Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049015	A. BUILDING: _____ B. WING _____	R 05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JURNEY'S ASSISTED LIVING	1942 VAN HAVEN DRIVE STATESVILLE, NC 28625

(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 the Iredell County Department of Social Services conducted an annual, follow-up and complaint investigations on 05/05/26 and 05/06/26. The complaint investigations were initiated by the Iredell County Department of Social Services on 04/01/26, 04/09/26, and 04/28/26.	D 000		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 5 residents (#8) observed during the morning medication pass with an error for a stomach acid reducer and 1 of 5 sampled residents (#4) for errors with sliding scale insulin. The findings are: 1. The medication error rate was 3.4% as evidenced by the observation of 1 error out of 29 opportunities during the 8:00am medication pass on 05/05/26 and 05/06/26. Review of Resident #8's current FL2 dated	D 358	**Disclaimer** The provider submits this plan of correction (POC) in accordance with specific regulatory requirements. The provider does acknowledge that even though the resident's responsible party and the law enforcement was contacted at the appropriate time, the department of social services was contacted after the incident was cleared but they were not immediately contacted when made aware of the situation per state regulations.	

AS Reviewed and Acknowledged 05/26/26

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D 358	Continued From page 1 01/08/26 revealed diagnoses included history of liver cancer and history of liver transplant. Review of Resident #8's upper gastrointestinal endoscopy (viewing the esophagus, stomach and small intestines through a camera) discharge note dated 04/02/26 revealed an order for pantoprazole (a medication to treat excess stomach acid) 40mg, one tablet twice daily. Observation of the morning medication pass on 05/06/26 at 10:00am revealed: -The medication aide (MA) removed a bottle of pantoprazole 20mg from the medication cart. -The MA placed pantoprazole 20mg, one tablet into the medication cup containing seven other medications. -The MA administered the eight medications to Resident #8. Interview with the MA on 05/06/26 at 10:00am revealed: -She placed pantoprazole 20mg, one tablet in Resident #8's medication cup. -She was nervous and did not look closely at the dosage on Resident #8's bottle of pantoprazole. -She should have given him two tablets of pantoprazole 20mg to equal the ordered dosage of 40mg. Telephone interview with a representative with the facility's contracted pharmacy on 05/06/26 at 11:42am revealed: -Resident #8 had a current order dated 04/02/26 for pantoprazole 40mg, one tablet twice daily. -Pantoprazole 40mg, one tablet twice daily was "profiled only" meaning the order was entered into the electronic medication administration system (eMAR) but not dispensed for Resident #8. -Resident #8's had a previous order dated	D 358	**Action Plan** It is this community's intent and practice to assure the residents medications are administered in accordance with the prescribing practitioner orders as stated by 10A NCAC 13F .1004. **Corrective Measures** All medication Aides will be required to attended an in-service to go over the 5 rights of medication administration per 10A NCAC 13F .1004 and the process of reviewing and approving medication orders as well as communication with the pharmacy about unclear or contradicting orders. In-service will be completed by June 5th 2026.	6/5/26

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D 358	Continued From page 2 02/09/26 for pantoprazole 20mg, one tablet twice daily. -On 02/20/26, the pharmacy was instructed by the facility not to dispense pantoprazole 20mg for Resident #8. -Resident #8 may have received pantoprazole 20mg from another pharmacy. -Resident #8 may experience increased heartburn if he did not receive pantoprazole 40mg, one tablet twice daily as ordered. Interview with the Resident Care Coordinator (RCC) on 05/06/26 at 4:20pm revealed: -The MAs were responsible for administering resident medications as ordered. -The MAs were responsible to review medications orders and medication labels prior to medication administration because medication orders changed frequently. Interview with the Administrator on 05/06/26 at 4:39pm revealed: -The MAs were responsible for ensuring resident medication dosages matched the dosage indicated on the resident's eMAR. -If the medication dosage did not match the order in the eMAR, the MA was to reach out to the pharmacy to get the order changed in the eMAR system or have them print a new medication label. -Facility staff did not have the capability to change orders in the eMAR system. 2. Review of Resident #4's current FL2 dated 01/15/26 revealed diagnoses included diabetes mellitus type 1. Review of Resident #4's Primary Care Provider's (PCP) orders dated 02/22/26 revealed an order for Humalog insulin (a medication to lower blood	D 358	**Monitoring** RCD and MCD will review all medication orders are transcribed correctly into Quick Mar and the medications on the cart match the practitioners' orders. Med Aides will complete cart audits weekly and RCD/MCD will complete cart audits monthly in sure accuracy of medications and orders. RCD and MCD will check emars daily x2 weeks, then weekly x4 weeks, then as needed indefinitely, for accuracy of medication administration.	6/5/26

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D 358	Continued From page 3	D 358		

sugar levels) 100units/ml, inject per sliding scale before meals and at bedtime for finger stick blood sugar (FSBS): 150-199= 3 units, 200-249= 6 units, 250-299= 9 units, 300-349= 12 units, 350 and greater = 15 units and notify the PCP if FSBSs greater than 400.

