 unit of Novolog was documented as administered. -At 8:00am on 08/13/26, the FSBS was documented as 143; however, 1 unit of Novolog was documented as administered. -At 5:00pm on 08/13/26, the FSBS was documented as 141; however, 1 unit of Novolog was documented as administered. -There were 21 opportunities when the amount of Novolog administered did not correspond with the ordered sliding scale. Examples included: -At 8:00am on 08/12/26, the FSBS was documented as 233 and 3 units of Novolog were documented as administered; however, the SSI indicated that 2 units should have been administered. -At 5:00pm on 08/16/26, the FSBS was	D 358		

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documented as 380 and 4 units of Novolog were documented as administered; however, the SSI indicated that 5 units should have been administered.
-At 8:00am on 08/23/26, the FSBS was documented as 234 and 3 units of Novolog were documented as administered; however, the SSI indicated that 2 units should have been administered.
-At 12:00pm on 08/26/26, the FSBS was documented as 302 and 3 units of Novolog were documented as administered; however, the SSI indicated that 5 units should have been administered.

Observation of Resident #1's medications on hand on 09/02/26 at 4:13pm revealed:
-There was one Novolog FlexPen dispensed on 08/12/26 and opened on 08/20/36 with the SSI directions.
-There was a second Novolog FlexPen dispensed on 08/31/26 with the SSI directions; it had not been opened.
-There was no Novolog FlexPen labeled for the scheduled administration of insulin.

Telephone interview with a representative from the facility's contracted pharmacy on 09/03/26 at 5:47pm revealed:
-The pharmacy dispensed Novolog FlexPens for the scheduled dosage and Novolog FlexPens for the SSI dosage.
-There was an order dated 06/29/26 for Novolog FlexPen administer SQ 11 units of Novolog with breakfast and 13 units with lunch and dinner.
-On 06/29/26, three Novolog FlexPens were dispensed, and each pen contained 300 units of insulin.
-Based on Resident #1's scheduled Novolog order dated 06/29/26, which included priming the

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pen before each injection with 2 units, Resident #1 would require 43 units per day, and one pen would last approximately 7 days.
-The three pens of Novolog dispensed on 06/29/26 would last approximately 21 days.
-Resident #1's order dated 07/24/26 revealed an order for 15 units of Novolog with breakfast and 14 units with lunch and dinner.
-On 07/24/26, five Novolog FlexPens were dispensed; each pen contained 300 units of insulin.
-Based on Resident #1's current scheduled Novolog order, which included priming the pen before each injection with 2 units, Resident #1 would require 49 total units per day, and one pen would last approximately 6 days.
-The 5 pens of Novolog dispensed on 07/24/26 would last approximately 30 days.
-No other pens of Novolog had been dispensed for the scheduled administration.
-One pen of Novolog had been dispensed on the following dates for the SSI order: 06/28/26, 07/21/26, 08/12/26, and 08/31/26; each pen contained 300 units of insulin.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/03/26 at 10:15am revealed:
-Novolog was a fast-acting insulin used to treat diabetes.
-If Novolog was administered to Resident #1 when her FSBS was less than 150 per SSI, it could cause her FSBS to lower further, causing hypoglycemia (low blood sugar).
-Hypoglycemia increased the resident's risk of dizziness, sweating, and falls.
-The goal of SSI was to lower elevated FSBS because uncontrolled FSBS would not be good for the resident.
-If Resident #1's FSBS was elevated and the

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THE PEARL AT SOUTH POINT	1002 EAST HIGHWAY 54 DURHAM, NC 27713

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resident was not administered enough Novolog, her FSBS would remain elevated.
-Resident #1 was a type 1 diabetic and her body did not make insulin; therefore, administering insulin correctly was essential.
-Long-term uncontrolled FSBS increased the risk of overall health issues, including heart disease, kidney disease, losing limbs, and other organ failures.

