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GOLDSBORO ASSISTED LIVING & ALZHEIMEI	2201 ROYALE AVENUE GOLDSBORO, NC 27534

(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 and Wayne County Department of Social Services conducted an annual survey on 04/29/26 through 05/01/26.	D 000		
D 079	10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the Special Care Unit (SCU) was free of hazards in 3 resident rooms including toiletries, cigarettes, and disinfectant spray that were accessible to residents on the SCU. The findings are: Review of the facility's license revealed: -The facility was licensed for a capacity of 56 with a capacity of 24 residents approved for the Special Care Unit (SCU) effective 01/01/26. -The expiration date of the facility's license was	D 079		

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D 079	Continued From page 1 12/31/26. Review of the facility's census on 04/29/26 revealed the facility's census in the SCU was 20 residents and there were 12 residents on the Assisted Living (AL) unit. Observation of resident room 112 on 04/29/26 at 8:48am revealed: -The room had two beds and two residents resided in that room. -There was a small refrigerator on top of a nightstand at the entrance of the room. -The side of the refrigerator door had two shelves. -There were two disposable razors on the top shelf on the side of the refrigerator door. -There were two shelves inside the refrigerator. -The top shelf of the refrigerator had a half pint of milk with a sell by date of 01/15, there was no year listed on the sell by date. -There was one loose cigarette on the top shelf of the refrigerator behind a 16 ounce bottle of soft drink. -There was a pack of cigarettes on the second shelf of the refrigerator with approximately 18 cigarettes in the pack. -There were five loose cigarettes behind two small bottles of water on the bottom shelf. -There was one loose cigarette on the nightstand beside the small refrigerator. -There were two 2.6 ounce deodorant sticks in a plastic zip up bag on the nightstand. -There was no lighter observed in the resident's room. Based on observations, interviews, and record reviews, it was determined that the two residents who resided in Room 112 were not interviewable.	D 079		

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D 079	Continued From page 2 Observation of resident room 102 on 04/29/26 at 8:657am revealed: -There was a 12.5 ounce can of aerosol disinfectant spray on the back of the toilet tank in a bathroom that was shared by two residents. -There was a warning to keep out of reach of children. Based on observations, interviews, and record reviews, it was determined that the two residents who resided in Room 102 were not interviewable. Interview with a personal care aide (PCA) on 04/29/26 at 9:19am revealed: -Residents on the SCU were not supposed to have toiletries, cleaning products, or cigarettes in their room because they were considered a hazard to residents. -Toiletries and cleaning products were supposed to remain locked in a storage room where each resident had a tote with their own personal care products. -The medication aides (MA) kept resident's cigarettes on the medication cart locked. -All hazards were supposed to be locked in the storage room to prevent residents from ingesting items they were not supposed to ingest which could cause them harm. Observation of the PCA on 04/29/26 at 9:22am revealed: -She entered resident room 112 and removed two disposable razors, cigarettes, soap, and milk from the room and placed them in storage room. -She took the resident's cigarettes to the MA. Observation of the PCA on 04/29/26 at 9:26am revealed she removed an aerosol spray can of disinfectant and a bar of soap from the bathroom for room 102 and took it to the locked storage	D 079		

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D 079	Continued From page 3 room and secured it. Interview with a housekeeping staff person on 04/29/26 at 9:29am revealed if she ever noticed toiletries or cleaning supplies in a resident's room she removed them and gave them to the MA so they could lock them up in the appropriate storage room. Interview with a medication aide (MA) on 05/01/26 at 1:56pm revealed: -Personal care items, cleaning supplies,and cigarettes should not be in residents rooms on the SCU. -These items were considered hazards and personal care items, cleaning supplies, and fingernail clippers were supposed to be locked in a storage area on the SCU. -The MAs kept resident's cigarettes on the medication carts locked. -PCAs were expected to check each resident room daily during their shift to ensure there were no hazards in resident's rooms. -The locked storage room had resident's totes with their name on the tote that contained all of their personal care items. Interview with the Resident Care Coordinator (RCC) on 05/01/26 at 2:27pm revealed: -Toiletries and cleaning products were supposed to remain locked in the storage area until PCAs needed to use the resident's labeled tote to provide personal care. -After PCAs provided personal care, they were expected to return the resident's personal tote to the locked storage area. -The MAs kept cigarettes and lighters locked on the medication cart. -Toiletry items and cleaning products were supposed to be secured to prevent residents from	D 079		

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D 079	Continued From page 4 accidentally ingesting the products. -She was not aware of any residents that had a history of attempting to ingest toiletries or cleaning supplies. -The PCAs were expected to look during their shift for any items that residents were not supposed to have in their rooms. -She was not sure how there was a partial pack of cigarettes and loose cigarettes in room 112. -The PCAs should have found them, taken them to the MA and reported it to the MA. Interview with the Administrator on 05/01/26 at 3:07pm revealed: -PCAs and MAs were expected to remove any toiletries, cleaning products or any other hazards from residents rooms on the SCU if they observed any. -Toiletries and cleaning supplies were supposed to be locked in the storage room on the SCU where each resident had their individual plastic tote with their toiletries. -She thought a family member had brought the aerosol can of disinfectant spray that was found in the bathroom for room 102. -Residents were not allowed to keep their own cigarettes on the SCU, all cigarettes and lighters were locked on the MA cart. -The PCAs or the MAs should have found the cigarettes in room 112 and it should not have been overlooked. -She expected the PCAs and MAs to ensure resident's safety on the SCU and ensure there were no hazards that could harm the residents on the SCU.	D 079		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident	D 164		

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D 164	Continued From page 5 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure 1 of 6 sampled medication aide (MA) (Staff D) completed training on the care of diabetic residents prior to administering insulin. The findings are: Review of Staff B's personnel record revealed: -Staff B was hired as a medication aide (MA) on 02/12/26.	D 164		

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D 164	Continued From page 6 -There was no documentation Staff B had completed training on the care of the diabetic resident prior to administering insulin. Review of March 2026 electronic medication administration records (eMAR) revealed there was documentation Staff D administered insulin on 03/13/26 through 03/16/26, 03/20/26 , 03/23/26, 03/26/26, 03/28/26, and on 03/29/26 through 03/30/26. Review of April 2026 eMAR revealed administered insulin on 04/03/26, 04/09/26, on 04/11/26 through 04/12/26, on 04/16/26 through 04/17/26, 04/20/26, 04/23/26, 04/25/26 through 04/26/26, and on 04/28/26 through 04/29/26. Interview with the Administrator on 05/01/26 at 1:15pm revealed: -Staff D administered medications, including insulin, independently. -Staff D had not completed training for the care of diabetic residents. -Staff D was medication skills competency validated for injection by an Registered Nurse on 02/19/26. -She thought the medication skills competency was enough for Staff D to be allowed to administer insulin. Attempted telephone interview with Staff D on 05/01/26 at 8:29 was unsuccessful.	D 164		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.	D 273		

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D 273	Continued From page 7 This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure referral and follow-up for 2 of 5 sampled residents (#1 and #5) including referrals for venous doppler ultrasound, labs, gastroenterology and a bone density test (#1) and failed to notify a resident's primary care provider (PCP) that the resident's finger stick blood sugar (FSBS) was less than 60. The findings are: Review of the facility's undated referral and follow-up policy revealed: -The facility was to assure documentation and implementation of procedures, treatments and orders from physicians and other licensed health professionals. -The Resident Care Coordinator (RCC) was to review all orders that came in for residents via FL-2, doctor's visits, faxes, etc, for any new or changed orders. -All new/changed orders were to be implemented as written. -Any order that required follow-up (with the physician) or referral that was written was to be carried out. -The referral/follow-up will be added to the referral/follow-up form with specific information to ensure follow-up was completed per order. -The outcome of the referral was to be documented, and any new order was to be followed. 1. Review of Resident #1's FL-2 dated 02/11/26 revealed:	D 273		

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-Diagnoses included closed head trauma, hypertension, history of positive PPD, encephalopathy, obesity, and left hemiparesis.

Review of Resident #1's Resident Register revealed he was admitted to the facility on 11/01/00

a. Review of Resident #1's primary care provider (PCP) evaluation dated 02/11/26 revealed:
-Resident #1 was being seen for his annual wellness exam.
-A representative from the facility attended Resident #1's appointment.
-Resident #1 had swelling in both legs, left greater than right, and was referred for venous doppler ultrasound of bilateral lower extremities to rule out possible deep vein thrombosis (DVT).
-There was a finding of left calf firmness compared to the right side.
-Resident #1 was having difficulty wearing shoes on his left foot due to swelling.
-Resident #1 had limited mobility, primarily using his right foot for movement.

Review of Resident #1's PCP notes to the facility dated 02/11/26 revealed:
-Resident #1 had edema in both legs that was worse on the left.
-Chronic venous insufficiency was suspected and DVT needed to be ruled out.
-There was a referral for bilateral lower extremity venous doppler ultrasound.

Observation of Resident #1's legs on 04/30/26 at 3:40pm revealed there was bilateral lower extremity swelling noted with the left leg larger than the right.

Interview with Resident #1 on 04/30/26 at 3:35pm

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revealed:
-His left leg ached every now and then, but it was no big deal.
-His legs were swollen for a time.

Telephone interview with the front desk supervisor at Resident #1's venous doppler ultrasound provider's office on 05/01/26 at 8:11am revealed:
-They received a referral in February, 2026 from Resident #1's PCP.
-They were trying to confirm which leg needed imaging with the PCP.
-Resident #1's appointment was not scheduled yet and they were reaching out to the PCP's office for clarification.
-They called the assisted living facility on 02/12/26 and left a voice message about scheduling Resident #1's appointment.
-There was no note that the facility called back.
-The assisted living facility called them back yesterday (04/30/26) about the venous doppler ultrasound.
-The referral they had was written for right and left leg venous doppler ultrasound.

Interview with the Resident Care Coordinator (RCC) on 04/30/26 at 2:25pm revealed:
-The hospital or PCP must send the referrals for the residents to the specialists.
-The facility could not call the specialists.

Interview with the RCC on 04/30/26 at 2:55pm revealed:
-She did not know what a DVT was.
-They did not contact the providers to ask if the referrals were sent.

Interview with the RCC on 04/30/26 at 4:30pm revealed:

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-She called the PCP today and spoke with an assistant.
-A venous doppler ultrasound referral was sent 02/11/26 by the PCP to Resident #1's venous doppler ultrasound provider.
-She called the venous doppler ultrasound provider today and they had a left leg venous doppler ultrasound order, but not a right leg venous doppler ultrasound order and the venous doppler ultrasound provider would call her back.

Interview with the RCC on 05/01/26 at 10:40am revealed:
-She called Resident #1's venous doppler ultrasound provider today.
-They received a new order and Resident #1 had an appointment booked for a venous doppler ultrasound on 05/13/26.

Interview with the Administrator on 04/30/26 2:20pm revealed:
-She did not know if Resident #1's venous doppler ultrasound was done and would have to call the PCP.
-Any referrals came from the provider's office, so the facility waited for contact from the PCP or specialists.
-The facility could not send referrals to the specialists, and it must go through the provider's office.
-The specialists would not talk to the facility about the residents.
-All the facility could do was to wait for the appointment to be set up.

Interview with the Administrator on 04/30/26 at 2:45pm revealed:
-The referrals to specialists could not be sent by the facility.
-It could take months for the specialists to make

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contact to the facility and let them know that the appointment was scheduled.
-Resident #1 needed three-day notice for transport due to his wheelchair and requiring a transport van booking.
-She could not say how urgent the venous doppler ultrasound was, and the facility staff were not doctors, so they could not set it up.
-The PCP's staff needed to set up the venous doppler ultrasound immediately if it was required to be immediate.

Interview with the Administrator on 05/01/26 at 3:07pm revealed:
-The referral and follow-up tracking form needed to be changed to help staff.
-There was not a form for Resident #1.