Review of Resident #4's PCP clarification order dated 04/06/26 revealed:
-Resident #4's sliding scale Humalog insulin order was clarified.
-Resident #4's sliding scale was to include Humalog insulin per SSI for FSBS: 350-400= 15 units, 401-450= 18 units and greater than 450 notify PCP.

Review of Resident #4's March 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for Humalog 100units/ml inject subcutaneously as directed per sliding scale before meals and at bedtime for FSBS: 150-199= 3 units, 200-249= 6 units, 250-299= 9 units, 300-349= 12 units, 350 and greater = 15 units, notify PCP if FSBS greater than 400 scheduled for administration at 7:30am, 11:30am, 4:30pm and 8:00pm.
-There were 3 of 124 opportunities for Humalog sliding scale insulin (SSI) administration from 03/01/26 to 03/31/26 when Humalog SSI was not documented as administered.
-On 03/28/26 at 7:30am Resident #4's FSBS was 191 and there was no Humalog insulin documented as administered when the resident should have received 3 units.
-On 03/29/26 at 4:30pm Resident #4's FSBS was 272 and there was no Humalog insulin documented as administered when the resident should have received 9 units.
-On 03/29/26 at 8:00pm Resident #4's FSBS was

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D 358	Continued From page 4 307 and there was no Humalog insulin documented as administered when the resident should have received 12 units. Review of Resident #4's April 2026 eMAR revealed: -There was an entry for Humalog 100units/ml inject subcutaneously as directed per sliding scale before meals and at bedtime for FSBS: 150-199= 3 units, 200-249= 6 units, 250-299= 9 units, 300-349= 12 units, 350 and greater = 15 units, notify PCP if FSBS greater than 400 scheduled for administration at 7:30am, 11:30am, 4:30pm and 8:00pm from 04/01/26 through 04/06/26. -There was an entry for Humalog 100units/ml inject subcutaneously as directed per sliding scale before meals and at bedtime for FSBS: 150-199= 3 units, 200-249= 6 units, 250-299= 9 units, 300-349= 12 units, 350-400= 15 units, 401-450= 18 units and notify PCP if FSBS greater than 450 scheduled for administration at 7:30am, 11:30am, 4:30pm and 8:00pm from 04/06/26 through 04/30/26. -There were 5 of 120 opportunities for Humalog SSI administration from 04/01/26 to 04/30/26 when Humalog SSI was not documented as administered. -For example, on 04/27/26 at 11:30am Resident #4's FSBS was 320 and there was no Humalog insulin documented as administered when the resident should have received 12 units. Review of Resident #4's May 2026 eMAR revealed: -There was an entry for Humalog 100units/ml inject subcutaneously as directed per sliding scale before meals and at bedtime for FSBS: 150-199= 3 units, 200-249= 6 units, 250-299= 9 units, 300-349= 12 units, 350-400= 15 units,	D 358		

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D 358	Continued From page 5 401-450= 18 units and notify PCP if FSBS greater than 450 scheduled for administration at 7:30am, 11:30am, 4:30pm and 8:00pm. -There was 1 of 15 opportunities for Humalog SSI administration from 05/01/26 to 05/05/26 when Humalog SSI was not documented as administered. -On 05/03/26 at 4:30pm Resident #4's FSBS was 396 and there was no Humalog insulin documented as administered when the resident should have received 15 units. Telephone interview with a representative with the facility's contracted pharmacy on 05/06/26 at 3:06pm revealed: -Resident #4 had an order dated 01/20/26 for Humalog 100units/ml inject subcutaneously as directed per sliding scale before meals and at bedtime: 150-199= 3 units, 200-249= 6 units, 250-299= 9 units, 300-349= 12 units, 350 and greater = 15 units and notify the resident's PCP. -Resident #4 had an order dated 04/06/26 for Humalog 100units/ml inject subcutaneously as directed per sliding scale before meals and at bedtime: 150-199= 3 units, 200-249= 6 units, 250-299= 9 units, 300-349= 12 units, 350-400 = 15 units, 401-450= 18 units and notify PCP if FSBS greater than 450 scheduled for administration at 7:30am, 11:30am, 4:30pm and 8:00pm. -If Resident #4 did not receive his sliding scale insulin as ordered he could experience increased blood sugars with possible symptoms of tiredness, increased urination, headaches and acting intoxicated. Observation of medication on hand for Resident #4 on 05/06/26 at 3:35pm revealed there was a Humalog flexpen available for administration.	D 358		