Telephone interview with Resident #1's hospice nurse on 09/03/26 at 1:48pm revealed:
-Resident #1 had type 1 DM, and the management of her diabetes was ongoing.
-The hospice team did not have anything to do with Resident #1's insulin; it was managed by her PCP.
-Resident #1 was in hospice primarily due to her progressive dementia.
-Resident #1's family member reported the resident had "crippling" diabetes.

Interview with a medication aide (MA) on 09/03/26 at 2:16pm revealed:
-She administered Resident #1's Novolog for the scheduled amount before meals.
-She would then administer the Novolog based on the SSI.
-She administered the amount based on the SSI and, if she had documented that she gave a different amount, she had typed in the wrong number.

Interview with the Resident Care Coordinator (RCC) on 09/03/26 at 6:00pm revealed:
-The only Novolog pens on hand were labeled for the SSI.
-One pen was on the medication cart and the second pen was in the refrigerator.
-Both the scheduled and the SSI was

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D 358	Continued From page 28 administered from the same pen. Interview with the Health and Wellness Director (HWD) on 09/03/26 at 3:12pm revealed she expected the MAs to follow the SSI order and administer the correct amount of insulin based on the FSBS readings. Interview with the Administrator on 09/03/26 at 4:09pm revealed she expected the MAs to follow the SSI insulin order as written. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable. Attempted telephone interview with Resident #1's family member on 09/03/26 at 10:00am was unsuccessful. Attempted telephone interview with a second MA on 09/03/26 at 4:31pm was unsuccessful. Attempted telephone interview with a third MA on 09/03/26 at 4:32pm was unsuccessful. Attempted telephone interview with Resident #1's PCP on 09/03/26 at 10:06am and 5:26pm was unsuccessful. 2. The medication error rate was 11% as evidenced by the observation of 3 errors out of 26 opportunities during the morning medication pass on 09/03/26. Review of Resident #4's current FL2 dated 07/30/26 revealed: -Diagnoses included dementia. -He was intermittently disoriented.	D 358		

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Review of Resident #4's physician orders revealed:
-There was an order for aspirin 81mg (used to prevent blood clots) daily.
-There was an order for metoprolol 25mg (used to manage blood pressure) twice daily.
-There was an order for sertraline 50mg (used to treat depression) 1 tablet daily.

Observation of the morning medication pass on 09/03/26 at 9:20am revealed:
-The medication aide (MA) reviewed the electronic medication administration record (eMAR) of the medication to be administered to Resident #4 for 9:00am.
-She pulled the medication blister pack cards for 3 medications.
-The medications included aspirin, metoprolol, and sertraline.
-She checked the medication cards against the electronic record, pushed out each medication from the blister pack, poured a cup of water and knocked on Resident #4's door.
-When Resident #4 opened the door the MA handed him the medication cup and water.
-Resident #4 took the cup of medications and water, and immediately closed the door without without the MA witnessing him take the medications.
-The MA turned to the eMAR and documented each medication as administered.

Interview with Resident #4 on 09/02/26 at 10:25am revealed:
-The MAs always handed him his medications and he closed the door.
-He did not know the name of his medications.
-He knew that he took medications two times per day.
-He took his medication whenever he got ready.

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D 358	Continued From page 30 Observation of Resident #4's room on 09/02/26 at 10:25am revealed there was a medication cup with the same 3 tablets poured by the MA sitting on his dresser. Observation of Resident #4's room on 09/02/26 at 11:25am revealed an empty medication cup in the trash can. Interview with the MA on 09/03/26 at 2:45pm revealed: -The MA was aware that she should have watched Resident #4 take the medication. -She had been trained by another MA to give Resident #4 the medication, and he would close his door. -The Health and Wellness Director (HWD) was aware of how medications were being administered to Resident #4. - Resident #4 would become physically aggressive if she had tried to enter the room to watch him swallow the medications. -She would go into his room once she saw him leave to verify he had taken the medications. -She knew seeing the empty cup did not verify he had taken the medications. -Resident #4 would leave the empty medication cup on his dresser. -She knew she needed to watch residents take medication from her original training of becoming an MA. Interview with the HWD on 09/03/26 at 5:16pm revealed: -She was aware the MAs were not watching Resident #4 swallow his medication and then documenting the medications as administered on the eMAR. -He did not want the MAs to watch him take his	D 358		