Telephone interview with Resident #1's PCP on 04/30/26 at 3:46pm revealed:
-Resident #1 was seen for an annual wellness visit on 02/11/26.
-Resident #1 was referred for a venous doppler ultrasound to rule out a DVT.
-He tried to get things set up right away.
-He told the facility, if you have not heard from the specialist provider in 7 days then contact the PCP and they would contact the specialist provider.
-If things did not get done it was not because of any delay at the PCP's office.
-If there was a delay in investigating a DVT that was extremely concerning.
-A DVT was a blood clot which could cause swelling, pain and further damage.
-A Homan's test was performed on Resident #1 and he documented left calf firmness.
-Venous insufficiency was possible for Resident #1.

b. Review of Resident #1's primary care provider

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D 273	Continued From page 12 (PCP) evaluation dated 02/11/26 revealed: -Resident #1 was being seen for his annual wellness exam. -A representative from the facility attended Resident #1's appointment. -Resident #1 had microcytic anemia and hypoalbuminemia. -Resident #1 was referred for updated labs with vitamin D level, comprehensive metabolic panel, and complete blood count with iron studies. -Resident #1 was to have labs completed by an external laboratory provider prior to his next visit. -Resident #1 was to follow up in one month to review the results of his laboratory work. Review of Resident #1's lab order dated 02/11/26 revealed: -There was an order for hemoglobin A1C (hemoglobin A1C is an indication of a person's average blood glucose for the past 3 months). -There was an order for complete blood count with differential (a complete blood count can be used to help diagnose infections, illnesses, or diseases). -There was an order for a lipid panel. -There was an order for a comprehensive metabolic panel. -There was an order for a prostate specific antigen (prostate specific antigen is tested to screen for prostate cancer). -There was an order for thyroid-stimulating hormone (TSH) with reflex to T4 (Thyroxine) (These are laboratory tests of thyroid function). -There was an order for Vitamin D 25-hydroxy. -There was an order for Vitamin B-12. -There was an order for Folate. -There was an order for Ferritin. -There was an order for an iron study for iron deficiency anemia. -The labs were to be drawn when Resident #1	D 273		

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D 273	Continued From page 13 was fasting. Review of Resident #1's hospital discharge summary dated 03/13/26 revealed: -Resident #1 was admitted on 03/04/26 and discharged on 03/13/26. -Resident #1 had discharge diagnoses of sepsis due to urinary tract infection, acute kidney injury, and newly diagnosed diabetes mellitus type 2-insulin requiring. -Resident #1 presented with generalized weakness, altered mental status and elevated blood glucose. -Resident #1 had blood glucose of 510 mg/dL on admission and a hemoglobin level of 10g/dL. -Resident #1's blood glucose improved to 423 mg/dL after administration of insulin. -Resident #1 had a mildly elevated beta-hydroxybutyrate level of 1.6 mmol/L (Beta-hydroxybutyrate is a test which can help determine if diabetic ketoacidosis is present where values less than 0.6 mmol/L are normal and values greater than 3.0 mmol/L can be found in diabetic ketoacidosis). -Resident #1's lactate was initially 2.4 and he was given 1 liter of fluid and it improved to 2.1 (lactate is a test which can help identify patients with sepsis and which can be tracked to help measure the improvement of patients with sepsis). -Resident #1's kidney function got worse during the hospitalization, likely in the setting of antibiotics used to treat his infection. -After a change in medication his renal function was gradually improving. -Pertinent test results were Hemoglobin A1c of 13 and Creatinine of 1.67 at discharge (A Hemoglobin A1c of 13 indicates an average blood sugar of greater than 300 over the past three months and Creatinine can help provide an estimate of kidney function).	D 273		

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D 273	Continued From page 14 -A follow-up basic metabolic panel was needed to monitor Resident #1's renal function. Review of Resident #1's PCP evaluation dated 03/19/26 revealed: -Resident #1 had newly diagnosed diabetes and required close monitoring and glycemic control. -Resident #1's kidney function required ongoing surveillance given recent acute kidney injury. Interview with a medication aide (MA) on 04/30/26 at 8:30am revealed: -Resident #1 was not himself when he went to the hospital. -Resident #1 could not remember where he sat in the dining room and had decreased strength to help with transfers. -The kitchen staff and MA noted a change in Resident #1's behavior the evening before the hospital admission. -She sent Resident #1 out to the hospital the next morning and received a report at shift change from the other MA. -Shift change reports could be verbal, but there might be a shift report document. Interview with the RCC on 04/29/26 at 12:00pm revealed: -Resident #1's labs ordered 02/11/26 were never performed. -She called the PCP's office, and the labs were listed as pending, so they had not been done. -The resident's labs on his 03/13/26 hospital discharge paperwork were the labs that had been done. Interview with the RCC on 04/29/26 at 3:00pm revealed: -There was not a basic metabolic panel completed as per the discharge summary.	D 273		

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-The PCP's office and the facility were responsible for getting the labs done.
-If a provider wants labs done, he must send the referral to a lab provider, but if a referral was given to her then she would book the labs.
-The 02/11/26 order for labs should have been scheduled.
-It was her responsibility to call the PCP's office and book the lab appointments.
-It was an oversight to not get the 02/11/26 labs done.
-The labs ordered on 02/11/26 and 03/13/26 should be done within one or two weeks after they were ordered.

Interview with the RCC on 05/01/26 at 8:39am revealed she attended Resident #1's appointment on 02/11/26.

Interview with the Administrator on 05/01/26 at 3:07pm revealed:
-The referral and follow-up tracking form needed to be changed to help staff.
-There was not a form for Resident #1.

Telephone interview with Resident #1's PCP on 04/30/26 at 3:46pm revealed:
-Resident #1 was seen for an annual wellness visit on 02/11/26.
-He tried to get things set up right away.
-The facility should coordinate to come back for an appointment for labs within 24 hours.
-He told the facility, if they had not heard from the specialist provider in 7 days then contact the PCP and the PCP will contact the specialist provider.
-If things did not get done it was not because of any delay at the PCP's office.
-The value of the A1C was that it was an indication of the average blood sugar for 3 months.

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-The delay in lab work ordered on 02/11/26 could cause diabetic ketoacidosis which could alter mentation and need to be addressed right away.

c. Review of the facility shift report for 1st shift on 03/01/26 revealed Resident #1 was having trouble standing and aides had to help him off the toilet.

Review of the facility shift report for first shift dated 03/02/26 revealed:
-It was noted that Resident #1 complained of burning when urinating and may have a urinary tract infection (UTI).
-The sheet was signed by the medication aide (MA).

Review of the facility shift report dated 03/03/26 for first shift revealed Resident #1 was "still not acting right."

Review of the facility shift report for 03/04/26 revealed Resident #1 was admitted to the hospital.

Review of Resident #1's facility progress note dated 03/04/26 revealed:
-At 8:20am Resident #1 had altered mental status and was unable to stand.
-Resident #1 complained of burning when urinating.
-Emergency medical services were called to transport Resident #1 to the hospital by ambulance.

Review of Resident #1's hospital discharge summary dated 03/13/26 revealed:
-Resident #1 was admitted on 03/04/26 and discharged on 03/13/26.
-Resident #1 had discharge diagnoses of sepsis

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due to urinary tract infection, acute kidney injury, and newly diagnosed insulin dependent diabetes mellitus.
-Resident #1 presented with generalized weakness, altered mental status and elevated blood glucose.

Interview with a medication aide (MA) on 04/30/26 at 8:30am revealed:
-Resident #1 was not himself when he went to the hospital.
-Resident #1 could not remember where he sat in the dining room and had decreased strength to help with transfers.
-The kitchen staff and MA noted a change in Resident #1's behavior the evening before the hospital admission.
-She sent Resident #1 out to the hospital the next morning and received a report at shift change from the other MA.
-Shift change reports could be verbal, but there might be a shift report document.

A second interview with the MA on 04/30/26 at 1:05pm revealed:
-She let the Resident Care Coordinator (RCC) know about Resident #1's burning with urination on 03/02/26.
-She thought the RCC made an appointment with the PCP.
-The RCC would contact the doctor regarding the symptoms of burning with urination.

Interview with the Administrator on 04/30/26 2:20pm revealed:
-When Resident #1's symptoms were noted, the facility kept an eye on Resident #1 for a day and sent him to the hospital the next day.
-Resident #1's PCP was contacted after Resident #1 was hospitalized.

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d. Review of Resident #1's primary care provider (PCP) evaluation dated 02/11/26 revealed:
-Resident #1 was being seen for his annual wellness exam.
-A representative from the facility attended Resident #1's appointment.
-Resident #1 had microcytic anemia and hypoalbuminemia.
-Resident #1 was referred to gastroenterology for colonoscopy and esophagogastroduodenoscopy (EGD) to investigate his iron deficiency anemia.
-Resident #1 had constipation with abdominal tenderness on examination.
-Resident #1 was given guaiac cards for stool occult blood testing.

Review of Resident #1's PCP notes to the facility dated 02/11/26 revealed there was a referral for "EGD/Colonoscopy" (EGD and colonoscopy are tests performed by a gastroenterologist).

Interview with the RCC on 04/30/26 at 2:25pm and 4:30pm revealed:
-The hospital or PCP must send the referrals for the residents to the specialists.
-The facility could not call the specialists.
-She called the PCP today and spoke with an assistant.
-Resident #1's colonoscopy was denied because the resident was not ambulatory.

Interview with the RCC on 05/01/26 at 8:39am revealed:
-She attended Resident #1's appointment on 02/11/26.
-She did not remember any discussion of guaiac cards to test for blood in the stool.

Interview with the RCC on 05/01/26 at 9:45am

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revealed:
-Resident #1's was referred to a gastroenterology provider who could not accept him because he was non-ambulatory.
-She would have to speak with the PCP about the gastroenterology referral.

Interview with the Administrator on 04/30/26 2:20pm revealed:
-Any referrals come from the provider's office, so the facility waits for contact from the PCP or specialists.
-The facility could not send referrals to the specialists, and it must go through the provider's office.
-The specialists would not talk to the facility about the residents.
-All the facility could do was to wait for the appointment to be set up.

Interview with the Administrator on 04/30/26 at 2:45pm revealed:
-It could take months for the specialists to make contact to the facility and let them know that the appointment was scheduled.
-Resident #1 needed three-day notice for transport due to his wheelchair and requiring a transport van booking.

Interview with the Administrator on 05/01/26 at 3:07pm revealed:
-The referral and follow-up tracking form needed to be changed to help staff.
-There was not a form for Resident #1.

Telephone interview with a gastroenterology provider's office staff on 05/01/26 at 9:57am revealed:
-The office received Resident #1's referral and spoke with the assisted living facility on 02/25/26.

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-They learned that Resident #1 was not able to transfer or change his clothing without assistance.
-They could not provide any lifting assistance at their office.
-They told the facility that the referral needed to be faxed to a different gastroenterology provider.

