STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064036	A. BUILDING: _____ B. WING _____	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAVION OF ROCKY MOUNT	650 GOLDROCK ROAD ROCKY MOUNT, NC 27804

(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 April 15, 2026 and April 16, 2026.	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 medication orders for 1 of 3 sampled residents (#1) for a medication used to treat elevated blood glucose levels. The findings are: Review of the facility's Physician/Healthcare Provider Orders policy dated 03/11/25 revealed: -New or changed orders, to include medication orders, can be written on Admission Orders, Facility Discharge Orders, a prescription pad, Physician Admission Orders, Fax Physician	D 344		

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 344	Continued From page 1 Order, Verbal Physician Order, Physician Visit Summary, Physician Communication sheet, and Diet Order Sheet. -Items to include in the medication order, resident's name, physician's name, medication name, strength of medication, directions of administration, dosage of medication to be administered, route of administration, duration of medication, if indicated, date ordered, and specific directions for use, including frequency of administration. -Clarification of orders; the community will contact the resident's physician/healthcare provider for verification or clarification of orders when orders are not clear, complete or have conflicting information. Review of the facility's Medication Administration Medication Administration Record/Electronic Medication Administration Record (MAR/eMAR) Review and Verification Policy dated 03/11/25 revealed: -At shift change the on-coming team member will review each MAR/eMAR with the off-going team member. -The Clinical Manager/Med Passer will verify the orders input in the eMAR to ensure they match prescription details when the medication arrives in the community. -If no discrepancies are found, the orders will be saved in the eMAR by the person verifying the orders. -If there is a discrepancy noted, the order, the order will not be saved in the eMAR or transcribed onto the MAR, and the person responsible for transcribing will notify the prescriber for clarification. Review of Resident #1's current FL-2 dated 06/23/25 revealed diagnoses included type 2	D 344		

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D 344	Continued From page 2	D 344		

diabetes mellitus, cerebral infarction, iron deficiency anemia, hypothyroidism, hyperlipidemia, dementia, hypertension, and bradycardia.

Review of Resident #1's signed physician's order sheet dated 12/30/25 revealed an order for Lantus (Lantus is a long-acting insulin used to improve blood sugar control in adults with type 2 diabetes) Solostar 100U/ml, inject 25 units sub-q at bedtime.

Review of a Physician Communication form dated 03/03/26 for Resident #1 revealed:
-There was an order to discontinue Lantus 25 units at bedtime.
-There was an order to increase Lantus to 30 units at bedtime.
-The Physician's Communication form was signed by Resident #1's primary care provider (PCP) on 03/03/26.

Review of a Physician Communication form dated 03/17/26 for Resident #1 revealed:
-There was an order to discontinue Lantus 25 units at bedtime.
-There was an order to start Lantus 28 units at bedtime.
-The Physician Communication form was signed by Resident #1's PCP on 03/17/26.

Review of a Physician Communication form dated 03/31/26 for Resident #1 revealed:
-There was an order to discontinue Lantus 28 units at bedtime.
-There was an order to start Lantus 30 units at bedtime.
-The Physician Communication form was signed by Resident #1's PCP on 03/31/26.

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Review of Resident #1's physician's orders and facility progress notes revealed no documentation the Lantus order on 03/17/26 had been clarified.

Review of Resident #1's March 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for Lantus Solostar Injection 100units/ml, inject 25 units at bedtime, scheduled for 9:00pm.
-Lantus 25 units was documented as administered at 9:00pm on 03/01/26 through 03/03/26.
-There was a second entry for Lantus Solostar Injection 100units/ml, inject 30 units at bedtime, scheduled at 9:00pm, with a start date of 03/04/26.
-Lantus 30 units was documented as administered at 9:00pm on 03/04/26 through 03/16/26.
-There was a third entry for Lantus Solostar Injection 100units/ml, inject 28 units at bedtime, scheduled at 9:00pm, with a start date of 03/17/26.
-Lantus 28 units was documented as administered at 9:00pm on 03/17/26 through 03/31/26.

Observation of Resident #1's medications on hand on 04/15/26 at 3:34pm revealed:
-There was one pen of Lantus Solostar 100U/ml labeled with Resident #1's name and a sticker with date opened documented as 04/14/26.
-The one pen of Lantus Solostar also had a "Directions changed, refer to chart" sticker.