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D 358	Continued From page 31 medications in his room. -Resident #4 was not safe to self-administer medications. -The MAs should watch residents take medications. -MAs had been encouraged to approach Resident #4 in the hall and give his medication. Interview with the Administrator on 09/03/26 at 5:45pm revealed: -She was aware that Resident #4 did not want the MAs to come into his room and watch him take medications. -She had instructed the MAs to give the medications to Resident #4 in the hall or in the dining room. -The MAs should witness residents swallow medications. -She was not aware that medications were left in Resident #4's room. Attempted telephone interview with Resident #4's primary care provider (PCP) on 09/03/26 at 3:00pm was unsuccessful. _____ The facility failed to administer SSI as ordered 37 times in a two-month period to a resident who was a type 1 diabetic (#1). Failure to administer the correct amount of SSI put Resident #1 at risk for hyperglycemia, hypoglycemia, worsening kidney disease, heart disease, and amputation of limbs. This failure was detrimental to the health, safety and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on September 3, 2026 for this violation. THE CORRECTION DATE FOR THIS TYPE B	D 358		

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D 358	Continued From page 32 VIOLATION SHALL NOT EXCEED OCTOBER 18, 2026.	D 358		
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records (MAR) were accurate for 1 of 3 sampled residents (#1), including documentation for two medications used for anxiety and agitation. The findings are:	D 367		

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D 367	Continued From page 33 Review of Resident #1's current FL2 dated 02/27/26 revealed diagnoses that included type 1 diabetes mellitus (DM) and dementia. a. Review of Resident #1's physician's order dated 03/08/26 revealed an order for hydroxyzine 25mg every eight hours as needed (PRN) for anxiety/agitation. Review of Resident #1's June 2026 electronic MAR (eMAR) from 06/18/26-06/30/26 revealed: -There was an entry for hydroxyzine 25mg twice daily as needed for agitation. -Hydroxyzine 25mg was documented as administered on 06/26/26 and 06/27/26. Review of Resident #1's July 2026 eMAR revealed: -There was an entry for hydroxyzine 25mg every eight hours as needed for anxiety/agitation. -Hydroxyzine 25mg was documented as administered on 07/03/26. Review of Resident #1's August 2026 eMAR revealed: -There was an entry for hydroxyzine 25mg every eight hours as needed for anxiety/agitation. -Hydroxyzine 25mg was documented as administered on 08/11/26, 08/14/26, 08/28/26, and 08/31/26. Review of Resident #1's September 2026 eMAR from 09/01/26-09/03/26 revealed: -There was an entry for hydroxyzine 25mg every eight hours as needed for anxiety/agitation. -Hydroxyzine 25mg was not documented as administered. Observation of Resident #1's medications on hand on 09/02/26 at 4:08pm revealed:	D 367		

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D 367	Continued From page 34 -There was a punch card of hydroxyzine 25mg dispensed 08/03/26 with 14 of 30 tablets remaining on the punch card. -There was a punch card of hydroxyzine 25mg dispensed 09/01/26 with 30 of 30 tablets remaining on the punch card. Telephone interview with a representative from the facility's contracted pharmacy on 09/03/26 at 10:13am revealed thirty tablets of hydroxyzine 25mg every eight hours as needed were dispensed on 06/18/26, 08/03/26, and 09/01/26; 90 tablets were dispensed. Based on record review, observations, and interviews, 7 tablets of hydroxyzine were documented as administered, 90 tablets were dispensed, and 44 tablets were on hand, leaving 39 tablets unaccounted for. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable. Attempted telephone interview with a medication aide (MA) on 09/03/26 at 4:31pm was unsuccessful. Attempted telephone interview with another MA on 09/03/26 at 4:32pm was unsuccessful. Attempted telephone interview with Resident #1's PCP on 09/03/26 at 10:06am and 5:26pm was unsuccessful. Refer to the interview with a MA on 09/03/26 at 2:16pm. Refer to the interview with the Resident Care Coordinator (RCC) on 09/03/26 at 2:45pm.	D 367		