Telephone interview with Resident #1's PCP on 04/30/26 at 3:46pm revealed:
-Resident #1 was seen for an annual wellness visit on 02/11/26.
-Resident #1 was referred for gastroenterology due to iron deficiency anemia.
-He told the facility, if you have not heard from the specialist provider in 7 days then contact the PCP and they would contact the specialist provider.
-If things did not get done it was not because of any delay at the PCP's office.
-Any time there were signs of anemia there could be a GI bleed with dark stools and the EGD could identify if there was bleeding.
-Guaiac cards could identify occult blood in the stool.
-Two cards were given on 02/11/26 and there were no results.

e. Review of Resident #1's primary care provider (PCP) evaluation dated 02/11/26 revealed:
-Resident #1 was being seen for his annual wellness exam.
-A representative from the facility attended Resident #1's appointment.
-Resident #1 had microcytic anemia and hypoalbuminemia.
-Resident #1 was referred for a dual-energy x-ray absorptiometry (DEXA) test (DEXA is a test to assess bone mineral density and bone quality).
-Resident #1's bone density may be compromised due to his hypoalbuminemia and

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D 273	Continued From page 21 limited mobility. Interview with the Resident Care Coordinator (RCC) on 04/30/26 at 2:25pm and 4:30pm revealed: -The facility could not call the specialists. -She called the PCP today and spoke with an assistant. -The office did not have Resident #1's DEXA in their paperwork. Interview with the RCC on 05/01/26 at 10:40am and 2:27pm revealed: -She called Resident #1's venous doppler ultrasound provider today. -Resident #1's referral for a DEXA scan was sent to another provider. -The venous doppler ultrasound provider told her that the DEXA referral would need to be sent by the PCP to a different provider. Interview with the Administrator on 04/30/26 2:20pm and 2:45pm revealed: -Any referrals come from the provider's office, so the facility waits for contact from the PCP or specialists. -The facility could not send referrals to the specialists, and it must go through the provider's office. -The specialists would not talk to the facility about the residents. -All the facility could do was to wait for the appointment to be set up. -The referrals to specialists could not be sent by the facility. -It could take months for the specialists to make contact to the facility and let them know that the appointment was scheduled. -Resident #1 needed three-day notice for transport due to his wheelchair and requiring a	D 273		

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D 273	Continued From page 22 transport van booking. Interview with the Administrator on 05/01/26 at 3:07pm revealed: -The referral and follow-up tracking form needed to be changed to help staff. -There was not a form for Resident #1. Telephone interview with Resident #1's PCP on 04/30/26 at 3:46pm revealed: -Resident #1 was seen for an annual wellness visit on 02/11/26. -For Resident #1's DEXA scan the facility needed to call and set up the appointment, and the referral was sent by the provider. -For some services an appointment was not required, but an appointment was required for a DEXA scan. -The facility performing the DEXA had to call the facility. -He told the facility, if you have not heard from the specialist provider in 7 days then contact the PCP and they would contact the specialist provider. -If things did not get done it was not because of any delay at the PCP's office. Telephone interview with the local imaging center on 05/01/26 at 11:01am revealed there was not a referral or an appointment made for Resident #1. 2. Review of the facility's undated Blood Sugar policy revealed: -Blood sugar checks will be completed according to policy and physician orders as specified. -If blood sugar is below 60, repeat the blood sugar test. -If blood sugar is still below 60, give 4 ounces of orange juice or other beverage (house supplement) and hold the scheduled dose of insulin until blood sugar is 60 or above. -Repeat the blood sugar test in 30 minutes.	D 273		

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D 273	Continued From page 23 -If the blood sugar reading is still 60 or below, monitor for signs and symptoms of hypoglycemia, notify physician and intervene as appropriate. -If the resident is unresponsive and unable to take anything by mouth, call 911. -If blood sugar is 350 or above, repeat the test. -If the 2nd reading is 350 or above, administer insulin as ordered and recheck in one hour. -If the reading remains 350 or above, contact the resident's physician. -Observe for signs and symptoms of hyperglycemia and intervene as appropriate, contact 911 if needed. Review of Resident #5's FL-2 dated 04/22/26 revealed: -Diagnoses included Type II diabetes, dementia, and chronic kidney disease. -There was an order for Novolog administer four times a day based on sliding scale insulin (SSI), if finger stick blood sugar (FSBS) was 201-250 administer 4 units of insulin, 251-300 administer 6 units of insulin, 301-350 administer 8 units of insulin, 351-400 administer 10 units of insulin, if FSBS is less than 60 or greater than 450 notify the primary care provider (PCP) (Novolog is a fast acting insulin). Review of Resident #5's physician order for dated 01/24/26 revealed there was an order to check the residents finger stick blood sugars (FSBSs) before meals at 6:00am, 12:00pm, and 4:00pm. Review of Resident #5's February 2026 electronic medication administration record (eMAR) revealed: -There was an entry to check FSBS three times a day, scheduled for 6:00am, 12:00pm, and 4:00pm. -There was an entry for Novolog Flexpen 100	D 273		

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unit/mL, check FSBS three times daily before meals and inject per SSI 201-250, 4 units of insulin, 251-300, 6 units of insulin, 301-350, 8 units of insulin, and 351-400, 10 units of insulin.
-If FSBS was less than 60 or great than 450, notify the PCP.
-There was an entry on 02/12/26 at 4:30pm that Resident #5's FSBS was 49.

Review of Resident #5's progress notes for 02/12/26 revealed there was no documentation that staff notified the resident's PCP of her FSBS reading of 49 at 4:30pm.

Review of the facility's shift reports for 02/12/26 revealed there was no documentation that staff notified the resident's PCP of her FSBS reading of 49 at 4:30pm.

Review of Resident #5's March 2026 eMAR revealed:
-There was an entry to check FSBS three times a day, scheduled for 6:00am, 12:00pm, and 4:00pm.
-There was an entry for Novolog Flexpen 100 unit/mL, check FSBS three times daily before meals and inject per SSI 201-250, 4 units of insulin, 251-300, 6 units of insulin, 301-350, 8 units of insulin, and 351-400, 10 units of insulin.
-If FSBS was less than 60 or great than 450, notify the PCP.
-There was an entry on 03/12/26 at 4:30pm that Resident #5's FSBS was 51.

Review of Resident #5's progress notes for 03/12/26 revealed there was no documentation that staff notified the resident's PCP of her FSBS reading of 51 at 4:30pm.

Review of the facility shift reports for 03/12/26

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D 273	Continued From page 25 revealed there was no documentation that staff notified the resident's PCP of her FSBS reading of 51 at 4:30pm. Interview with a medication aide (MA) on 05/01/26 at 1:56pm revealed: -MAs were expected to follow physician orders when there were parameters to notify the physician if a FSBS was less than 60 or over 400. -When a resident's FSBS was less than 60 and there were orders to notify the physician MAs should call the physician, if they were unable to reach the physician they should leave a message and also fax the physician. -MAs should document on a progress note or shift report that the resident's physician was notified of a FSBS less than 60. -He did not work on the days that the resident's FSBS was less than 60 and did not understand why the MAs that worked those days did not have documentation that they notified the resident's physician. Interview with the Resident Care Coordinator (RCC) on 05/01/26 at 2:27pm revealed: -When a resident had FSBS parameters ordered by their physician, the MAs were expected to place a written notification in her folder which was placed under her door. -She would notify the physician of the FSBS being below or above the parameter the following day. -The MAs were not expected to notify the physician when there was a FSBS reading outside of the parameters. -If she had a notification from a MA in her office the next morning she called the physician, left a message if she was unable to speak with the physician directly and sent a fax to the physician's office. -MAs were expected to follow the Blood Sugar	D 273		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDSBORO ASSISTED LIVING & ALZHEIMEI	2201 ROYALE AVENUE GOLDSBORO, NC 27534

(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 273	Continued From page 26	D 273		

policy which included to repeat the FSBS if the resident's blood sugar was less than 60, give 4 ounces of orange juice and hold scheduled insulin.
-She had not thought about having the MAs notify the resident's physician when their FSBS was outside of parameters and there was an order to notify the physician, she just thought she could notify the physician the next morning.
-She completed a progress note or a shift report when she notified the resident's physician of a FSBS outside of parameters.
-The MAs must have forgotten to notify her that Resident #5's FSBS was less than 60 on two occasions because she was not aware that the resident's FSBS had dropped as low as 49 and 51.
-She usually completed chart audits of the eMAR and would have caught the low FSBS for Resident #5 but she had not completed a chart audit since December 2025.
-Resident #5 was at risk of a diabetic coma or stroke when her FSBS was less than 60 and the resident's physician was not notified as ordered.

Interview with the Administrator on 05/01/26 at 3:07pm revealed:
-She expected MAs to notify a resident's primary care provider (PCP) immediately if they had an order to notify the PCP when their FSBS was outside of parameters.
-She did not agree with the MAs notifying the RCC so that the RCC could notify the resident's PCP the next morning of a FSBS below 60.
-The MAs should notify Resident #5's PCP immediately when her FSBS was below 60 because that is what the PCP ordered.
-If the MAs were unable to reach the PCP by telephone, they were expected to send a fax that the resident's FSBS was outside of parameters

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D 273	Continued From page 27 and document in the resident's progress note or shift report. -The PCP needed to know what was going on with a resident's FSBS so they knew how to treat their diabetes and make changes in medications if necessary. Attempted telephone interview with Resident #5's PCP on 04/29/26 at 4:20pm, 04/30/26 at 3:30pm and 05/01/26 at 1:30pm were unsuccessful. _____ The facility failed to ensure referral and follow-up for 2 sampled residents including a resident who had referrals for venous doppler ultrasound to rule out deep vein thrombosis which could have caused pain or further damage, labs when the patient was found to have HgA1c of 13 and blood sugar of 513 placing him at risk for diabetic ketoacidosis, gastroenterology to follow up on anemia, a bone density scan, and signs and symptoms of infection including weakness and altered mental status (#1). The facility failed to notify the primary care provider (PCP) regarding low blood sugar levels for a resident with poorly controlled diabetes which put her at risk of hypoglycemia (#5). This failure placed the residents at substantial risk for serious physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/30/26 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 31, 2026.	D 273		

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D 344	Continued From page 28	D 344		
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 orders for 1 of 5 sampled residents related to medications for spasticity and allergies (Resident #1). The findings are: Review of Resident #1's FL-2 dated 02/11/26 revealed diagnoses included closed head trauma, hypertension, history of positive PPD, encephalopathy, obesity, and left hemiparesis. Review of Resident #1's FL-2 dated 03/13/26 revealed diagnoses included hemiparesis of the left side, history of closed head injury, anemia, hypertension, benign prostate hyperplasia, diabetes, hypercholesterolemia. a. Review of Resident #1's FL-2 dated 02/11/26	D 344		

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revealed there was an order for Baclofen 10mg 1 tab twice daily (Baclofen is medication given to treat spasticity, muscle spasms or musculoskeletal pain).

Review of Resident #1's hospital discharge summary dated 03/13/26 revealed there was an order to discontinue Baclofen 10mg.

Review of Resident #1's pharmacy omission order clarification form dated 03/19/26 revealed:
-Medications listed on the form were unclear or not listed on the current orders or FL-2.
-The form asked whether the orders for the listed medications were to be continued or discontinued.
-Baclofen 10mg was to continue as ordered.

Review of Resident #1's physician order sheet dated 04/15/26 revealed there was an order for Baclofen 10mg take one tablet twice a day at 9:00am and 9:00pm as needed (PRN) without specification of indication.

Review of Resident #1's March 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for Baclofen 10mg take one tablet twice a day discontinued on 03/13/26.
-There was an entry for Baclofen 10mg take one tablet twice a day PRN with no specified indication for use with a start date of 03/19/26.

Review of Resident #1's April 2026 eMAR revealed there was an entry for Baclofen 10mg take one tablet twice a day PRN with no specified indication for use.

Observation of Resident #1's medications on hand on 04/29/26 at 3:45pm revealed:

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D 344	Continued From page 30 -There was a card of Resident #1's Baclofen 10mg tablets on hand with 30 doses remaining of 30 which were dispensed on 03/19/26. -There were instructions on the card of Resident #1's Baclofen 10mg to take one tablet twice a day as needed without specification of indication. Telephone interview with quality assurance staff from the facility's contracted pharmacy on 04/30/26 at 8:39am revealed: -Resident #1's current Baclofen order was for 10mg one tablet twice daily as needed. -There was no indication for use listed on the order for Resident #1's PRN Baclofen. -There was no Baclofen on Resident #1's FL-2 dated 03/13/26. -An omission clarification form was sent by the pharmacy to Resident #1's primary care provider (PCP) and they faxed it back on 03/19/26. -There were directions on the 03/19/26 clarification form to continue Baclofen 10mg PRN. -There was no specification of the indication on the omission clarification form. -There was no other communication about the Baclofen. Interview with a medication aide (MA) on 04/29/26 at 3:45pm revealed: -She did not know what the PRN Baclofen indication was. -She thought it was for his urinary retention, to help him go to the bathroom. -To figure it out she would look on his eMAR or in his chart for the order. -She would call the doctor if the order did not specify the indication for use. -The eMAR should require MA's to match the reason a medication was given to the provider's order.	D 344		

