Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034097	A. BUILDING: _____ B. WING _____	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA CREEK ASSISTED LIVING	2560 WILLARD ROAD WINSTON SALEM, NC 27107

(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 and follow-up survey from 03/17/26 through 03/19/26.	D 000		
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 and interviews, the facility failed to ensure residents' ice supply was protected from contamination as evidenced by a scoop for the ice machine in the kitchen uncovered on top of the machine. The findings are:	D 283	Responses to cited deficiencies do not constitute an admission or agreement by the facility of truth of facts alleged or conclusions set forth in the Statement of Deficiencies or the Corrective Action Report. The Plan of Correction is prepared solely as a matter of compliance with state laws.	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Chaunda Nicole Moore 4/30/26

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D 283	Continued From page 1 Initial observation of the kitchen on 03/17/26 at 10:30am revealed the scoop for the ice machine was lying uncovered on top of the machine. Second observation of the kitchen on 03/18/2026 at 10:13am revealed the ice scoop for the ice machine was lying uncovered on top of the ice machine. Interview with the Dietary Manager (DM) on 03/18/2026 at 10:17am revealed: -The ice machine in the kitchen serviced the entire facility. -She was aware that the ice scoop needed to be covered when outside the machine, but she did not have a cover for it. -She had contacted the corportate office for an approval for an ice scoop holder on one occasion but the approval was denied. -She expected the ice scoop to be run through the dishwasher at least once daily. Interview with the Administrator on 03/18/26 at 10:40am revealed: -She was aware that the ice scoop needed to be covered when outside the ice machine. -The DM had reported to her that she had requested an ice scoop holder but the request was denied. -She expected the ice scoop to be in a holder at all times when not in use.	D 283	10 NCAC 13F .0904 (a)(2) Ice scoop was delivered and mounted for use in kitchen as well as a spare, larger ice scoop. ED in-serviced DSM on 10 NCAC 13F .0904 (a)(2) ED and/or other designee will complete daily walk throughs to ensure proper use and storage of ice scoop for 30 days and randomly thereafter.	03/20/26 03/19/26 03/23/26
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	D 358		

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D 358	Continued From page 2 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 ensure medications were administered as ordered for 2 of 5 residents sampled residents including errors regarding sliding scale insulin (SSI) (#4) and including errors for insulin to treat elevated blood sugar levels for resident (#1) in the Special Care Unit (SCU). The findings are: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 residents related to errors with sliding scale insulin (#4). The findings are: Review of Resident #4's current FL-2 dated 09/25/25 revealed diagnoses included type 2 diabetes mellitus and hypertension. Review of Resident #4's signed physician order dated 01/15/26 revealed there was an order for insulin lispro (a medication used to treat diabetes mellitus) 100 unit/mL, finger stick blood sugar (FSBS) before meals three times daily. For FSBS 150-200, administer 2 units; FSBS 201-250, administer 4 units; FSBS 251-300, administer 6 units; FSBS 301-350, administer 8 units; FSBS 351-400, administer 10 units; FSBS 401-450, administer 12 units; FSBS 451-500, administer 15 units; FSBS 501 and above administer 20 units. If	D 358	10A NCAC 13F .1004 (a) Regional Clinical Director will complete diabetic training with ED, Care Coordinators, and medication staffing on 05/12/26. ED, Care Coordinators, and/or designee will complete record review on diabetic residents to ensure recording of all required documentation Regional Clinical Director will review no less than 5 diabetic charts on monthly site visit for next quarter to review diabetic documentation ED, Care Coordinators, and/or RCD/RN will conduct Insulin order audits monthly for 2 months.	05/12/26 05/12/26 05/31/26 05/20/26