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D 367	Continued From page 35 Refer to the interview with the Health and Wellness Director (HWD) on 09/03/26 at 3:12pm. Refer to the interview with the Administrator on 09/03/26 at 4:09pm. b. Review of Resident #1's physician's order dated 03/08/26 revealed an order for olanzapine 5mg twice daily as needed for agitation. Review of Resident #1's June 2026 eMAR from 06/18/26-06/30/26 revealed: -There was an entry for olanzapine 5mg twice daily as needed for agitation. -Olanzapine 5mg was not documented as administered. Review of Resident #1's July 2026 eMAR revealed: -There was an entry for olanzapine 5mg twice daily as needed for agitation. -Olanzapine 5mg was documented as administered on 07/01/26. Review of Resident #1's August 2026 eMAR revealed: -There was an entry for olanzapine 5mg twice daily as needed for agitation. -Olanzapine 5mg was not documented as administered. Review of Resident #1's September 2026 eMAR from 09/01/26-09/03/26 revealed: -There was an entry for olanzapine 5mg twice daily as needed for agitation. -Olanzapine 5mg was not documented as administered. Observation of Resident #1's medications on	D 367		

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hand on 09/02/26 at 4:08pm revealed:
-There was a punch card of olanzapine 5mg dispensed 06/18/26 with 10 of 30 tablets remaining on the punch card.
-There was a punch card of olanzapine 5mg dispensed 08/03/26 with 27 of 30 tablets remaining on the punch card.

Telephone interview with a representative from the facility's contracted pharmacy on 09/03/26 at 10:13am revealed thirty tablets of olanzapine 5mg twice daily as needed were dispensed on 06/18/26 and 08/03/26; 60 tablets were dispensed.

Based on record review, observations, and interviews, 1 tablet of olanzapine was documented as administered, 60 tablets were dispensed, and 37 tablets were on hand, leaving 22 tablets unaccounted for.

Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable.

Attempted telephone interview with a MA on 09/03/26 at 4:31pm was unsuccessful.

Attempted telephone interview with another MA on 09/03/26 at 4:32pm was unsuccessful.

Attempted telephone interview with Resident #1's PCP on 09/03/26 at 10:06am and 5:26pm was unsuccessful.

Refer to the interview with a MA on 09/03/26 at 2:16pm.

Refer to the interview with the RCC on 09/03/26 at 2:45pm.

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D 367	Continued From page 37 Refer to the interview with the HWD on 09/03/26 at 3:12pm. Refer to the interview with the Administrator on 09/03/26 at 4:09pm. _____ _ Interview with a MA on 09/03/26 at 2:16pm revealed: -She was not sure why PRN medications had not been documented for Resident #1. -Maybe the MAs had forgotten to document the PRN medications when they were administered. -The MAs were supposed to document all medications given to the residents. Interview with the RCC on 09/03/26 at 2:45pm revealed: -The MAs were expected to document PRN medication on the eMAR when the medication was administered. -If medication had been popped, more than likely the medication had been administered. Interview with the HWD on 09/03/26 at 3:12pm revealed: -She expected the MAs to administer PRN medication as ordered and document the administration on the eMAR. -The concern would be the eMAR would not be an accurate reflection of how the medications had been administered to know how to adjust the order if needed. Interview with the Administrator on 09/03/26 at 4:09pm revealed: -She expected the MAs to document when PRN medication was administered. -If another MA looked at the eMAR and did not	D 367		