Telephone interview with a certified pharmacy technician with the facility's contracted pharmacy on 04/16/26 at 9:34am revealed:
-An order was received for Resident #1 for Lantus

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D 344	Continued From page 4 Solostar 100U/ml, inject 25 units at bedtime on 12/30/25. -An order was received for Resident #1 on 03/03/26 to increase Lantus to 30 units at bedtime and to discontinue Lantus 25 units at bedtime. -An order was received for Resident #1 on 03/17/26 to discontinue Lantus 25 units at bedtime and to start Lantus 28 units at bedtime. -There was no documentation the facility was contacted to clarify the 03/17/26 order for Resident #1 to discontinue Lantus 25 units instead of Lantus 30 units at bedtime, and to increase Lantus to 28 units. -An order was received on 04/04/26 but was dated 03/31/26 for Resident #1 to discontinue Lantus 28 units at bedtime and to start Lantus 30 units at bedtime. Interview with a medication aide (MA) on 04/16/26 at 10:20am revealed: -The MAs or the Resident Care Director (RCD) were responsible for sending all PCP orders to the pharmacy. -Orders from the residents' PCP were faxed to the pharmacy. -The pharmacy entered all the medication orders into the eMAR system. -The MAs or the RCD were responsible for reviewing and approving all orders after they were entered by the pharmacy. -If a medication on hand had a dosage change such as insulin, the MAs or the RCD placed a dosage change sticker on the medication label and reported the medication change to the oncoming MA at shift report. -If there were any questions about an order for a resident, the resident's PCP was contacted for clarification of the order.	D 344		

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D 344	Continued From page 5 Interview with the RCD on 04/16/26 at 9:22am revealed: -Either she or the MAs were responsible to fax all orders to the facility's contracted pharmacy. -Medication orders were not entered by the facility. -Medication orders were only entered by the pharmacy only. -Once the pharmacy entered a resident's orders into the eMAR system, the orders came through a queue and were reviewed and approved by her or the MAs. -If there were any questions about an order, the resident's PCP was contacted for clarification of the order. Second interview with the RCD on 04/16/26 at 1:00pm revealed: -She had faxed Resident #1's 03/17/26 order to discontinue Lantus 25 units at bedtime and to start Lantus 28 units at bedtime to the pharmacy. -She felt Resident #1's PCP wrote the 03/17/26 order to discontinue Lantus 25 units instead of 30 units at bedtime in error. -She was very busy and did not catch the 03/17/26 Lantus order discrepancy for Resident #1. -She should have compared Resident #1's new order for Lantus on 03/17/26 to his previous Lantus order and contacted his PCP to notify and clarify that Resident #1 was receiving Lantus 30 units at bedtime instead of Lantus 25 units at bedtime. Interview with the Administrator on 04/16/26 at 1:33pm revealed: -The RCD and MAs were responsible to send all orders for the residents to the pharmacy. -If there were any questions about a resident's orders, she expected the resident's PCP to be	D 344		

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D 344	Continued From page 6 contacted for clarification of order by the RCD or the MAs. -Resident #1's 03/17/26 dosage change order for his Lantus should have been clarified with his PCP since she wrote to discontinue Lantus 25 units at bedtime when the resident was receiving Lantus 30 units at bedtime. Attempted telephone interview with Resident #1's PCP on 04/16/26 at 12:13pm was unsuccessful.	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 interviews and record reviews, the facility failed to administer medications according to provider orders for 1 of 3 sampled residents (#1) for medications used to treat elevated blood glucose levels. The findings are: Review of the facility's Medication Agreement Policy dated 03/11/25 revealed: -Medications will be ordered in a timely manner by the community. -All necessary information regarding the medication order will be faxed to the pharmacy	D 358		