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D 358	Continued From page 3 FSBS less than 60 administer 1 glutose tab or cup of juice. Review of Resident #4's January 2026 electronic medication administration record (eMAR) revealed: -There was an entry for insulin lispro 100 units/ml, check BS three times a day before meals; 150-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, 401-450 = 12 units, 451-500 = 15 units, 501 and above = 20 units; if FSBS less than 60 administer 1 glutose tab or cup of juice. -It could not be determined how many units of insulin were administered to Resident #4 for 43 of 48 instances where there were no unit amounts of insulin documented on the eMAR. Review of Resident #4's February 2026 eMAR revealed: -There was an entry for insulin lispro 100 units/ml, check BS three times a day before meals; 150-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, 401-450 = 12 units, 451-500 = 15 units, 501 and above = 20 units; if FSBS less than 60 administer 1 glutose tab or cup of juice. -It could not be determined how many units of insulin were administered to Resident #4 for 63 of 84 instances where there were no unit amounts of insulin documented on the eMAR. -There was documentation 0 units of insulin were administered for a BS of 190 on 02/25/26 at 7:30am instead of the ordered dose of 2 units. -There was documentation 6 units of insulin were administered for a BS of 250 on 02/28/26 at 4:30pm instead of the ordered dose of 4 units. Review of Resident #4's March 2026 eMAR revealed:	D 358	Weekly EMAR to Cart to Physician Orders audit will be conducted by Care Coordinators and/other designee. Cart audits are to be reviewed at stand up for the next quarter	06/20/26

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D 358	Continued From page 4 -There was an entry for insulin lispro 100 units/ml, check BS three times a day before meals; 150-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, 401-450 = 12 units, 451-500 = 15 units, 501 and above = 20 units; if FSBS less than 60 administer 1 glutose tab or cup of juice. -There was documentation 6 units of insulin were administered for a BS of 164 on 03/04/26 at 7:30am instead of the ordered dose of 2 units. Observation of the medications on hand for Resident #4 on 03/19/25 at 11:25am revealed: -There was a 3mL (100 units/mL) insulin lispro pen opened on 03/02/26 available for administration. -There were approximately 80 units of insulin lispro remaining in the insulin lispro pen. Telephone interview with a representative from the facility's contracted pharmacy on 03/19/26 at 11:54am revealed: -Resident #4 had an active order for insulin lispro 100 units/ml, check BS three times a day before meals; 150-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, 401-450 = 12 units, 451-500 = 15 units, 501 and above = 20 units; if FSBS less than 60 administer 1 glutose tab or cup of juice. -Resident #4's insulin lispro was dispensed on 01/15/26 and 02/05/26 for a quantity of five 3mL (100 units/mL) insulin lispro pens for each dispensed date. Attempted interview with Resident #4 on 03/19/26 at 3:00pm was unsuccessful. Interview with Resident #4's primary care provider (PCP) on 03/18/26 at 12:35pm revealed she expected the facility to document the amount of	D 358		

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D 358	Continued From page 5 insulin lispro units administered to Resident #4. Interview with a medication aide (MA) on 03/19/26 at 11:35am revealed: -She knew there was not a space to document the amount of insulin lispro units administered to Resident #4 from 01/16/26 to 02/23/26. -She had told the Resident Care Coordinator (RCC) there was not a space on the eMAR to document the number of units of insulin lispro administered to Resident #4. -Resident #4 had never refused insulin administration. -The RCC or the pharmacy placed medication order entries on the eMAR. Interview with the Resident Care Coordinator (RCC) on 03/19/26 at 2:30pm revealed: -She knew there was not a place to document Resident #4's insulin lispro units administered from 01/16/26 to 02/23/26. -She changed the order entry on Resident #4's eMAR so there was a space to document insulin units administered on 02/23/26. -There was a checkbox in the eMAR system that needed to be checked for there to be a space to document insulin units on Resident #4's eMAR. -The pharmacy normally placed order entries on the eMAR. -The MAs or whoever was administering insulin to Resident #4 were responsible to document the number of insulin units administered. Interview with the Regional Operations Specialist on 03/19/26 at 2:35pm revealed: -He did not know there was no documentation of insulin units administered to Resident #4 for 43 of 48 instances in January 2026 and 63 of 84 instances in February 2026. -The MAs were responsible to document the	D 358		

