STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034116	A. BUILDING: _____ B. WING _____	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA ASSISTED LIVING AT WINSTON	2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127

(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 an annual survey on 12/16/25 through 12/18/25.	D 000		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to clarify a medication order for 2 of 5 sampled residents (#2, #5) related to an order for a fast-acting medication used to treat high blood sugar and an order for a medication used to treat high blood pressure (#2), and an order for a medication used to treat insomnia (#5). The findings are: 1. Review of Resident #2's current FL2 dated 09/03/25 revealed diagnoses included hypertension, type 2 diabetes, heart failure, hyperlipidemia, and toe swelling. a. Review of Resident #2's FL2 dated 09/03/25	D 344	The community has completed an audit of the resident orders and MARS. The RCC, MCC or designee will be responsible to ensure that all orders are clarified by the PCP. The RCC, MCC or designee will send all orders daily to the pharmacy to be entered and they will follow up the next day on all previous orders sent. Any orders needing clarification will be sent to the PCP for clarification immediately and documentation made in the resident file. Date of compliance: January 29, 2026	

"Reviewed and Acknowledge" CPP 01/30/26

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revealed:
-There was an order for Lispro insulin (a fast-acting medication used to treat high blood sugar) inject as directed three times daily before meals per sliding scale.
-There were no orders for a sliding scale to indicate the amount of Lispro insulin to be administered.

Review of Resident #2's signed physician orders dated 07/18/25 revealed:
-There was an order to check blood sugar readings before meals and at bedtime.
-There was an order to administer Lispro insulin per sliding scale according to finger stick blood sugar (FSBS), 150-200 = 2 units, 201-250=3 units, 251-300=4 units, 301-350=5 units, 351-400=6 units.

Review of Resident #2's October 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Lispro insulin per sliding scale according to FSBS, 200-250 = 2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units, 401-400=10 units scheduled for administration at 7:30am, 11:30am, 4:30pm, and 8:00pm.
-There was documentation Lispro was administered 124 of 124 opportunities.

Review of Resident #2's November 2025 eMAR revealed:
-There was an entry for Lispro insulin per sliding scale according to FSBS, 200-250 = 2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units, 401-400=10 units scheduled for administration at 7:30am, 11:30am, 4:30pm, and 8:00pm.
-There was documentation Lispro was

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D 344	Continued From page 2 administered 120 of 120 opportunities. Review of Resident #2's December 2025 eMAR from 12/01/25 to 12/16/25 revealed: -There was an entry for Lispro insulin per sliding scale according to FSBS, 200-250 = 2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units, 401-400=10 units scheduled for administration at 7:30am, 11:30am, 4:30pm, and 8:00pm. -There was documentation Lispro was administered 64 of 64 opportunities. Observation of Resident #2's medications on hand on 12/17/25 revealed Lispro insulin, dispensed 12/12/25, was available for administration, but there was not a sliding scale order attached to the medication. Telephone interview with Resident #2's primary care provider (PCP) on 12/17/25 at 1:41pm revealed: -She was not working with the facility when Resident #2's Lispro sliding scale orders were written. -She was okay with facility staff administering Resident #2's Lispro sliding scale according to the eMAR entry. Attempted telephone interview with Resident #2's previous PCP on 12/17/25 at 2:00pm was unsuccessful. Interview with the medication aide (MA) on 12/17/25 at 1:36pm revealed: -She had administered Resident #2's Lispro per the sliding scale on the eMAR entry. -When the PCP wrote a new medication order for residents, it was given to a MA or the Resident Care Coordinator (RCC), then faxed to the	D 344		

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facilities contracted pharmacy so that the new medication order could be implemented.

Interview with the RCC on 12/18/25 at 8:45am revealed:
-She was responsible for writing medication orders on the FL2.
-There was not enough room, on Resident #2's current FL2, to include the most up to date Lispro sliding scale orders.

Refer to interview with the Administrator on 12/18/25 at 9:42am.

b. Review of Resident #2's FL2 dated 09/03/25 revealed there was an order for metoprolol (a medication used to treat high blood pressure) 25mg take 1 tablet 1 time a day.

Review of Resident #2's October 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for metoprolol 25mg take 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm.
-There was documentation metoprolol 25mg was administered 62 of 62 opportunities.

Review of Resident #2's November 2025 eMAR revealed:
-There was an entry for metoprolol 25mg take 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm.
-There was documentation metoprolol 25mg was administered 60 of 60 opportunities.

Review of Resident #2's December 2025 eMAR from 12/01/25 to 12/16/25 revealed:
-There was an entry for metoprolol 25mg take 1 tablet twice daily scheduled for administration at

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8:00am and 8:00pm.
-There was documentation metoprolol 25mg was administered 32 of 32 opportunities.

Telephone interview with Resident #2's primary care physician (PCP) on 12/17/25 at 1:40pm revealed:
-Resident #2's metoprolol 25mg should have been administered twice daily.
-She signed Resident #2's FL2 without reading the medication listed and how they were ordered.

Interview with the Resident Care Coordinator (RCC) on 12/18/25 at 8:32am revealed:
-She was responsible to filling out and clarifying orders on Resident #2's FL2.
-She entered Resident #2's metoprolol 25mg medication order incorrectly on his current FL2.

Refer to interview with the Administrator on 12/18/25 at 9:42am.

2. Review of Resident #5's FL2 dated 09/03/25 revealed:
-Diagnoses included dementia, hypertension, chronic kidney disorder, and depression.
-There was an order for melatonin (a medication used to treat insomnia) 5mg 1 tablet daily at bedtime.