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D 358	Continued From page 7 and medications with delivery in a timely manner. Review of the facility's Physician /Healthcare Provider Orders policy dated 03/11/25 revealed: -New or changed orders, to include medication orders, can be written on Admission Orders, Facility Discharge Orders, a prescription pad, Physician Admission Orders, Fax Physician Order, Verbal Physician Order, Physician Visit Summary, Physician Communication sheet, and Diet Order Sheet. -Items to include in the medication order, resident's name, physician's name, medication name, strength of medication, directions of administration, dosage of medication to be administered, route of administration, duration of medication, if indicated, date ordered, and specific directions for use, including frequency of administration. -When a order is received, a copy of the order will be faxed to the dispensing pharmacy. -The community will assure the fax was received, assure the order is transcribed to the resident's medication administration record, will assure the medication will be available for administration for the next scheduled dose, unless otherwise documented. Review of the facility's Medication/Treatment Administration policy dated 03/11/25 revealed: -Each medication/treatment will be compared with the medication administration record/electronic medication administration record verifying the right medication/treatment is being administered to the right resident, right medication/treatment, right dose, right time, and right route. -Documentation will be completed at the time of administration. Review of Resident #1's current FL-2 dated	D 358		

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D 358	Continued From page 8 06/23/25 revealed diagnoses included type 2 diabetes mellitus, cerebral infarction, iron deficiency anemia, hypothyroidism, hyperlipidemia, dementia, hypertension, and bradycardia. a. Review of a Physician Communication form dated 03/17/26 for Resident #1 revealed: -There was an order to discontinue Lantus 25 units at bedtime. -There was an order to start Lantus 28 units at bedtime. -The Physician Communication form was signed by Resident #1's PCP on 03/17/26. Review of a Physician Communication form dated 03/31/26 for Resident #1 revealed: -There was an order to discontinue Lantus 28 units at bedtime. -There was an order to start Lantus 30 units at bedtime. -The Physician Communication form was signed by Resident #1's PCP on 03/31/26. -The Physician Communication form dated and signed 03/31/26 for Resident #1 was initialed by staff and stamped faxed on 04/04/26. Review of Resident #1's March 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Lantus Solostar Injection 100units/ml, inject 28 units at bedtime, scheduled at 9:00pm, with a start date of 03/17/26. -Lantus 28 units was documented as administered at 9:00pm on 03/17/26 through 3/31/26. Review of Resident #1's April 2026 eMAR revealed: -There was an entry for Lantus Solostar Injection	D 358		

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100units/ml, inject 28 units at bedtime, scheduled for 9:00pm.
-Lantus 28 units was documented as administered at 9:00pm on 04/01/26 through 04/03/26.
-There was second entry for Lantus Solostar Injection 100units/ml, inject 30 units at bedtime, scheduled for 9:00pm.
-Lantus 30 units was documented as administered at 9:00pm on 04/04/26 through 04/13/26.

Observation of Resident #1's medications on hand on 04/15/26 at 3:34pm revealed:
-There was one pen of Lantus Solostar 100u/ml labeled with Resident #1's name and a sticker with date opened documented as 04/14/26.
-The one pen of Lantus Solostar also had a "Directions changed, refer to chart" sticker.

Telephone interview with a certified pharmacy technician with the facility's contracted pharmacy on 04/16/26 at 9:34am revealed:
-An order was received for Resident #1 for Lantus Solostar 100u/ml, inject 25 units at bedtime on 12/30/25.
-An order was received for Resident #1 on 03/03/26 to increase Lantus to 30 units at bedtime and to discontinue Lantus 25 units at bedtime.
-An order was received for Resident #1 on 03/17/26 to discontinue Lantus 25 units at bedtime and to start Lantus 28 units at bedtime.
-An order was received on 04/04/26 but was dated and signed 03/31/26 for Resident #1 to discontinue Lantus 28 units at bedtime and to start Lantus 30 units at bedtime.

Interview with a medication aide (MA) on 04/16/26 at 10:20am revealed:

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-When the resident's primary care provider (PCP) wrote orders, the orders were placed in a folder.
-The MAs or the Resident Care Director (RCD) were responsible for reviewing the order folder daily on each shift and sent all PCP orders to the pharmacy via fax.
-The pharmacy entered all the medication orders into the eMAR system, and the MAs or the RCD reviewed and approved the orders after they were entered into the eMAR system by the pharmacy.
-Resident #1's insulin dose was changed frequently.
-She remembered that she found Resident #1's 03/31/26 order for Lantus behind the order folder with some other papers.
-When she saw the date on Resident #1's 03/31/26 Lantus order, she immediately faxed the new Lantus order to the pharmacy and placed a "dosage change sticker" on Resident #1's Lantus pen and communicated to the next shift that the Lantus order had changed.
-She always checked the order folder daily, but she was not certain that the order folder was checked daily by the second shift staff.

