STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034109	A. BUILDING: _____ B. WING _____	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHULER HEALTH CARE/PIERCE VILLA	250 PITT STREET KERNERSVILLE, NC 27284

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 02/24/26.	D 000		
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 that residents were provided with non-disposable place settings, including plates, forks, knives, spoons, and cups, during meal service. The findings are: Observation of the lunch meal service on 02/24/26 at 12:00pm revealed: -There were 11 residents in the dining room. -Residents were served water in a Styrofoam cup. Observation of the kitchen on 02/24/26 at 3:46pm revealed there was a supply of non-disposable cups for all the residents for the meal services.	D 286		

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D 286	Continued From page 1 Interview with a resident on 02/24/26 at 12:25pm revealed: -The dining tables were set before he walked in for every meal. -He usually was provided with a paper cup for his water at every meal. Interview with a second resident on 02/24/26 at 12:30pm revealed: -The dining tables were set before he walked in for every meal. -Every table usually was set with a fork, spoon, knife, napkin, a non-disposable cup and a paper cup with water. -He was not sure why the residents were not served with non-disposable cups of water during meals but he preferred to have a real cup for all his beverages. Interview with a medication aide (MA) on 02/24/26 at 3:50pm revealed: -She was aware residents were drinking water from paper cups because there had been an issue with the residents taking the non-disposable cups with them to their rooms. -She was not aware residents were supposed to be provided with non-disposable cups. Interview with the Manager on 02/24/26 at 4:15pm revealed: -She was not aware residents were drinking water from paper cups. -She expected every resident to be provided with non-disposable cups during meals. Interview with the Administrator on 02/24/26 at 4:55pm revealed: -She was not aware residents were drinking water from paper cups.	D 286		

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D 286	Continued From page 2 -She expected every resident to be provided with non-disposable cups for every beverage during meals.	D 286		
D 299	10A NCAC 13F .0904(d)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall be based on the U.S. Department of Agriculture Dietary guidelines for Americans 2020-2025, which are hereby incorporated by reference including subsequent amendments and editions. These guidelines can be found at https://dietaryguidelines.gov/sites/default/files/2021-03/Dietary_Guidelines_for_Americans-2020-2025.pdf for no cost. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that 8 ounces of milk or other equivalent dairy products were served three times daily to the Assisted Living (AL) residents. The findings are: Review of the facility's census revealed a census of 12 residents. Review of the facility's daily menu for 02/24/26 revealed no milk or equivalent dairy products listed on the menu to be served on 02/24/26. Observation of the kitchen on 02/24/26 at 9:20am	D 299		

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D 299	Continued From page 3 revealed there were 2 unopened gallons of milk in the refrigerator. Observation of the lunch meal service on 02/24/26 between 11:40am and 12:30pm revealed: -There were 11 residents present in the dining room. -There were 12 place settings prepared for residents with 2 cups at each place setting pre-filled with water and tea. -The beverages were pre-filled by the medication aide (MA). -Beverages included tea, coffee, lemonade, and water. -All residents were served water and tea. -There were 11 residents who were not offered or served milk and there were no other dairy products offered or served to the 11 residents. Interview with a resident on 02/24/26 at 12:25pm revealed: -The dining tables were set with beverages pre-filled before he walked in for every meal. -He could not remember the last time he was offered milk during his meal but he would not drink milk even if it was offered to him. Interview with a second resident on 02/24/26 at 12:30pm revealed: -The dining tables were set with beverages before he walked in for every meal. -Every table usually was set with a paper cup with water and a real cup with tea or lemonade. -He would drink milk if it was offered to him but the staff were not consistent to offer milk to the residents. Interview with a MA on 02/24/26 at 3:50pm revealed:	D 299		

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D 299	Continued From page 4 -She was not aware milk should have been offered with each meal to residents. -Milk was always available from the kitchen in the reach-in-refrigerator for all residents during every meal. -She was aware milk was not served and was not offered with the lunch meal service on 02/24/26 for all the residents because usually there was only one resident who would drink milk. -She thought staff only had to offer milk to the residents for two meals and milk was optional for the residents during the other meal. Interview with the Manager on 02/24/26 at 4:40pm revealed: -She was not aware residents were not offered milk during the lunch meal on 02/24/26. -She thought staff only had to offer milk to the residents for two meals and milk was optional for the residents during the other meal. Interview with the Administrator on 02/24/26 at 4:55pm revealed: -She was not aware residents were not offered milk during the lunch meal on 02/24/26. -She thought staff only had to offer milk to the residents for two meals and milk was optional for the residents during the other meal.	D 299		
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	D 358		