Review of Resident #5's signed physician's order dated 12/17/25 revealed an order for melatonin 5mg with a start date of 12/03/25.

Review of Resident #5's October 2025 electronic medication administration record (eMAR) revealed:
-There was no entry for melatonin 5mg.
-There was no documentation that melatonin 5mg had been administered.

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D 344	Continued From page 5 Review of Resident #5's November 2025 eMAR revealed: -There was no entry for melatonin 5mg. -There was no documentation that melatonin 5mg had been administered. Review of Resident #5's December 2025 eMAR from 12/01/25 to 12/16/25 revealed: -There was an entry for melatonin 5mg take 1 tablet every night at bedtime scheduled to be administered at 8:00pm. -There was documentation melatonin 5mg was administered from 12/03/25 to 12/15/25. Telephone interview with Resident #5's primary care physician (PCP) on 12/17/25 at 1:50pm revealed: -Resident #5 should have been administered melatonin 5mg according to the current order written on 12/03/25. -She gave new orders to the Resident Care Coordinator (RCC) or the Memory Care Coordinator (MCC). Interview with the MCC on 12/18/25 at 8:34am revealed: -She filled out Resident #5's medication list on his FL2 dated 09/03/25. -She was not sure how Resident #5's melatonin 5mg order ended up on the 09/03/25 FL2 despite the medication order being written on 12/03/25. Refer to interview with the Administrator on 12/18/25 at 9:42am. _____ _ Interview with the Administrator on 12/18/25 at 9:42am revealed:	D 344		

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D 344	Continued From page 6 -The RCC and MCC was responsible for reviewing physician orders. -She expected the RCC and MCC to clarify medication orders when completing residents' FL2's so that medications can be administered correctly.	D 344		
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: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a licensed practitioner for 1 of 5 residents (# 2) related to a medication used to lower blood pressure (BP). The findings are: Review of Resident #2's current FL2 dated 09/03/25 revealed: -Diagnoses included hypertension, heart failure, hyperlipidemia, toe swelling, and type 2 diabetes. -There was an order for hydralazine (a medication used to lower BP) 50mg take 1 tablet three times a day. -There was no order that indicated instructions on when to hold Resident #2's hydralazine 50mg.	D 358	The community has completed an inservice for all med techs on medication administration along with an audit of the resident MARS. The RCC, MCC or designee will be responsible to review all MARS weekly and daily for all residents with parameters and sliding scales. The RCC, MCC or designee will notify the PCP and RP immediately of any missed medications and documentation made in the resident file. Date of compliance: January 29, 2026	

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D 358	Continued From page 7 Review of Resident #2's October 2025 electronic medication administration record (eMAR) revealed: -There was an entry for hydralazine 50mg take 1 tablet three times a day, hold if the systolic BP was less than 115, scheduled for administration at 12:00am, 8:00am and 4:00pm. -There was an entry to record Resident #2's systolic BP. -Hydralazine 50mg was not administered as ordered on 7 out of 93 opportunities when the SBP was below 115. Review of Resident #2's November 2025 eMAR revealed: -There was an entry for hydralazine 50mg take 1 tablet three times a day, hold if the systolic BP was less than 115, scheduled for administration at 12:00am, 8:00am and 4:00pm. -There was an entry to record Resident #2's systolic BP. -Hydralazine 50mg was not administered as ordered on 23 out of 90 opportunities when the SBP was below 115. Review of Resident #2's December 2025 MAR from 12/01/25 to 12/16/25 revealed: -There was an entry for hydralazine 50mg take 1 tablet three times a day, hold if the systolic BP was less than 115, scheduled for administration at 12:00am, 8:00am and 4:00pm. -There was an entry to record Resident #2's systolic BP. -Hydralazine 50mg was not administered as ordered on 4 out of 47 opportunities when the SBP was below 115. Observation of Resident #2's medications on hand on 12/17/25 revealed: -There was a bubble pack of hydralazine 50mg	D 358		

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with 20 of 30 tablets remaining available for administration dispensed on 12/02/25.
-There was a second bubble pack of hydralazine 50mg with 30 of 30 tablets remaining available for administration dispensed on 12/02/25.
-The order on both bubble pack labels read hydralazine 50mg take 1 tablet every 8 hours hold if the systolic BP was less than 115.

Telephone interview with Resident #2's primary care provider (PCP) on 12/17/25 at 1:44pm revealed:
-She expected the facility staff to administer Resident #2's hydralazine 50mg as ordered.
-If Resident #2 was not receiving his hydralazine 50mg as ordered, he could experience an extremely low BP.
-She did not recall assessing any adverse effects related to Resident #2 not receiving his hydralazine 50mg as ordered.

Interview with a medication aide (MA) on 12/17/25 at 1:30pm revealed:
-She administered Resident #2's medications according to the eMAR entries.
-She was aware of Resident #2's hydralazine 50mg BP order and she only administered if his BP was high enough.
-It was possible that other MA's were not reading the eMAR order instructions correctly.

Interview with the Resident Care Coordinator (RCC) on 12/18/25 at 8:29am revealed:
-It was possible some MA's did not know the difference between systolic BP and diastolic BP.
-She expected MA's to administer or hold medication as ordered.

Interview with the Administrator on 12/18/25 at 9:41am revealed:

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D 358	Continued From page 9 -The RCC was responsible for auditing eMAR's daily to ensure order parameters were being followed. -She expected all MA's to administer medication as ordered and follow any order parameters.	D 358		