Interview with the RCD on 04/16/26 at 1:00pm revealed:
-When the facility's contracted PCP wrote orders, the orders were placed in a folder.
-Either she or the MA on duty were responsible for faxing all orders to the facility's contracted pharmacy.
-The pharmacy entered all orders into the eMAR system, once the pharmacy entered a resident's orders into the eMAR system, the orders came through a queue and were reviewed and approved by her or the MAs.
-All orders should be faxed the same day and should never sit.
-The MAs on all shifts were responsible to review

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the order folder and to send the orders to the pharmacy immediately.
-She was not aware that Resident #1's 03/31/26 order for Lantus was not sent to the pharmacy until 04/04/26.
-It was possible Resident #1's 03/31/26 Lantus order was misfiled but the MAs from all shifts were responsible for checking the order folder for new orders.
-It was not acceptable that Resident #1's 03/31/26 Lantus was not sent until 4 days later.

Interview with the Administrator on 04/16/26 at 1:33pm revealed:
-The RCD and MAs were responsible to send all orders for the residents to the pharmacy.
-She expected all orders to be faxed to the pharmacy the same day they were ordered so medications were available for the residents.

Attempted telephone interview with Resident #1's PCP on 04/16/26 at 12:13pm was unsuccessful.

b. Review of a Physician Communication form dated 03/17/26 for Resident #1 revealed:
-There was an order to discontinue Humalog (Humalog is a rapid acting insulin used to treat elevated blood sugar) 5 units, three times a day before meals.
-There was an order to start Humalog 6 units, three times a day with meals, hold if finger stick blood sugar (FSBS) is less than 70, notify provider if FSBS is greater than 400.
-The Physician Communication form was signed by Resident #1's PCP on 03/17/26.

Review of a Physician Communication form dated 04/14/26 for Resident #1 revealed:
-There was an order to discontinue Humalog 6 units, three times a day before meals.

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D 358	Continued From page 12 -There was an order to start Humalog 8 units, three times a day 30 minutes before meals, hold if finger stick blood sugar (FSBS) is less than 100, notify provider if FSBS is less than 70 or greater than 400. -The Physician Communication form was signed by Resident #1's PCP on 04/14/26. Review of Resident #1's March 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Humalog Kwikpen 100units/ml, inject 6 units three times a day with meals, hold for FSBS less than 70, call provider if FSBS is greater than 400, scheduled at 8:00am, 12:00pm and 5:00pm. -Humalog 6 units was documented as administered at 8:00am, 12:00pm and 5:00pm on 03/18/26 through 03/31/26. Review of Resident #1's April 2026 eMAR revealed: -There was an entry for Humalog Kwikpen 100units/ml, inject 6 units three times a day with meals, hold for FSBS less than 70, call provider if FSBS is greater than 400, scheduled at 8:00am,12:00pm and 5:00pm. -Humalog 6 units was documented as administered at 8:00am on 04/01/26 through 04/12/26. -Humalog 6 units was documented as not administered at 8:00am on 04/13/26 with the exception documented as resident refused. -Humalog 6 units was not documented as administered at 8:00am on 04/14/26 with no exception documented and the entry space was blank. -Humalog 6 units was documented as administered at 12:00pm on 04/01/26 through 04/13/26.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064036	A. BUILDING: _____ B. WING _____	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAVION OF ROCKY MOUNT	650 GOLDROCK ROAD ROCKY MOUNT, NC 27804

(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 13 -Humalog 6 units was not documented as administered at 12:00pm on 04/14/26 with no exception documented and the entry space was blank. -Humalog 6 units was documented as administered at 5:00pm on 04/01/26. -Humalog 6 units was documented as not administered at 5:00pm on 04/02/26 with the exception documented as resident refused. -Humalog 6 units was documented as administered at 5:00pm on 04/03/26 through 04/10/26. -Humalog 6 units was documented as not administered at 5:00pm on 04/11/26 with the exception documented as resident refused. -Humalog 6 units was documented as administered at 5:00pm on 04/12/26 and on 04/13/26. -There was a second entry for Humalog Kwikpen 100units/ml, inject 8 units three times a day 30 minutes before meals, hold for FSBS less than 100, call provider if FSBS is less than 70 or greater than 400, scheduled at 7:30am, 11:30am and 4:30pm. -Humalog 8 units was documented as administered at 4:30pm on 04/14/26. -Humalog 8 units was documented as administered at 7:30am on 04/15/26. Observation of Resident #1's medications on hand on 04/15/26 at 3:34pm revealed: -There was one Humalog Kwikpen 100u/ml labeled with Resident #1's name and a sticker with date opened documented as 04/03/26. -The Humalog Kwikpen also had a "Directions changed, refer to chart" sticker. Telephone interview with a certified pharmacy technician with the facility's contracted pharmacy on 04/16/26 at 9:34am revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064036	A. BUILDING: _____ B. WING _____	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAVION OF ROCKY MOUNT	650 GOLDROCK ROAD ROCKY MOUNT, NC 27804