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D 358	Continued From page 5 (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 ensure medications were administered as ordered for 1 of 3 sampled residents (#2) including failure to hold a medication used to treat low blood pressure (BP). The findings are: Review of Resident #2's current FL2 dated 08/19/25 revealed: -Diagnoses included hypertensive chronic kidney disease, fracture of facial bones, dysphagia, atherosclerotic heart disease, anxiety, and mild cognitive impairment. -There was an order for midodrine (used to treat hypotension) 2.5mg take one tablet twice daily. Review of Resident #2's signed physician order dated 01/14/26 revealed an order for midodrine 5mg 1 tablet twice a day, hold for blood pressure (BP) greater than 130/80. Review of Resident #2's January 2026 electronic medication administration record (eMAR) from 01/01/26 to 01/31/26 revealed: -There was an entry for midodrine 2.5mg tablet take one tablet twice daily at 8:00am and at 8:00pm from 01/01/26 through 01/15/26. -There was an entry for midodrine 5mg tablet take one tablet twice daily at 8:00am and at 8:00pm, hold for BP greater than 130/80. -There was a space on the eMAR to document Resident #2's BP values. -There was documentation midodrine was administered when it should have been held, with examples as follows:	D 358		

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D 358	Continued From page 6 -On 01/16/26 Resident #2's BP value was documented as 151/81 at 8:00pm. -On 01/17/26 Resident #2's BP value was documented as 137/75 at 8:00am. -On 01/22/26 Resident #2's BP value was documented as 142/66 at 8:00am. -On 01/30/26 Resident #2's BP value was documented as 140/79 at 8:00am. -On 01/31/26 Resident #2's BP value was documented as 141/74 at 8:00am. Review of Resident #2's February 2026 eMAR from 02/01/26 to 02/23/26 revealed: -There was an entry for midodrine 5mg tablet take one tablet twice daily at 8:00am and at 8:00pm, hold for BP greater than 130/80. -There was a space on the eMAR to document Resident #2's BP values. -There was documentation midodrine was administered when it should have been held, with examples as follows: -On 02/05/26 and Resident #2's BP value was documented as 132/78 at 8:00am. -On 02/12/26 and Resident #2's BP value was documented as 136/88 at 8:00am. -On 02/20/26 and Resident #2's BP value was documented as 130/115 at 8:00pm. Observation of the medications on hand for Resident #2 on 02/24/26 at 3:00pm revealed there were 5 tablets remaining of 14 tablets dispensed on 02/17/26 in a bubble pack labeled as midodrine 5mg one tablet twice daily, hold for BP greater than 130/80. Review of Resident #2's blood pressure values revealed the facility documented a blood pressure value of 129/76 on 02/24/26 at 8:00am. Telephone interview with a pharmacist from the	D 358		

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facility's contracted pharmacy on 02/24/26 at 2:30pm revealed:
-Resident #2 had a current order dated 01/14/26 on file for midodrine 5mg take one tablet twice daily at 8:00am and at 8:00pm, hold for BP greater than 130/80.
-Midodrine 5mg was dispensed for Resident #2 on 02/17/26 for 14 tablets.

Interview with Resident #2 on 02/24/26 at 3:40pm revealed:
-The medication aides (MA) obtained his BP readings in the mornings and in the evenings.
-He was not sure if he had ever gone without any of his medications.
-He denied any current issues with high blood pressure levels or having experienced symptoms related to headaches or dizziness.

Interview with a MA on 02/24/26 at 3:50pm revealed:
-She administered medications to Resident #2 and she followed the medication orders in the eMAR system when administering medications to residents.
-She knew there was a parameter to hold Resident #2's midodrine if her BP was above 130/80.
-She was not aware Resident #2's midodrine had been documented as administered when it should have been held according to Resident #2's ordered parameters in January 2026 and February 2026.
-The Manager was responsible for reviewing the eMAR audits but she had not been informed of any medication errors.

Interview with the Business Office Manager (BOM) on 02/24/26 at 4:25pm revealed:
-She did not know Resident #2's midodrine was

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administered when it should have been held from in January 2026 and February 2026.
-The MA administering medications would be responsible to hold Resident #2's midodrine if it should be held.
-She and the Manager were responsible for reviewing the eMAR audits but she was not sure they could view held medications unless the MAs entered the "hold" on the eMAR correctly.

Interview with the Manager on 02/24/26 at 4:15pm revealed:
-She and the BOM were responsible for completing eMAR audits daily but they would only see held medications if the MAs entered the administration record correctly.
-She expected the MAs to follow provider orders and MAs were responsible to hold Resident #2's midodrine if it should be held.
-She was not aware Resident #2's midodrine had been documented as administered when it should have been held according to Resident #2's ordered parameters in January 2026 and February 2026.

Telephone interview with the Administrator on 02/24/26 at 4:55pm revealed:
-She did not know Resident #2's midodrine was administered when it should have been held in January 2026 and February 2026.
-The Manager and BOM was responsible for completing eMAR audits daily and the pharmacy audited the eMAR's for errors.
-She expected the MAs to follow provider orders and hold medications according to ordered parameters.
-She expected the Manager and BOM to review the eMAR audits daily and to identify medication errors.

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D 358	Continued From page 9 Attempted telephone interview with a second MA on 02/24/26 at 3:35pm was unsuccessful. Attempted telephone interview with Resident #2's primary care provider (PCP) on 02/24/26 at 3:33pm was unsuccessful.	D 358		