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D 344	Continued From page 31 -That function was not working for Resident #1's Baclofen. -Nobody had given Resident #1's Baclofen this month. Interview with a second MA on 04/30/26 at 8:30am revealed: -If a PRN indication for use was not on the eMAR she would go to the chart to check the indication for use. -She would mention it to the Resident Care Coordinator (RCC) as well. -Resident #1 never requested his Baclofen. -She did not know what it was for and would have to look it up. -The RCC handled orders. -The pharmacy puts entries on the eMAR and the RCC and MA's would approve the entries. -If an order needed to be clarified she would not approve the eMAR entry and she would contact the provider. -The initials of the person who approved the Baclofen entry should be on the eMAR. -She was not sure if she would approve the Baclofen PRN eMAR entry because Resident #1 had been on the medication previously. Interview with a third MA on 05/01/26 at 1:55pm revealed: -If a medication was to be given PRN then it should state the indication on the eMAR entry. -If no indication was listed MAs could get clarification from the doctor on what the medication was for. Interview with the RCC on 04/30/26 at 9:00am revealed she sent for the PCP to clarify Resident #1's Baclofen today (04/30/26). Refer to interview with the RCC on 05/01/26 at	D 344		

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D 344	Continued From page 32 2:27pm. Refer to interview with the Administrator on 05/01/26 at 3:07pm. b. Review of Resident #1's primary care provider (PCP) notes to the facility dated 03/19/26 revealed Resident #1 was to start Azelastine nasal spray, but there was no specification of dose, frequency, or indication for use (Azelastine nasal spray is medication used to treat seasonal or perennial allergy symptoms). Review of Resident #1's PCP evaluation dated 03/19/26 revealed Resident #1 had light upper airway congestion and nasal congestion per the physical exam. Review of Resident #1's March 2026 electronic medication administration record (eMAR) revealed there was not an entry for Azelastine. Review of Resident #1's April 2026 eMAR revealed there was not an entry for Azelastine. Telephone interview with quality assurance staff from the facility's contracted pharmacy on 04/30/26 at 8:39am revealed the pharmacy did not have an order for Azelastine for Resident #1. Interview with a MA on 04/30/26 at 8:30am revealed: -She had never administered Azelastine for Resident #1. -The Resident Care Coordinator (RCC) handled orders. Interview with the RCC on 04/30/26 at 9:00am revealed she sent for the PCP to clarify Resident #1's Azelastine today (04/30/26).	D 344		

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D 344	Continued From page 33 Refer to interview with the RCC on 05/01/26 at 2:27pm. Refer to interview with the Administrator on 05/01/26 at 3:07pm. _____ Interview with the Resident Care Coordinator (RCC) on 05/01/26 at 2:27pm revealed: -She had not done chart audits lately. -The last time she did one was probably in December 2025. -Pharmacy would create the eMAR entry, she would compare the eMAR entry to the order and approve the eMAR entry if it was accurate. -She would try to identify indications for use with PRN medications and clarify with the provider. Interview with the Administrator on 05/01/26 at 3:07pm revealed: -The RCC was responsible for clarifying orders that came into the facility. -If the pharmacy asked for clarification the RCC was responsible to contact the PCP for clarification. -The RCC was responsible to deal with the providers and the pharmacy, but after hours the MA's could do it.	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	D 358		

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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 for 2 of 5 sampled residents including medication to control blood sugar (#1) and a medication used to treat infection (#3).

The findings are:

1. Review of Resident #3's current FL-2 dated 09/16/25 revealed:
-Diagnoses included cellulitis of the right lower extremity, diabetes and hydrocephalus.
-She was semi-ambulatory and there was no information regarding orientation status.

Review of Resident #3's Resident Register revealed she was admitted to the facility on 02/10/23.

Review of Resident #3's physician's visit summary dated 04/08/26 revealed:
-The visit for an acute visit that was conducted via telehealth and no in-person exam was conducted.
-Resident #3's family member noticed a large warm, shiny reddened area on Resident #3's right hip and a separate 4-6 inch reddened area on the back right upper thigh.
-Resident #3 previously diagnosed with cellulitis that started at the hip and spread down the leg.
-Pictures of the affected area were uploaded to Resident #3's chart by the facility and were concerning for cellulitis and antibiotics were prescribed.
-There was a physician's order for Cephalexin

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D 358	Continued From page 35 500mg, 1 tablet to be administered four times a day for 10 days. (Cephalexin is an antibiotic medication used to treat infection.) Review of Resident #3's electronic medication administration record (eMAR) for April 2026 revealed: -There was an electronic entry for Cephalexin 500mg, take 1 tablet four times a day for 10 days and scheduled for 8:00am, 12:00pm, 4:00pm and 8:00pm. -There was documentation Cephalexin 500mg was administered at 8:00am, 12:00pm, 4:00pm and 8:00pm on 04/09/26 through 04/15/26. -There was documentation Cephalexin 500mg was administered at 8:00am, 12:00pm and 4:00pm on 04/16/26 but was not administered at 8:00pm because the medication course was finished. -There was documentation Cephalexin 500mg was administered at 8:00am on 04/17/26 but was not administered at 12:00pm, 4:00pm and 8:00pm because the medication course was finished. -There was documentation Cephalexin 500mg was administered at 8:00am, 4:00pm and 8:00pm on on 04/18/26 but was not administered at 12:00pm because Resident #3 was done with the medication. -There was documentation 5 of 40 doses were not administered as ordered. Review of a packing slip from the facility's contracted pharmacy dated 04/08/26 revealed 40 tablets of Cephalexin 500mg was sent the facility. Observation of Resident #3's medications on hand for administration on 04/30/26 at 12:50pm revealed there were no Cephalexin 500mg tablets available.	D 358		

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D 358	Continued From page 36 Interview with Resident #3 on 04/30/26 at 9:30am revealed: -She had cellulitis in the past and thought it was sometime in 2025. -She did not remember taking any antibiotics in the last few months. -She denied pain or swelling of her right hip or thigh. Telephone interview with a pharmacy technician for the facility's contracted pharmacy 0n 04/30/26 at 10:07am revealed: -They received an electronic prescription on 04/08/26 for Resident #3 to take Cephalexin 500mg four times a day for 10 days. -A quantity of 40 tablets were dispensed on 04/08/26 and delivered to the facility at 12:43am on 04/09/26. Interview with a medication aide (MA) on 04/30/26 at 12:54pm revealed: -Resident #3's Cephalexin was dispensed in 2 cards. -One card of 20 tablets was placed on the medication cart and the other card of 20 tablets was placed in a cabinet with back-up medications. -The cards were labeled "1 of 2" and "2 of 2" at the top of each card. -She thought a MA thought the medication was ended once the first card was completed and the MA did not check for the second card in the back-up supply. -When she returned to work, she found a dispensing card of Cephalexin on the cart but the medication was not popping up during administration times. -There were 5 tablets in the card labeled "2 of 2". -She reported to the Resident Care Coordinator	D 358		

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D 358	Continued From page 37 (RCC) who instructed her to continue administering the antibiotic until it was gone but the administration was not documented. Interview with the RCC on 04/30/26 at 2:25pm revealed: -Two dispensing cards of 20 tablets were delivered to the facility for Resident #3. -One was placed on the cart and the other in overstock cabinet. -She did not remember which MA got the second card from back-up but a MA did report to her that antibiotics were on the card but no longer on the eMAR to document administration. -She told the MA to finish administration of the course of antibiotic because the resident needed to finish the medication in order to effectively treat the infection. -She did not give instructions on where to document. Interview with the Administrator on 05/01/26 at 3:07pm revealed: -The RCC was responsible for ensuring medications were available for administration. -The MA administering medications should have checked the overstock cabinet when the medication showed for administration and it was not on the cart. Attempted telephone interview with Resident #3's family member on 04/30/26 at 9:41am was unsuccessful. Attempted telephone interview with Resident #3's primary care provider (PCP) on 04/30/26 at 12:30pm was unsuccessful. 2. Review of Resident #1's FL-2 dated 03/13/26 revealed:	D 358		

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-Diagnoses included hemiparesis of the left side, history of closed head injury, anemia, hypertension, benign prostate hyperplasia, diabetes, hypercholesterolemia.
-There was an order for Lantus 20 units subcutaneously twice daily (Lantus is long-acting insulin which can be used to control blood sugar).

Review of Resident #1's hospital discharge summary dated 03/13/26 revealed:
-Resident #1 had discharge diagnoses of sepsis due to urinary tract infection, acute kidney injury, and newly diagnosed diabetes mellitus type 2-insulin requiring.
-Pertinent test results included Hemoglobin A1c of 13.
-Resident #1 presented with generalized weakness, altered mental status and elevated blood glucose.
-Resident #1 had blood glucose of 510 mg/dL on admission.
-There was an order for Lantus 20 units subcutaneously twice daily.

Review of Resident #1's primary care provider (PCP) evaluation dated 03/19/26 revealed there was an order to continue Lantus 20 units subcutaneous twice daily for diabetes management.

Review of Resident #1's physician order sheet dated 04/15/26 revealed there was an order for Lantus injection 100/ml inject 20 units subcutaneously twice a day with instructions to prime the pen with 2 units prior to each use.

Review of Resident #1's March 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for Lantus injection 100/ml

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(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
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inject 20 units subcutaneously twice a day with instructions to prime the pen with 2 units prior to each use, scheduled at 7:00am and 8:00pm.
-Lantus 20 units was documented as administered at 7:00am daily from 03/14/26 to 03/27/26 and from 03/29/26 to 03/31/26.
-Lantus 20 units was documented as administered at 8:00pm daily from 03/13/26 to 03/31/26.
-Lantus was documented as not administered at 7:00am on 03/28/26 with reason that the medication was not in from pharmacy.

Review of Resident #1's April 2026 eMAR revealed:
-There was an entry for Lantus injection 100/ml inject 20 units subcutaneously twice a day with instructions to prime the pen with 2 units prior to each use, scheduled at 7:00am and 8:00pm.
-Lantus 20 units was documented as administered at 7:00am daily from 04/01/26 to 04/30/26.
-Lantus 20 units was documented as administered at 8:00pm daily from 04/01/26 to 04/29/26.

Observation of medications on hand on 04/29/26 at 3:45pm revealed there was no Lantus available for administration for Resident #1.

Second observation of medications on hand on 04/30/26 at 8:17am revealed:
-There were two Lantus pens available for Resident #1.
-The unused pen was refrigerated.
-The open pen had a dispense date of 04/29/26 and an open date of 04/30/26.

Telephone interview with quality assurance staff from the facility's contracted pharmacy on

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D 358	Continued From page 40 04/30/26 at 8:39am revealed: -There was an order for Resident #1's Lantus 20 units to be given twice daily. -Resident #1's Lantus was dispensed on 03/13/26, 03/28/26, 04/13/26, and 04/29/26 for a quantity of 6ml on each date. -A quantity of 6ml meant there were two 3ml insulin pens dispensed each time. -Resident #1's Lantus was signed for at the facility at 11:18pm on 04/29/26. -6ml was a 15 day supply, so each 6ml dispensed should last 15 days. -The facility sent a request for refill of Resident #1's Lantus yesterday morning (04/29/26) at 7:48am and sent a duplicate request in the evening. Second telephone interview with quality assurance staff from the facility's contracted pharmacy on 04/30/26 at 3:20pm revealed: -Resident #1's Lantus dispensed on 03/13/26 arrived 03/13/26 at 11:43pm -Resident #1's Lantus dispensed on 03/28/26 arrived on 03/28/26 at 8:04pm -Resident #1's Lantus dispensed on 04/13/26 arrived on 04/13/26 at 11:41pm -Resident #1's Lantus dispensed on 04/29/26 arrived on 04/29/26 at 11:18pm Interview with a medication aide (MA) on 04/29/26 at 3:45pm revealed: -There was no Lantus in the building for Resident #1. -Resident #1 was supposed to receive Lantus at 8:00pm so she would call the pharmacy right now. Interview with a second MA on 04/30/26 at 8:30am revealed: -The pharmacy was sending one Lantus pen at a	D 358		

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time, so MA's had to pay attention when pens got low.
-It seemed like they had run out of Resident #1's Lantus before.
-Resident #1 received Lantus in the morning and at night

Interview with a third MA on 05/01/26 at 1:55pm revealed:
-Each medication cart may be checked to make sure all medications were on the cart daily or every other day.
-To audit the insulin staff must check what time it was brought in and the date that it was opened because it was good for about 28 days.
-If an insulin pen was half-way used, he would pull a sticker that could be faxed to the pharmacy for a refill.
-If the pharmacy received the refill request by 2:00pm it would arrive by that night.
-Every time he was on the cart Resident #1's insulin was available.
-The eMAR should reflect the basis of what's been given.
-If MA's ran out of a medication they should document it as not administered or not in the building.
-MA's could inform the physician that doses were missed and the physician could advise on how to address the missed doses.