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D 358	Continued From page 6 number of insulin units administered to Resident #4. Refer to the interview with the Special Care Unit Coordinator (SCUC) on 03/19/26 at 8:22am. Refer to the interview with the RCC on 03/19/26 at 8:55am. Refer to the interview with the Administrator on 03/19/26 at 9:15am. Refer to the interview with the Regional Operations Specialist on 03/19/26 at 2:35pm. 2. Review of Resident #1's current FL2 dated 02/17/26 revealed: -Diagnoses included Type dementia major depressive disorder, Type 2 diabetes mellitus, chronic obstructive lung disease, and essential hypertension. -There was an order to check fingerstick (FSBS) twice daily. Review of Resident #1's record revealed Resident #1's signed physician's orders dated 02/19/25 for insulin glargine pen (a medication used to treat diabetes mellitus) 100 unit/ml inject 6 units twice daily, check FSBS if BS is 100 or less only give 3 units. Review of Resident #1's January 2026 electronic medication administration record (eMAR) revealed: -There was an entry for a insulin glargine pen 100 unit/ml inject 6 units twice daily, check FSBS if BS is 100 or less only give 3 units scheduled for 7:00am and 7:00pm. -FSBS's ranged from 78 to 544. -The eMAR had a space for documentation of the staff member obtaining the FSBS, a space for the	D 358		

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D 358	Continued From page 7 site of administration, a space for documenting FSBS values, and a space for documenting the amount of insulin glargine administered. -Examples of Resident #1's FSBS values documented on the January 2026 eMAR but documentation for the different amount of insulin glargine administered were as follows for 1 of 62 opportunities: -On 01/25/26 at 7:00am, FSBS was 99 and 3 units of insulin glargine should have been administered but 6 units of insulin glargine was documented as administered on the eMAR. -There was no additional notes for the amount of insulin glargine administered for 01/25/26. Review of Resident #1's February 2026 eMAR revealed: -There was an entry for insulin glargine pen 100 unit/ml inject 6 units twice daily, check FSBS if BS is 100 or less only give 3 units scheduled for 7:00am and 7:00pm. -FSBS's ranged from 94 to 469. -The eMAR had a space for documentation of the staff member obtaining the FSBS, a space for the site of administration, a space for documenting FSBS values, and a space for documenting the amount of insulin glargine administered. -Examples of Resident #1's FSBS values documented on the February 2026 eMAR but documentation for the different amount of Insulin glargine administered were as follows for 4 of 56 opportunities: -On 02/06/26 at 7:00am, FSBS was 94 and 3 units of insulin glargine should have been administered but 6 units of insulin glargine was documented as administered on the eMAR. -On 02/09/26 at 7:00am, FSBS was 97 and 3 units of insulin glargine should have been administered but 6 units of insulin glargine was documented as administered on the eMAR.	D 358		

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D 358	Continued From page 8 -On 02/12/26 at 7:00am, FSBS was 100 and 3 units of insulin glargine should have been administered but 6 units of insulin glargine was documented as administered on the eMAR. -On 02/22/26 at 7:00am, FSBS was 99 and 3 units of insulin glargine should have been administered but 6 units of insulin glargine was documented as administered on the eMAR. -There was no additional notes for the amount of insulin glargine administered for 02/06/26, 02/09/26, 02/12/26, and 02/22/26. Observation of medications available for administration for Resident #1 on 03/18/26 at 10:56am revealed insulin glargine was available for administration and was dispensed on 02/15/26. Telephone interview with a representative from the facility's contracted pharmacy on 03/19/26 at 11:54am revealed: -Resident #1 had an active order for a insulin glargine 100 unit/mL pen inject 6 units twice daily, check FSBS if BS is 100 or less only give 3 units. -Resident #1's insulin glargine pen was dispensed on 02/15/26 and on 03/04/26. Interview with Resident #1's primary care provider (PCP) on 03/18/26 at 12:30pm revealed: -She did not know there were errors with Resident #1's insulin administration in January 2026 and in February 2026. -She had no concerns related to low blood sugars for Resident #1 but she expected the medication aides (MA) to administer Resident #1's insulin as she had ordered according to the FSBS values. Telephone interview with Resident #1's guardian on 03/19/26 at 11:15am revealed: -The MAs completed Resident #1's FSBS	D 358		