(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 14	D 358		

-An order was originally received for Resident #1 for Humalog inject 5 units three times a day before meals, hold if FSBS is less than 100, notify Provider if FSBS is less than 70 or greater than 400 on 09/15/25.
-An order was received for Resident #1 on 03/17/26 to discontinue Humalog 5 units three times a day and start Humalog 6 units, three times a day before meals, hold if FSBS less than 70, call provider if FSBS greater than 400.
-An order was received for Resident #1 on 04/14/26 to discontinue Humalog 6 units three times a day and start Humalog 8 units three times a day 30 minutes before meals, hold if FSBS is less than 100, contact provider if FSBS is less than 70 or greater than 400.
-Orders and discontinued orders were entered by the pharmacy technician then verified by a pharmacist.
-Once reviewed by the pharmacist, the orders were keyed into the eMAR system and went to the facility to approve.
-The order entry and review process by the pharmacy usually was completed in 2 to 3 hours.

Interview with the medication aide (MA) on 04/16/26 at 10:20am revealed:
-She always checked Resident #1's FSBS prior to administering his insulin.
-Both of Resident #1's insulin orders had recently changed.
-She remembered administering Resident #1's morning and noon Humalog on 04/14/26.
-She administered 6 units of Humalog to Resident #1 on 04/14/26 at 8:00am and 12:00pm because his Humalog order had not changed yet.
-Resident #1's PCP was here on 04/14/26 around 11:30am or noon and she changed his Humalog and his Lantus orders.
-She placed dosage change stickers on Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064036	A. BUILDING: _____ B. WING _____	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAVION OF ROCKY MOUNT	650 GOLDROCK ROAD ROCKY MOUNT, NC 27804

(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 15	D 358		

#1's Humalog and Lantus pens and reported to the oncoming MA that his insulin dosages changed.
-There should never be blanks on the eMAR, if medications were not administered it should be documented as such with a reason why the medications were not administered.
-She did not know why Resident #1's morning and noon Humalog did not show as administered on his eMAR for 04/14/26 but it was possible when the Humalog 6 units was discontinued for Resident #1 that the entry for Humalog 6 units dropped off his eMAR.

Interview with the Resident Care Director (RCD) on 04/16/26 at 1:02pm revealed:
-The MAs were to always document when medications were administered.
-If a medication was not administered, a reason should be documented.
-There should never be blanks on the residents' eMARs.
-It was possible when Resident #1's Humalog order changed on 04/14/26 from 6 units to 8 units three times a day, the Humalog 6 units entry fell off the eMAR when the order for Humalog 6 units was discontinued.
-She expected the MAs to let her know if there was a problem documenting on the residents' eMAR.
-She performed eMAR audits daily on all the residents.
-During an eMAR audit, she looked for missed and late medications, medications not available and why, and follow-up for medications documented as needed.
-She could not conduct her daily eMAR audits on 04/15/26 or 04/16/26 due to state surveyors being in the facility.
-She would have noticed that Resident #1's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064036	A. BUILDING: _____ B. WING _____	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAVION OF ROCKY MOUNT	650 GOLDROCK ROAD ROCKY MOUNT, NC 27804

(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 16 Humalog was not documented as administered on 04/14/26 at 8:00am and 12:00pm if she had been able to do her daily eMAR audit. Interview with the Administrator on 04/16/26 at 1:35pm: -She expected the MAs to always document the administration of medications to the residents. -If a medication was not administered to a resident, an exception should always be documented. -The RCD did daily eMAR audits to make sure medications were being administered as ordered. Attempted telephone interview with Resident #1's PCP on 04/16/26 at 12:13pm was unsuccessful.	D 358		