Interview with the Resident Care Coordinator (RCC) on 04/30/26 at 8:19am revealed Resident #1's Lantus arrived last night (04/29/26), about 11:00pm or 11:30pm.

Telephone interview with Resident #1's PCP on 04/30/26 at 3:46pm revealed:
-Lantus was a long-acting insulin which could bring the blood sugar down slowly.

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D 358	Continued From page 42 -Lantus was prescribed to control Resident #1's blood sugar, and it was necessary. Interview with the RCC on 05/01/26 at 2:27pm revealed: -She had not done chart audits lately. -The last time she did one was probably in December. -It was important for the eMAR to be accurate to show that medication was given as ordered. -The staff did not give Lantus on the evening of 04/29/26 and that was false documentation. Interview with the Administrator on 05/01/26 at 3:07pm revealed: -The RCC was responsible to make sure that medications were on the cart. -MA's could notify the RCC that the medication was low and pull stickers used for refill requests. -The RCC was responsible to deal with the providers and the pharmacy, but after hours the MA's could do it. -A sticker for refill should be pulled when there were seven days of medication remaining. -The RCC was responsible to audit the cart for the medication supply. -Cart audits were to be performed monthly due to the facility's batch supply system which runs 27-28 days, and should be done one to two weeks before the batch changes. -Resident #1's Lantus was not a batch medication. -The diabetic cart should be audited periodically for diabetic supplies and insulin at least monthly. -If the eMAR said to give the medication but it was not available then staff should document that it was not administered and document the reason it was not given. -The eMAR needed to be accurate.	D 358		

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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 document medications as given for 2 of 5 sampled residents related to medication used to control blood sugar (#1) and a medication used to treat infection (#3). The findings are: 1. Review of Resident #3's current FL-2 dated	D 367		

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09/16/25 revealed:
-Diagnoses included cellulitis of the right lower extremity, diabetes and hydrocephalus.
-She was semi-ambulatory and there was no information regarding orientation status.

Review of Resident #3's Resident Register revealed she was admitted to the facility on 02/10/23.

Review of Resident #3's physician's visit summary dated 04/08/26 revealed:
-The visit for an acute visit that was conducted via telehealth and no in-person exam was conducted.
-Resident #3's family member noticed a large warm, shiny reddened area on Resident #3's right hip and a separate 4-6 inch reddened area on the back right upper thigh.
-Resident #3 was previously diagnosed with cellulitis that started at the hip and spread down the leg.
-Pictures of the affected area were uploaded to Resident #3's chart by the facility and were concerning for cellulitis and antibiotics were prescribed.
-There was a physician's order for Cephalexin 500mg, 1 tablet to be administered four times a day for 10 days.

Review of Resident #3's electronic medication administration record for April 2026 revealed:
-There was an electronic entry for Cephalexin 500mg, take 1 tablet four times a day for 10 days and scheduled for 8:00am, 12:00pm, 4:00pm and 8:00pm.
-There was documentation Cephalexin 500mg was administered at 8:00am, 12:00pm, 4:00pm and 8:00pm on 04/09/26 through 04/15/26.
-There was documentation Cephalexin 500mg was administered at 8:00am, 12:00pm and

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4:00pm on 04/16/26 but was not administered at 8:00pm because the medication course was finished.
-There was documentation Cephalexin 500mg was administered at 8:00am on 04/17/26 but was not administered at 12:00pm, 4:00pm and 8:00pm because the medication course was finished.
-There was documentation Cephalexin 500mg was administered at 8:00am, 4:00pm and 8:00pm on on 04/18/26 but was not administered at 12:00pm because Resident #3 was done with the medication.
-There was documentation 5 of 40 doses were not administered as ordered.

Review of a packing slip from the facility's contracted pharmacy dated 04/08/26 revealed 40 tablets of Cephalexin 500mg was sent the facility.

Telephone interview with a pharmacy technician for the facility's contracted pharmacy 0n 04/30/26 at 10:07am revealed:
-They received an electronic prescription on 04/08/26 for Resident #3 to take Cephalexin 500mg four times a day for 10 days.
-A quantity of 40 tablets were dispensed on 04/08/26 and delivered to the facility at 12:43am on 04/09/26.

Interview with a medication aide on 04/30/26 at 12:54pm revealed:
-Resident #3's Cephalexin was dispensed in 2 cards.
-One card of 20 tablets was placed on the medication cart and the other card of 20 tablets was placed in a cabinet with back-up medications.
-The cards were labeled "1 of 2" and "2 of 2" at the top of each card.

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D 367	Continued From page 46 -She thought a MA thought the medication was ended once the first card was completed and the MA did not check for the second card in the back-up supply. -When she returned to work, she found a dispensing card of Cephalexin on the cart but the medication was not popping up during administration times. -There were 5 tablets in the care labeled "2 of 2". -She reported to the Resident Care Coordinator (RCC) who instructed her to continue administering the antibiotic until it was gone but the administration was not documented. Interview with the Resident Care Coordinator (RCC) on 04/30/26 at 2:25pm revealed: -Two dispensing cards of 20 tablets were delivered to the facility for Resident #3. -One was placed on the cart and the other in overstock cabinet. -She did not remember which MA got the second card from back-up but a MA did report to her that antibiotics were on the care but no longer on the eMAR to document administration. -She told the MA to finish administration of the course of antibiotic because the resident needed to finish the medication in order to effectively treat the infection. -She did not give instructions on where to document and the administration was not documented. Interview with the Administrator on 05/01/26 at 3:07pm revealed: -The RCC was responsible for ensuring medications were available for administration. -The eMARs should be accurate so the shows medications were administered as ordered. Attempted telephone interview with Resident #3's	D 367		

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primary care provider (PCP) on 04/30/26 at 12:30pm was unsuccessful.

2. Review of Resident #1's FL-2 dated 03/13/26 revealed:
-Diagnoses included hemiparesis of the left side, history of closed head injury, anemia, hypertension, benign prostate hyperplasia, diabetes, hypercholesterolemia.
-There was an order for Lantus 20 units subcutaneously twice daily (Lantus is long-acting insulin which can be used to control blood sugar).

Review of Resident #1's hospital discharge summary dated 03/13/26 revealed:
-Resident #1 had discharge diagnoses of sepsis due to urinary tract infection, acute kidney injury, and newly diagnosed diabetes mellitus type 2-insulin requiring.
-Pertinent test results included Hemoglobin A1c of 13.
-Resident #1 presented with generalized weakness, altered mental status and elevated blood glucose.
-Resident #1 had blood glucose of 510 mg/dL on admission.
-There was an order for Lantus 20 units subcutaneously twice daily.

Review of Resident #1's primary care provider (PCP) evaluation dated 03/19/26 revealed there was an order to continue Lantus 20 units subcutaneous twice daily for diabetes management.

Review of Resident #1's physician order sheet dated 04/15/26 revealed there was an order for Lantus injection 100/ml inject 20 units subcutaneously twice a day with instructions to prime the pen with 2 units prior to each use.

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D 367	Continued From page 48 Review of Resident #1's April 2026 eMAR revealed: -There was an entry for Lantus injection 100/ml inject 20 units subcutaneously twice a day with instructions to prime the pen with 2 units prior to each use, scheduled at 7:00am and 8:00pm. -Lantus 20 units was documented as administered at 7:00am on 04/13/26 and 04/29/26. -Lantus 20 units was documented as administered at 8:00pm on 04/13/26 and 04/29/26. Observation of medications on hand on 04/29/26 at 3:45pm revealed there was no Lantus available for administration for Resident #1. Second observation of medications on hand on 04/30/26 at 8:17am revealed: -There were two Lantus pens available for Resident #1. -The unused pen was refrigerated. -The open pen had a dispense date of 04/29/26 and an open date of 04/30/26. Telephone interview with quality assurance staff from the facility's contracted pharmacy on 04/30/26 at 8:39am revealed: -There was an order for Resident #1's Lantus 20 units to be given twice daily. -Resident #1's Lantus was dispensed on 03/13/26, 03/28/26, 04/13/26, and 04/29/26 for a quantity of 6ml on each date. -A quantity of 6ml meant there were two 3ml insulin pens dispensed each time. -Resident #1's Lantus was signed for at the facility at 11:18pm on 04/29/26. -6ml was a 15 day supply, so each 6ml dispensed should last 15 days.	D 367		

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D 367	Continued From page 49 -The facility sent a request for refill of Resident #1's Lantus yesterday morning (04/29/26) at 7:48am and sent a duplicate request in the evening. Second telephone interview with quality assurance staff from the facility's contracted pharmacy on 04/30/26 at 3:20pm revealed: -Resident #1's Lantus dispensed on 03/13/26 arrived 03/13/26 at 11:43pm -Resident #1's Lantus dispensed on 03/28/26 arrived on 03/28/26 at 8:04pm -Resident #1's Lantus dispensed on 04/13/26 arrived on 04/13/26 at 11:41pm -Resident #1's Lantus dispensed on 04/29/26 arrived on 04/29/26 at 11:18pm Interview with a medication aide (MA) on 04/29/26 at 3:45pm revealed: -There was no Lantus in the building for Resident #1. -Resident #1 was supposed to receive Lantus at 8:00pm so she would call the pharmacy right now. Interview with a second MA on 04/30/26 at 8:30am revealed: -It seemed like they had run out of Resident #1's Lantus before. -Resident #1 received Lantus in the morning and at night Interview with a third MA on 05/01/26 at 1:55pm revealed: -The eMAR should reflect the basis of what's been given. -If MA's ran out of a medication they should document it as not administered or not in the building. -MA's could inform the physician that doses were	D 367		

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D 367	Continued From page 50 missed and the physician could advise on how to address the missed doses. Interview with the Resident Care Coordinator (RCC) on 04/30/26 at 8:19am revealed Resident #1's Lantus arrived last night (04/29/26), about 11:00pm or 11:30pm. Interview with the RCC on 05/01/26 at 2:27pm revealed: -She had not done chart audits lately. -The last time she did one was probably in December. -It was important for the eMAR to be accurate to show that medication was given as ordered. -The staff did not give Lantus on the evening of 04/29/26 and that was false documentation. Interview with the Administrator on 05/01/26 at 3:07pm revealed: -If the eMAR said to give the medication but it was not available then staff should document that it was not administered and document the reason it was not given. -The eMAR needed to be accurate.	D 367		
D 610	10A NCAC 13F .1801(a) Infection Prevention & Control Policies & Pro 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL POLICIES AND PROCEDURES (a) In accordance with Rule .1211(a)(4) of this Subchapter and G.S. 131D-4.4A(b)(1), the facility shall establish and implement infection prevention and control policies and procedures consistent with the federal Centers for Disease Control and Prevention (CDC) published guidelines on infection prevention and control.	D 610		

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D 610	Continued From page 51 The Department shall approve a set of policies and procedures for infection prevention and control consistent with the federal CDC published guidelines on infection prevention and control that shall be made available on the Division of Health Service Regulation, Adult Care Licensure Section website at https://info.ncdhhs.gov/dhsr/acls/acforms.html at no cost. The facility shall either: (1) utilize the set of policies and procedures for infection prevention and control approved by the Department; (2) develop policies and procedures for infection prevention and control that are consistent with the set of Department approved policies and procedures; or (3) develop policies and procedures for infection prevention and control that are based on nationally recognized standards in infection prevention and control that are consistent with the federal CDC published guidelines on infection prevention and control. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record	D 610		

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(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 610	Continued From page 52	D 610		

reviews, the facility failed to implement infection control procedures for glucometers used to obtain fingerstick blood sugar (FSBS) readings for 5 of 5 residents (#1, #5, #6, #7, #8) in the facility with an order for FSBS monitoring.