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D 358	Continued From page 9 frequently every day and sometimes her insulin changes. -She was not sure how much insulin Resident #1 received but she felt Resident #1 received insulin every day. -She had no concerns and was not aware if Resident #1 had any issues with low blood sugar levels. Interview with a MA on 03/18/26 at 11:20am revealed: -She was aware of Resident #1's insulin parameters and about her FSBS 2 times a day. -She was aware Resident #1's insulin parameters were for 6 units administered with BS levels above 100 and for 3 units administered with a BS level of 100 or less. -She was not aware Resident #1's insulin amounts were documented for 6 units instead of 3 units with BS levels of 100 or less for Residents #1 during January 2026 and February 2026. -The Resident Care Coordinator (RCC) and the Special Care Unit Coordinator (SCUC) were responsible for reviewing the eMAR audits but she had not been informed of any medication errors. Interview with another MA on 03/19/26 at 8:15am revealed: -Resident #1 had insulin and FSBS 2 times a day. -She was aware Resident #1's insulin parameters were for 6 units administered with BS levels above 100 and for 3 units administered with a BS level of 100 or less. -She was not aware Resident #1's insulin amounts were documented for 6 units instead of 3 units with BS levels of 100 or less for Residents #1 during January 2026 and February 2026. Interview with the SCUC on 03/19/26 at 8:22am	D 358		

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D 358	Continued From page 10 revealed: -She was aware Resident #1 had parameters but she was not sure of how many insulin units of were to be administered when Resident #1 BS values were 100 or less. -She expected MAs to administer Resident #1's insulin as ordered. -She did not see that Resident #1's insulin amounts were administered differently than the parameter requirements ordered by Resident #1's PCP. Interview with the RCC on 03/19/26 at 8:55am revealed: -She was aware of Resident #1's insulin parameters and about her FSBS 2 times a day because she had previously worked as an MA. -She was aware Resident #1's insulin parameters were for 6 units administered with BS levels above 100 and for 3 units administered with a BS level of 100 or less. -She was not aware Resident #1's insulin amounts were documented for 6 units instead of 3 units with BS levels of 100 or less for Residents #1 during January 2026 and February 2026. -She expected MAs to administer Resident #1's insulin as ordered by the PCP. Interview with the Administrator on 03/19/26 at 9:15am revealed she was not aware Resident #1's insulin amounts were documented for 6 units instead of 3 units with BS levels of 100 or less for Residents #1 during January 2026 and February 2026. Refer to the interview with the Special Care Unit Coordinator (SCUC) on 03/19/26 at 8:22am. Refer to the interview with the RCC on 03/19/26 at 8:55am.	D 358		

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D 358	Continued From page 11 Refer to the interview with the Administrator on 03/19/26 at 9:15am. Refer to the interview with the Regional Operations Specialist on 03/19/26 at 2:35pm. Based on observations and interviews it was determined Resident #1 was not interviewable. Interview with the Special Care Unit Coordinator (SCUC) on 03/19/26 at 8:22am revealed she and the RCC were responsible for auditing the eMARs for exceptions daily. Interview with the RCC on 03/19/26 at 8:55am revealed: -She and the SCUC were responsible for auditing the eMARs for exceptions daily but she had not been able to complete eMAR audits because she had been the RCC only for two weeks now. -She expected MAs to administer any resident's insulin as ordered by the PCP. Interview with the Administrator on 03/19/26 at 9:15am revealed: -The RCC was responsible for auditing the Assisted Living (AL) residents' eMARs monthly and the SCUC was responsible for auditing the SCU residents' eMARs monthly. -The SCUC was responsible to ensure medication errors were addressed with SCU MAs and corrected. -She expected MAs to administer insulin as ordered by the provider. -She indicated the Regional Operations Specialist would be interviewable in her absence later today (03/19/26). Interview with the Regional Operations Specialist	D 358		

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D 358	Continued From page 12 03/19/26 at 2:35pm revealed: -The RCC, MAs and the Administrator all completed eMAR audits. -The MAs completed eMAR audits every other week and the RCC and the Administrator completed eMAR audits monthly.	D 358		