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D 367	Continued From page 38 see that a PRN had been administered, the MA could administer another PRN not knowing one had already been administered, which could lead to the resident receiving too much medication before the next dose was due.	D 367		
D 371	10A NCAC 13F .1004 (n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure medication were administered in accordance with infection control measures during the morning medication pass by a medication aide (MA) who did not sanitize her hands between the preparation and administration of medications to each resident. The findings are: Review of the facility's Medication Administration policy dated 07/15/15 revealed the policy did not include infection control practices. Observation of the MA during the morning medication pass on 09/02/26 between 9:28am-10:04am revealed: -The MA returned to the medication cart from administering medications to a resident.	D 371		

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D 371	Continued From page 39 -She did not wash her hands. -There was no hand sanitizer on the medication cart. -She used the keys to unlock the medication cart. -She reviewed a resident's electronic medication administration record (eMAR) using the computer keyboard and mouse on the medication cart. -She removed medication cards from the medication cart, prepared 3 oral medications, poured a cup of water and locked the medication cart. -The medications were administered to a resident in the day room, and the MA took the empty medication cup and water cup from the resident. -The MA returned to the medication cart, disposed of the empty cups and documented the resident's medication as administered on the eMAR using the computer mouse. -She did not wash or sanitize her hands. Interview with the MA on 09/02/26 at 10:42 am revealed: -She was able to repeat the process that should be followed for administering medications step-by-step including hygienic measures. -She washed her hands before starting her medication pass. -She washed her hands if she held the cup to the resident's mouth when administering the medications. -The hand sanitizer was not given to her by the Health and Wellness Director (HWD) until mid-way her medication pass on 09/02/26. Interview with the HWD on 09/03/26 at 5:16pm revealed: -The MAs were taught to wash hands or sanitize between touching items and preparing medication. -The MAs were taught to wash or sanitize their	D 371		

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D 371	Continued From page 40 hands after giving medications. -The MAs had the responsibility of making sure hand sanitizer was on the cart prior to the medication pass. Interview with the Administrator on 09/03/26 at 5:40pm revealed: -The MAs were taught good hand hygiene when administering medications. -The HWC was responsible for assuring the MAs were following good hand hygiene during the medication pass. -The HWC should have ongoing monitoring of the MAs' hand hygiene with medication passes at different intervals. Attempted telephone interview with the facility's primary care provider (PCP) on 09/03/26 at 3:00pm was unsuccessful.	D 371		
D 378	10A NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that stored medications were	D 378		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032109	A. BUILDING: _____ B. WING _____	R 09/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 378	Continued From page 41 locked when not under the direct supervision of staff. The findings are: Review of the facility's license revealed an effective date of January 1, 2026, and an expiration date of December 31, 2026, with a facility capacity of 51 special care unit (SCU) residents. Review of the facility's Medication Storage policy revealed the policy did not include information on locking the medication cart. Observation of the medication room on 09/02/26 at various times from 8:00am until 11:55am throughout the morning revealed: -The medication cart was unlocked at 8:10am and at 8:20am with no direct supervision of the medication aide (MA). -The medication cart had 8 medication cards at 8:16am stacked on top of the medication cart with no direct supervision of the MA. -At 10:33am, the medication cart was in the doorway of a resident's room, and the MA was 12 feet from the medication cart with her back turned away from the unlocked medication cart. -The medication cart drawers could be opened, with multiple punch cards accessible. -There were liquid medications, inhalers, and eye drops accessible in the medication cart. -There were residents wandering the halls. Observation of the medication cart on 09/03/26 at 7:32am revealed the medication cart was unlocked with no direct supervision by the MA. Interview with the MA on 09/02/26 at 11:10am revealed:	D 378		

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 378	Continued From page 42 -The medication cart should always be locked if unsupervised by the MA. -Medication cards should not be left on top of the cart. -She watched the cart whenever she stepped away. Interview with the Health and Wellness Director (HWD) on 09/03/26 at 5:15pm revealed: -The medication cart should be locked unless the MA was at the cart preparing medications. -Medications should never be left on top of the medication cart. Interview with the Administrator on 09/03/26 at 5:45pm revealed it was the expectation that the MA would keep the medication cart locked and keys with them at all times.	D 378		