The findings are:

Review of the facilities infection control and standard precautions for blood glucose monitoring and insulin administration policy dated 12/07/20 revealed:
-The purpose of the policy was to prevent bloodborne pathogen transmission during blood glucose monitoring and insulin administration and to assure proper disposal of single-use-equipment used to puncture skin, mucous membranes, and other tissues.
-Finger stick devices would never be used for more than one person.
-Each glucose meter should be labeled with the resident's name and blood glucose meter should not be shared.
-Staff should wear gloves during blood glucose monitoring, insulin administration and during any other procedure that involves potential exposure to blood or body fluids.
-Staff should change gloves between resident contacts.
-Staff should change gloves that have touched potentially blood-contaminated objects or finger stick wounds before touching clean surfaces.
-Staff should discard gloves in appropriate receptacles.
-Staff should perform hand hygiene immediately after removal of gloves and before touching other medical supplies intended for use on other people.

Review of the facilities undated glucometer policy

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D 610	Continued From page 53 revealed: -Each resident had their own glucometer. -Glucometers should not be shared and each glucometer should be labeled with the resident's name. -Each glucometer should be checked every 1-2 weeks and as needed to ensure it is working properly, the time and date were correct and the batteries were adequate. Review of manufacturer's user manual for Brand A glucometers revealed: -The cover of the user manual indicated that the Brand A glucometer was for single patient use only. -Pages 6-7 of the device user manual indicated that the device was intended for single patient use only and should not be shared with another person. -All parts of the device were considered biohazardous and could potentially transmit infectious diseases, even after pre-cleaning and disinfection was performed. -The device was not intended for use in healthcare or assisted-use settings such as hospitals, physician offices or long-term care facilities because it had not been cleared by the Food and Drug Administration (FDA) for use in these settings. -Use of the device on multiple patients could lead to the transmission of Human Immunodeficiency Virus (HIV), Hepatitis C Virus (HCV), Hepatitis B Virus (HBV), or other bloodborne pathogens. Public Health Notification use of fingerstick devices on more than one person poses risk for transmitting bloodborne pathogens. -Page 7 of the device manual referenced for further information refer to the Centers for Disease Control (CDC) use of fingerstick devices on more than one person poses risk for	D 610		

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D 610	Continued From page 54 transmitting bloodborne pathogens. Review of manufacturer's user manual for Brand B glucometers revealed: -The cover of the user manual indicated that the Brand B glucometer was for single patient use only. -Page 2 of the device manual indicated that the device was intended for single patient use only, and should not be shared. -Page 4 of the device manual indicated that during normal testing, any blood glucose meter may come in contact with blood, all parts of the kit are considered biohazardous and can potentially transmit infectious diseases from bloodborne pathogens, even after you have performed cleaning and disinfecting. -Page 4 of the device manual indicated that the glucometer should not be used by more than one person, the glucometer should not be shared with anyone, including family due to the risk of infection from bloodborne pathogens, do not use on multiple patients. -Page 4 of the device manual indicated that the glucometer if used on multiple patients, this may lead to transmission of Human Immunodeficiency Virus (HIV), Hepatitis C Virus (HCV), Hepatitis B Virus (HBV), or other bloodborne pathogens. Review of manufacturer's user manual for Brand C glucometers revealed: -Page 7 of the device manual indicated that the device was intended for single patient use only, and should not be shared. -Page 7 of the device manual indicated the glucometer should not be used to collect blood from more than one person. -Page 7 of the device manual indicated the glucometer should not be shared with anyone including family members and do not use on	D 610		

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D 610	Continued From page 55 multiple patients. -Page 7 of the device manual indicated the use of finger stick devices on more than one person poses risk for transmitting bloodborne pathogens. Review of manufacturer's user manual for Brand D glucometers revealed: -The cover of the user manual indicated that the Brand D glucometer was for single patient use only. -The meter device for use by a single person and should not be shared on page 6. -Use of the device on multiple patients could lead to the transmission of Human Immunodeficiency Virus (HIV), Hepatitis C Virus (HCV), Hepatitis B Virus (HBV), or other bloodborne pathogens on page 9. -The device was not to be shared with anyone including other family members. -The glucometer device was not to be used on multiple patents. 1. Review of Resident #1's FL-2 dated 03/13/26 revealed diagnoses included diabetes, anemia, and history of closed head injury. Review of a physician order dated 03/19/26 revealed there was an order to check the residents finger stick blood sugars (FSBS) at meals and bedtime. Review of Resident #1's physician orders dated 04/15/26 revealed there was an order to check FSBS before meals and at bedtime, at 6:00am, 12:00pm, 4:00pm, and 9:00pm. Review of Resident #1's glucometer history Brand C on 04/30/26 at 4:43pm revealed: -Resident #1's glucometer was in a black zipped cloth bag that had his name on the front.	D 610		

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D 610	Continued From page 56 -Resident #1's glucometer did not have his name labeled or written on the device. -Turning the glucometer on revealed the screen showed a current date of 04/30 and time of 4:27pm. -There was no year displayed with the date on the glucometer screen. -The following 23 finger stick blood sugar (FSBS) readings with the date, time, and FSBS readings for 7 days were on the glucometer. -There was a FSBS reading of 139 on 04/30 at 4:27pm. -There was a FSBS reading of 113 on 04/30 at 12:01pm. -There was a FSBS reading of 100 on 04/30 at 6:49am. -There was a FSBS reading of 107 on 04/30 at 6:46am. -There was a FSBS reading of 93 on 04/30 at 6:35am. -There was a FSBS reading of 183 on 04/29 at 4:14pm. -There was a FSBS reading of 125 on 04/29 at 4:09pm. -There was a FSBS reading of 114 on 04/29 at 11:57am. -There was a FSBS reading of 179 on 04/29 at 11:48am. -There was a FSBS reading of 92 on 04/29 at 6:18am. -There was a FSBS reading of 113 on 04/28 at 1:10pm. -There was a FSBS reading of 274 on 04/28 at 11:18am. -There was a FSBS reading of 118 on 04/28 at 11:14am. -There was a FSBS reading of 102 on 04/28 at 5:53am. -There was a FSBS reading of 129 on 04/27 at 6:34am.	D 610		

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D 610	Continued From page 57 -There was a FSBS reading of 157 on 04/26 at 8:02pm. -There was a FSBS reading of 271 on 04/26 at 7:49pm. -There was a FSBS reading of 176 on 04/26 at 3:37pm. -There was a FSBS reading of 265 on 04/26 at 11:18am. -There was a FSBS reading of 147 on 04/26 at 11:15am. -There was a FSBS reading of 98 on 04/26 at 6:32am. -There was a FSBS reading of 104 on 04/25 at 6:07am. -There was a FSBS reading of 134 on 04/24 at 6:43am. Review of Resident #1's April 2026 electronic medication administration record (eMAR) compared to the glucometer readings revealed: -There was an entry for FSBS check before meals and at bedtime. -There was an entry for FSBS checks at 6:00am, 12:00pm, 4:00pm, and 9:00pm. -FSBS was documented as 134 on 04/24/26 at 6:00am. -FSBS was documented as 120 on 04/24/26 at 12:00pm. -FSBS was documented as 400 on 04/24/26 at 4:00pm. -FSBS was documented as 341 on 04/24/26 at 9:00pm. -FSBS was documented as 104 on 04/25/26 at 6:00am. -FSBS was documented as 119 on 04/25/26 at 12:00pm. -FSBS was documented as 124 on 04/25/26 at 4:00pm. -FSBS was documented as 202 on 04/25/26 at 9:00pm.	D 610		

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D 610	Continued From page 58 -FSBS was documented as 96 on 04/26/26 at 6:00am. -FSBS was documented as 147 on 04/26/26 at 12:00pm. -FSBS was documented as 144 on 04/26/26 at 4:00pm. -FSBS was documented as 157 on 04/26/26 at 9:00pm. -FSBS was documented as 129 on 04/27/26 at 6:00am. -FSBS was documented as 156 on 04/27/26 at 12:00pm. -FSBS was documented as 174 on 04/27/26 at 4:00pm. -FSBS was documented as 174 on 04/27/26 at 9:00pm. -FSBS was documented as 102 on 04/28/26 at 6:00am. -FSBS was documented as 118 on 04/28/26 at 12:00pm. -FSBS was documented as 152 on 04/28/26 at 4:00pm. -FSBS was documented as 140 on 04/28/26 at 9:00pm. -FSBS was documented as 92 on 04/29/26 at 6:00am. -FSBS was documented as 114 on 04/29/26 at 12:00pm. -FSBS was documented as 125 on 04/29/26 at 4:00pm. -FSBS was documented as 129 on 04/29/26 at 9:00pm. -FSBS was documented as 93 on 04/30/26 at 6:00am. -FSBS was documented as 113 on 04/30/26 at 12:00pm. -There were 11 times from 04/24/26 to 04/30/26 that the April 2026 eMAR did not match the glucometer readings for Resident #1.	D 610		

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D 610	Continued From page 59 Refer to interview with a medication aide (MA) on 05/01/26 at 1:56pm. Refer to interview with the Resident Care Coordinator (RCC) on 05/01/26 at 2:27pm. Refer to interview with the Administrator on 05/01/26 at 3:07pm. 2. Review of Resident #5's FL-2 dated 04/22/26 revealed diagnoses included Type II diabetes, dementia, and chronic kidney disease. Review of Resident #5's physician order for dated 04/24/26 revealed there was an order to check the residents finger stick blood sugars (FSBSs) before meals at 6:00am, 12:00pm, and 4:00pm. Review of Resident #5's glucometer history Brand D on 04/30/26 at 4:05pm revealed: -Resident #5's glucometer was in a black zipped cloth bag that had her name on the front. -Resident #5's glucometer was labeled with the resident's name. -Turning the glucometer on revealed the screen showed a current date of 03/10 and time of 11:06am. -There was no year displayed with the date on the glucometer screen. -The following 22 FSBS readings with the date, time, and FSBS readings for 8 days were on the glucometer. -There was a FSBS reading of 161 on 03/10 at 11:06am. -There was a FSBS reading of 174 on 03/10 at 6:37am. -There was a FSBS reading of 89 on 03/10 at 1:20am. -There was a FSBS reading of 99 on 03/10 at 1:18am.	D 610		

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D 610	Continued From page 60 -There was a FSBS reading of 109 on 03/09 at 11:15am. -There was a FSBS reading of 74 on 03/09 at 1:07am. -There was a FSBS reading of 138 on 03/08 at 3:37pm. -There was a FSBS reading of 121 on 03/08 at 11:10am. -There was a FSBS reading of 184 on 03/08 at 5:53am. -There was a FSBS reading of 99 on 03/08 at 1:14am. -There was a FSBS reading of 114 on 03/07 at 11:47am. -There was a FSBS reading of 144 on 03/07 at 5:06am. -There was a FSBS reading of 260 on 03/04 at 4:49pm. -There was a FSBS reading of 130 on 03/03 at 1:21pm. -There was a FSBS reading of 153 on 03/03 at 11:06am. -There was a FSBS reading of 240 on 03/03 at 5:45am. -There was a FSBS reading of 142 on 03/02 at 10:46am. -There was a FSBS reading of 60 on 02/27 at 2:49pm. -There was a FSBS reading of 58 on 02/27 at 2:46pm. -There was a FSBS reading of 61 on 02/27 at 2:43pm. -There was a FSBS reading of 45 on 02/27 at 2:37pm. -There was a FSBS reading of 44 on 02/27 at 2:25pm. -There was a FSBS reading of 94 on 02/27 at 1:28am. Review of Resident #5's April 2026 electronic	D 610		

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D 610	Continued From page 61 medication administration record (eMAR) compared to glucometer readings revealed: -There was an entry for FSBS check before meals. -There was an entry for FSBS checks at 6:00am, 12:00pm, and 4:00pm. -FSBS was documented as 89 on 04/30/26 at 6:00am. -FSBS was documented as 174 on 04/30/26 at 12:00pm. -FSBS was documented as 161 on 04/30/26 at 4:00pm. -FSBS was documented as 74 on 04/29/26 at 6:00am. -FSBS was documented as 192 on 04/29/26 at 12:00pm. -FSBS was documented as 109 on 04/29/26 at 4:00pm. -FSBS was documented as 99 on 04/28/26 at 6:00am. -FSBS was documented as 184 on 04/28/26 at 12:00pm. -FSBS was documented as 121 on 04/28/26 at 4:00pm. -FSBS was documented as 92 on 04/27/26 at 6:00am. -FSBS was documented as 144 on 04/27/26 at 12:00pm. -FSBS was documented as 114 on 04/27/26 at 4:00pm. -FSBS was documented as 94 on 04/26/26 at 6:00am. -FSBS was documented as 168 on 04/26/26 at 12:00pm. -FSBS was documented as 113 on 04/26/26 at 4:00pm. -FSBS was documented as 128 on 04/25/26 at 6:00am. -FSBS was documented as 198 on 04/25/26 at 12:00pm.	D 610		

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-FSBS was documented as 144 on 04/25/26 at 4:00pm.
-FSBS was documented as 106 on 04/24/26 at 6:00am.
-FSBS was documented as 262 on 04/24/26 at 12:00pm.
-FSBS was documented as 137 on 04/24/26 at 4:00pm.
-FSBS was documented as 163 on 04/23/26 at 6:00am.
-FSBS was documented as 240 on 04/23/26 at 12:00pm.
-FSBS was documented as 153 on 04/23/26 at 4:00pm.
-There were 11 times from 04/23/26 to 04/30/26 that the April 2026 eMAR did not match the glucometer readings for Resident #5.

Refer to interview with a medication aide (MA) on 05/01/26 at 1:56pm.

Refer to interview with the Resident Care Coordinator (RCC) on 05/01/26 at 2:27pm.

Refer to interview with the Administrator on 05/01/26 at 3:07pm.

3. Review of Resident #6's current FL-2 dated 06/04/25 revealed:
-Diagnoses included Type II diabetes with diabetic neuropathy and epilepsy.
-She was constantly disoriented and ambulatory.
-There was an order to check blood sugar four times a day.

Review of Resident #6's physician's order dated 07/07/25 revealed there was an order to check blood sugar four times a day at 6:00am, 12:00pm, 4:00pm and 8:00pm.

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D 610	Continued From page 63 Review of Resident #6's glucometer history Brand D on 04/30/26 at 3:59pm compared to the April 2026 eMAR revealed: -The glucometer was stored inside a black zipped cloth bag and had a homemade vinyl label with Resident #6's first initial and last name affixed to the front of the device. -Turning the glucometer on revealed the screen showed a current date of 04/30 and time was 1:57pm. -There was no year displayed with the date on the glucometer screen. -There were FSBS readings of 202 at 6:42pm and 298 at 6:29pm on 04/25 when the April 2026 electronic medication administration record (eMAR) documentation revealed Resident #6 was in the hospital. -There was one FSBS reading on 04/19 at 4:11am. -There were no FSBS readings on the glucometer for 04/18. -There were two FSBS readings on 04/17 at 4:36am and 4:30am that did not match Resident #6's April 2026 eMAR. -There were two FSBS readings on 04/16 at 4:29am and 4:19am that did not match Resident #6's April 2026 eMAR. -There was one FSBS reading on 04/15 at 4:12am that did not match Resident #6's April 2026 eMAR. -There were no FSBS readings on the glucometer for 04/14. -There were no FSBS readings on the glucometer for 04/12. -There were no FSBS readings on the glucometer for 04/10. -There was one FSBS reading on 04/08 at 2:02pm that did not match the April 2026 eMAR. -There were no FSBS readings on Resident #6's glucometer for 04/01-04/06.	D 610		

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D 610	Continued From page 64 Review of Resident #6's electronic medication administration (eMAR) record for April 2026 compared to glucometer readings revealed: -There was an entry for finger stick blood sugar (FSBS) to be checked four times each day and scheduled for 6:00am, 12:00pm, 4:00pm and 8:00pm. -There was documentation FSBS were checked each day at 6:00am, 12:00pm, 4:00pm and 8:00pm on 04/01/26 through 04/21/26. -There was documentation FSBS were checked each day at 6:00am, 12:00pm, 4:00pm on 04/22/26. -There was documentation FSBS were not checked at 6:00am, 12:00pm, 4:00pm and 8:00pm on 04/23/26 through 04/30/26 because the resident remained in the hospital. -There was a FSBS reading of 82 on 04/19 at 6:00am. -There was a FSBS reading of 131 on 04/19 at 12:00pm. -There was a FSBS reading of 112 on 04/19 at 4:00pm. -There was a FSBS reading of 129 on 04/19 at 8:00pm. -There was a FSBS reading of 95 on 04/18 at 6:00am. -There was a FSBS reading of 177 on 04/18 at 12:00pm. -There was a FSBS reading of 177 on 04/18 at 4:00pm. -There was a FSBS reading of 177 on 04/18 at 8:00pm. -There was a FSBS reading of 111 on 04/17 at 6:00am. -There was a FSBS reading of 177 on 04/17 at 12:00pm. -There was a FSBS reading of 150 on 04/17 at 4:00pm.	D 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096031	A. BUILDING: _____ B. WING _____	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDSBORO ASSISTED LIVING & ALZHEIMEI	2201 ROYALE AVENUE GOLDSBORO, NC 27534

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D 610	Continued From page 65 -There was a FSBS reading of 87 on 04/17 at 8:00pm. -There was a FSBS reading of 92 on 04/16 at 6:00am. -There was a FSBS reading of 118 on 04/16 at 12:00pm. -There was a FSBS reading of 89 on 04/16 at 4:00pm. -There was a FSBS reading of 125 on 04/16 at 8:00pm. -There was a FSBS reading of 94 on 04/15 at 6:00am. -There was a FSBS reading of 115 on 04/15 at 12:00pm. -There was a FSBS reading of 85 on 04/15 at 4:00pm. -There was a FSBS reading of 85 on 04/15 at 8:00pm. -There was a FSBS reading of 98 on 04/14 at 6:00am. -There was a FSBS reading of 129 on 04/14 at 12:00pm. -There was a FSBS reading of 110 on 04/14 at 4:00pm. -There was a FSBS reading of 133 on 04/14 at 8:00pm. -There was a FSBS reading of 112 on 04/13 at 6:00am. -There was a FSBS reading of 108 on 04/13 at 12:00pm. -There was a FSBS reading of 133 on 04/13 at 4:00pm. -There was a FSBS reading of 133 on 04/13 at 8:00pm. -There was a FSBS reading of 109 on 04/12 at 6:00am. -There was a FSBS reading of 103 on 04/12 at 12:00pm. -There was a FSBS reading of 134 on 04/12 at 4:00pm.	D 610		

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 610	Continued From page 66 -There was a FSBS reading of 127 on 04/12 at 8:00pm. -There was a FSBS reading of 70 on 04/11 at 6:00am. -There was a FSBS reading of 98 on 04/11 at 12:00pm. -There was a FSBS reading of 136 on 04/11 at 4:00pm. -There was a FSBS reading of 103 on 04/11 at 8:00pm. -There was a FSBS reading of 92 on 04/10 at 6:00am. -There was a FSBS reading of 112 on 04/10 at 12:00pm. -There was a FSBS reading of 202 on 04/10 at 4:00pm. -There was a FSBS reading of 200 on 04/10 at 8:00pm. -There was a FSBS reading of 93 on 04/09 at 6:00am. -There was a FSBS reading of 92 on 04/09 at 12:00pm. -There was a FSBS reading of 132 on 04/09 at 4:00pm. -There was a FSBS reading of 132 on 04/09 at 8:00pm. -There was a FSBS reading of 106 on 04/08 at 6:00am. -There was a FSBS reading of 144 on 04/08 at 12:00pm. -There was a FSBS reading of 84 on 04/08 at 4:00pm. -There was a FSBS reading of 100 on 04/08 at 8:00pm. -There was a FSBS reading of 100 on 04/07 at 6:00am. -There was a FSBS reading of 129 on 04/07 at 12:00pm. -There was a FSBS reading of 134 on 04/07 at 4:00pm.	D 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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 610	Continued From page 67 -There was a FSBS reading of 134 on 04/07 at 8:00pm. -There was a FSBS reading of 88 on 04/06 at 6:00am. -There was a FSBS reading of 103 on 04/06 at 12:00pm. -There was a FSBS reading of 104 on 04/06 at 4:00pm. -There was a FSBS reading of 132 on 04/06 at 8:00pm. -There was a FSBS reading of 80 on 04/05 at 6:00am. -There was a FSBS reading of 152 on 04/05 at 12:00pm. -There was a FSBS reading of 123 on 04/05 at 4:00pm. -There was a FSBS reading of 158 on 04/05 at 8:00pm. -There was a FSBS reading of 96 on 04/04 at 6:00am. -There was a FSBS reading of 103 on 04/04 at 12:00pm. -There was a FSBS reading of 106 on 04/04 at 4:00pm. -There was a FSBS reading of 109 on 04/04 at 8:00pm. -There was a FSBS reading of 104 on 04/03 at 6:00am. -There was a FSBS reading of 104 on 04/03 at 12:00pm. -There was a FSBS reading of 143 on 04/03 at 4:00pm. -There was a FSBS reading of 128 on 04/03 at 8:00pm. -There was a FSBS reading of 94 on 04/02 at 6:00am. -There was a FSBS reading of 110 on 04/02 at 12:00pm. -There was a FSBS reading of 109 on 04/02 at 4:00pm.	D 610		

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D 610	Continued From page 68	D 610		

-There was a FSBS reading of 151 on 04/02 at 8:00pm.
-There was a FSBS reading of 96 on 04/01 at 6:00am.
-There was a FSBS reading of 135 on 04/01 at 12:00pm.
-There was a FSBS reading of 131 on 04/01 at 4:00pm.
-There was a FSBS reading of 131 on 04/01 at 8:00pm.
-There were 24 times from 04/01/26 to 04/25/26 that the April eMAR did not match the glucometer readings for Resident #6.

Refer to interview with a medication aide (MA) on 05/01/26 at 1:56pm.

Refer to interview with the Resident Care Coordinator (RCC) on 05/01/26 at 2:27pm

Refer to interview with the Administrator on 05/01/26 at 3:07pm.

4. Review of Resident #7's FL-2 dated 12/05/25 revealed:
-Diagnoses included type II diabetes and hypertension.
-There was an order to check finger stick blood sugars (FSBSs) three times a day.

Review of Resident #7's physician order dated 04/24/26 revealed there was an order to check the residents FSBS before meals and at bedtime at 6:00am, 11:30pm, 4:30pm, and 8:00pm.

Review of Resident #7's glucometer history Brand B on 04/30/26 at 3:57pm revealed:
-Resident #7's glucometer was in a black zipped cloth bag that had her name on the front.
-Resident #7's glucometer was labeled with the

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D 610	Continued From page 69 resident's name. -Turning the glucometer on revealed the screen showed a current date of 04/13/26 and time of 12:29am. -The following 16 FSBS readings with the date, time, and FSBS readings for 8 days were on the glucometer. -There was a FSBS reading of 101 on 04/13 at 12:29am. -There was a FSBS reading of 118 on 04/07 at 12:36am. -There was a FSBS reading of 256 on 03/19 at 5:47am. -There was a FSBS reading of 90 on 03/19 at 5:46am. -There was a FSBS reading of 117 on 03/18 at 10:41am. -There was a FSBS reading of 208 on 03/18 at 10:37am. -There was a FSBS reading of 117 on 03/17 at 3:00pm. -There was a FSBS reading of 259 on 03/17 at 10:07am. -There was a FSBS reading of 104 on 03/16 at 3:15pm. -There was a FSBS reading of 144 on 03/15 at 2:41pm. -There was a FSBS reading of 111 on 03/15 at 2:35pm. -There was a FSBS reading of 230 on 03/15 at 1:41pm. -There was a FSBS reading of 102 on 03/15 at 10:32am. -There was a FSBS reading of 186 on 03/15 at 10:21am. -There was a FSBS reading of 51 on 03/12 at 9:36am. -There was a FSBS reading of 143 on 03/12 at 12:23am.	D 610		

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D 610	Continued From page 70 Review of Resident #7's April 2026 electronic medication administration record (eMAR) compared to glucometer readings revealed: -There was an entry for FSBS check before meals and at bedtime. -There was an entry for FSBS checks at 6:00am, 11:30am, 4:30pm, and 8:00pm. -FSBS was documented as 107 on 04/30/26 at 6:00am. -FSBS was documented as 88 on 04/30/26 at 11:30am. -FSBS was documented as 113 on 04/29/26 at 6:00am. -FSBS was documented as 179 on 04/29/26 at 11:30am. -FSBS was documented as 183 on 04/29/26 at 4:30pm. -FSBS was documented as 184 on 04/29/26 at 8:00pm. -FSBS was documented as 161 on 04/28/26 at 6:00am. -FSBS was documented as 274 on 04/28/26 at 11:30am. -FSBS was documented as 237 on 04/28/26 at 4:30pm. -FSBS was documented as 123 on 04/28/26 at 8:00pm. -FSBS was documented as 173 on 04/27/26 at 6:00am. -FSBS was documented as 230 on 04/27/26 at 11:30am. -FSBS was documented as 112 on 04/27/26 at 4:30pm. -FSBS was documented as 112 on 04/27/26 at 8:00pm. -FSBS was documented as 160 on 04/26/26 at 6:00am. -FSBS was documented as 265 on 04/26/26 at 11:30am. -FSBS was documented as 179 on 04/26/26 at	D 610		

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D 610	Continued From page 71	D 610		

4:30pm.
-FSBS was documented as 271 on 04/26/26 at 8:00pm.
-FSBS was documented as 119 on 04/25/26 at 6:00am.
-FSBS was documented as 238 on 04/25/26 at 11:30am.
-FSBS was documented as 134 on 04/25/26 at 4:30pm.
-FSBS was documented as 298 on 04/25/26 at 8:00pm.
-FSBS was documented as 138 on 04/24/26 at 6:00am.
-FSBS was documented as 232 on 04/24/26 at 11:30am.
-FSBS was documented as 183 on 04/24/26 at 4:30pm.
-FSBS was documented as 183 on 04/24/26 at 8:00pm.
-FSBS was documented as 155 on 04/23/26 at 6:00am.
-FSBS was documented as 258 on 04/23/26 at 11:30am.
-FSBS was documented as 247 on 04/23/26 at 4:30pm.
-FSBS was documented as 252 on 04/23/26 at 8:00pm.
-There were 30 times from 04/23/26 to 04/30/26 that the April 2026 eMAR did not match the glucometer readings for Resident #7.

Refer to interview with a medication aide (MA) on 05/01/26 at 1:56pm.

Refer to interview with the Resident Care Coordinator (RCC) on 05/01/26 at 2:27pm.

Refer to interview with the Administrator on 05/01/26 at 3:07pm.

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D 610	Continued From page 72 5. Review of Resident #8's FL-2 dated 04/23/26 revealed: -Diagnoses included type II diabetes, chronic kidney disease, hypertension, and morbid obesity. -There was an order to check finger stick blood sugars (FSBS) one time a day. Review of Resident #8's physician order dated 04/23/26 revealed there was an order to check the resident's FSBS once a day at 6:00am. Review of Resident #8's glucometer history Brand C on 04/30/26 at 4:37pm revealed: -Resident #8's glucometer was in a black zipped cloth bag that had her name on the front. -Resident #8's glucometer was labeled with the resident's name. -Turning the glucometer on revealed the screen showed a current date of 01/24 and time of 6:03pm. -There was no year on the glucometer display screen. -The following 18 FSBS readings with the date, time, and FSBS readings for 6 days were on the glucometer. -There was a FSBS reading of 88 on 01/24 at 6:03pm. -There was a FSBS reading of 103 on 01/23 at 12:14pm. -There was a FSBS reading of 113 on 01/23 at 12:07pm. -There was a FSBS reading of 128 on 01/23 at 3:39am. -There was a FSBS reading of 123 on 01/23 at 3:02am. -There was a FSBS reading of 140 on 01/23 at 2:33am. -There was a FSBS reading of 152 on 01/22 at 10:07pm.	D 610		

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D 610	Continued From page 73 -There was a FSBS reading of 237 on 01/22 at 10:01pm. -There was a FSBS reading of 161 on 01/22 at 12:13pm. -There was a FSBS reading of 105 on 01/22 at 12:02pm. -There was a FSBS reading of 173 on 01/21 at 12:40pm. -There was a FSBS reading of 100 on 01/21 at 12:29pm. -There was a FSBS reading of 160 on 01/20 at 12:47pm. -There was a FSBS reading of 117 on 01/20 at 12:03pm. -There was a FSBS reading of 167 on 01/20 at 1:14am. -There was a FSBS reading of 134 on 01/19 at 9:55pm. -There was a FSBS reading of 124 on 01/19 at 9:50pm. -There was a FSBS reading of 92 on 01/19 at 12:11pm. Review of Resident #8's April 2026 electronic medication administration record (eMAR) compared to glucometer readings revealed: -There was an entry for FSBS checks once a day. -There was an entry for FSBS checks at 6:00am. -FSBS was documented as 100 on 04/30/26 at 6:00am. -FSBS was documented as 103 on 04/29/26 at 6:00am. -FSBS was documented as 105 on 04/28/26 at 6:00am. -FSBS was documented as 100 on 04/27/26 at 6:00am. -FSBS was documented as 117 on 04/26/26 at 6:00am. -FSBS was documented as 92 on 04/25/26 at 6:00am.	D 610		

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D 610	Continued From page 74 -There were 13 times from 04/25/26 to 04/30/26 that the April 2026 eMAR did not match the glucometer readings for Resident #8. Refer to interview with a medication aide (MA) on 05/01/26 at 1:56pm. Refer to interview with the Resident Care Coordinator (RCC) on 05/01/26 at 2:27pm. Refer to interview with the Administrator on 05/01/26 at 3:07pm. 6. Review of the house glucometer (Brand A) on 05/01/26 at 8:07am compared to the April 2026 eMARs for Residents #1, #6 and #7 revealed: -The glucometer was stored inside a black zipped cloth bag and had a homemade vinyl label with the initials "H.S." affixed to the front of the device. -Turning the glucometer on revealed the screen showed a current date of 03/31 and time was 5:59am. -There was no year displayed with the date on the glucometer screen. -There were FSBS readings on 03/27 of 156 at 9:03am, 230 at 9:05am, 174 at 2:06pm and 112 at 2:17pm. -There were FSBS readings on 03/24 of 234 at 9:07am, 120 at 9:09am, "HI" at 2:10pm, 391 at 2:13pm and 183 at 2:15pm. (According to the user manual for Brand A glucometer, "HI" meant the FSBS reading was greater than 600.) -There were FSBS readings on 03/22 of 96 at 9:25am, 185 at 9:26am, 161 at 1:37pm and 309 at 1:38pm. -There were FSBS readings on 03/21 of 229 at 8:57pm, 142 at 8:59am 103 at 9:01am, and readings of 104 and 167 at 2:08pm. -There were FSBS readings on 03/19 of 199 at 8:06am, 122 at 8:07am, 112 at 1:56pm and 218	D 610		

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D 610	Continued From page 75 at 1:58pm. -There were FSBS readings on 03/18 of 125 at 8:41am, 185 at 8:42am 151 at 1:54pm and 289 at 1:55pm. -There were FSBS readings on 03/17 of 177 at 9:20am and 102 at 9:22am. -There were FSBS readings on 03/16 of 197 at 9:05am and 98 at 9:07am. -There were FSBS readings on 03/15 of 201 at 9:16am, 110 at 9:19am, 85 at 2:01pm and 282 at 2:02pm. -There were FSBS readings on 03/14 of 110 at 2:05pm, 179 at 2:06pm and 115 at 2:08pm. -There were FSBS readings on 03/13 of 152 at 9:06am, 295 at 9:09am and 108 at 9:11am. -There were FSBS readings on 03/12 of 110 at 9:05am and 103 at 9:06am. -There were FSBS readings on 03/07 of 264 at 2:11pm, 136 at 2:14pm and 124 at 2:16pm. -The next readings included daily finger stick blood sugar (FSBS) readings with the date, time, and FSBS readings. -The following 9 readings were consecutive in the device. -There was a FSBS reading of 123 on 03/03 at 6:00pm which matched the 04/03/26 reading on the April 2026 eMAR for Resident #1 at 9:00pm. -There was a FSBS reading of 409 on 03/03 at 5:52pm which matched the 04/03/26 reading on the April 2026 eMAR for Resident #7 at 8:00pm. -There was a FSBS reading of 128 on 03/03 at 5:48pm which matched the 04/03/26 reading on the April 2026 eMAR for Resident #6 at 8:00pm. -There was a FSBS reading of 104 on 03/03 at 9:25am which matched the 04/03/26 reading on the April 2026 eMAR for Resident #6 at 10:00am. -There was a FSBS reading of 271 on 03/03 at 9:20am which matched the 04/03/26 reading on the April 2026 eMAR for Resident #7 at 10:00am. -There was a FSBS reading of 164 on 03/03 at	D 610		

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	HAL096031	A. BUILDING: _____ B. WING _____	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDSBORO ASSISTED LIVING & ALZHEIMEI	2201 ROYALE AVENUE GOLDSBORO, NC 27534

(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 610	Continued From page 76 9:19am which matched the 04/03/26 reading on the April 2026 eMAR for Resident #1 at 10:00am. -There was a FSBS reading of 113 on 03/03 at 4:50am which matched the 04/03/26 reading on the April 2026 eMAR for Resident #1 at 6:00am. -There was a FSBS reading of 82 on 03/03 at 4:42am but did not match on an eMAR for the residents. -There was a FSBS reading of 110 on 03/03 at 4:34am which matched the 04/03/26 reading on the April 2026 eMAR for Resident #7 at 6:00am. -There were 8 glucometer readings that matched documented FSBS readings on 04/03/26 for Residents #1, #6 and #7. Interview with the Administrator on 05/01/26 at 3:07pm revealed: -She was not aware there was a house glucometer used in the facility. -The house glucometer was manufactured for use by a single resident and should not have been used to check FSBS on more than one resident. -She was aware there was a back-up glucometer in the facility in case a resident's glucometer was not working but it should be assigned to the resident once it was used. -Single resident use glucometers could not be taken apart and cleaned appropriately so there was a risk of spreading bloodborne illness when the device was shared. Refer to interview with a medication aide (MA) on 05/01/26 at 1:56pm. Refer to interview with the Resident Care Coordinator (RCC) on 05/01/26 at 2:27pm. Refer to interview with the Administrator on 05/01/26 at 3:07pm.	D 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096031	A. BUILDING: _____ B. WING _____	05/01/2026

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D 610	Continued From page 77 Interview with a medication aide (MA) on 05/01/26 at 1:56pm revealed: -Each resident had their own glucometer and there was a house glucometer available in case the resident's personal glucometer was not working. -The house glucometer was used on multiple residents, and he would clean it with an alcohol pad between uses. -It was not always known what someone might have in their blood and cross contamination of blood borne pathogens such as tuberculosis (TB) or Acquired Immunodeficiency Syndrome (AIDS) could occur if glucometers were shared. Interview with the Resident Care Coordinator (RCC) on 05/01/26 at 2:27pm revealed: -Each resident had their own glucometer. -There was a house glucometer that was used when a resident's own glucometer wasn't working MAs may use the house glucometer when the batteries went dead. -She was not aware the house glucometer was not marketed for use by a single person and was not to be shared. -When there was only 1-2 minutes between FSBS, there was not enough time to clean the device between uses. -MAs were trained to clean the each glucometer after each use during annual training. Interview with the Administrator on 05/01/26 at 3:07pm revealed: -Each resident had their own glucometer, and the glucometers were kept on the diabetic medication cart and not on the regular medication carts. -MAs should have taken the diabetic cart down the hall to do FSBS checks to ensure they had each residents' glucometer with them when they	D 610		

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 610	Continued From page 78 obtained FSBS and should not be sharing glucometers. -Single resident use glucometers could not be taken apart and cleaned appropriately so there was a risk of spreading bloodborne illness when the device was shared. _____ The facility failed to implement infection control procedures for glucometers used to obtain finger stick blood sugar (FSBS) readings for 5 of 5 residents (#1, #5, #6, #7, #8) with an order for FSBS monitoring, including a glucometer that was manufactured for single patient use that was used to collect FSBS testing on more than one resident in the facility, resulting in substantial risk of transmission of bloodborne pathogens due to the sharing of glucometers between the residents that required FSBS checks. The facility's failure resulted in substantial risk for serious physical harm to the residents and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/30/26 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 31, 2026.	D 610		