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D 358	Continued From page 6 Interview with a medication aide (MA) on 05/06/26 at 3:35pm revealed: -She usually worked second shift and administered Resident #4's sliding scale insulin to him at 4:30pm and 8:00pm. -She did not know why there were blanks on Resident #4's eMAR where his sliding scale insulin units should have been documented. -The eMAR system would not allow her to complete the documentation of Resident #4's sliding scale insulin if she did not put in the units administered. -She did not know if there were any audits done of resident eMARs. Interview with the Special Care Coordinator (SCC) on 05/06/26 at 3:48pm revealed: -She tried to review resident eMARs weekly for missed medications. -She did not notice there were times when Resident #4's Humalog insulin units were not documented. -She did not know how the units for Resident #4's Humalog sliding scale was not documented because the eMAR system would not let the MAs complete the administration documentation without the units being documented. Interview with the Administrator on 05/06/26 at 4:39pm revealed: -The RCC reviewed resident eMARs for missed documentation but she did not know how often. -If a medication was not documented as administered, then it was not administered. Attempted interview with Resident #4 revealed he was not interviewable.	D 358		

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D 463	Continued From page 7	D 463		
D 463	10A NCAC 13F .1306 Admission To The Special Care Unit 10A NCAC 13F .1306 Admission To The Special Care Unit In addition to meeting all requirements specified in the rules of this Subchapter for the admission of residents to the home, the facility shall assure that the following requirements are met for admission to the special care unit: (1) A physician shall specify a diagnosis on the resident's FL-2 that meets the conditions of the specific group of residents to be served. (2) There shall be a documented pre-admission screening by the facility to evaluate the appropriateness of an individual's placement in the special care unit. (3) Family members seeking admission of a resident to a special care unit shall be provided disclosure information required in G.S. 131D-8 and any additional written information addressing policies and procedures listed in Rule .1305 of this Subchapter that is not included in G.S. 131D-8. This disclosure shall be documented in the resident's record. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to document a pre-admission screening by the facility to evaluate the appropriateness of an individual's placement in the special care unit (SCU) for 3 of 3 sampled residents (Resident #1, #2 and #4). The findings are: Review of the facility's current license effective 01/01/26 revealed the facility had a licensed capacity of 60 beds including an Alzheimer's/Dementia SCU with a capacity of 16	D 463	**Disclaimer** The provider submits this plan of correction (POC) in accordance with specific regulatory requirements. The provider does acknowledge that even though the resident's responsible party and the law enforcement was contacted at the appropriate time, the department of social services was contacted after the incident was cleared but they were not immediately contacted when made aware of the situation per state regulations.	

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D 463	Continued From page 8 residents. Review of the facility's current census on 05/05/26 revealed there was a census of 16 SCU residents. 1. Review of Resident #1's current FL2 dated 01/07/2026 revealed: -Diagnoses included dementia with agitation, acute respiratory failure with hypoxia, pneumonia, type 2 diabetes, anxiety and hyperlipidemia. -Resident #1's recommended level of care was "Memory Care". -Resident #1 was constantly disoriented. Review of Resident #1's Resident Register revealed as admission date of 01/06/26. Review of Resident #1 Care plan dated 02/21/2026 revealed the resident was totally dependent with eating and transfers. Review of Resident #1's record revealed there was no pre-admission screening assessment prior to her admission to the SCU. Interview with the Administrator on 05/06/26 at 4:39pm revealed no pre-screening assessment was completed for Resident #1 prior to her admission to the SCU. Refer to the interview with the Special Care Coordinator (SCC) on 05/06/26 at 4:39pm. Refer to the interview with the Administrator on 05/06/26 at 4:39pm. 2. Review of Resident #2's current FL2 dated 04/23/26 revealed: -Diagnoses included Alzheimer's disease,	D 463	**Action Plan** It is this community's intent and practice to assure all new admission paperwork is completed accurately and all forms are included during the admission and preadmission process to the special care unit as stated by 10A NCAC 13F .1306. **Corrective Measures** Executive Director or designee will be required to create and include pre-screening assessment form to all future move-ins to the special care unit per 10A NCAC 13F .1306. effective immediately. **Monitoring** Pre-admission form will be placed in the residents file located in the ED's office for review by county and state representatives upon request. The MCD will ensure every new admission has the prescreening before they move in to the community.	5/8/26

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D 463	Continued From page 9 cerebral vascular accident with left-sided weakness. -Resident #2's recommended level of care was "Memory Care" -Resident #2 was constantly disoriented. Review of Resident #2 Resident Register revealed an admission date of 01/21/15. Review of Resident #2 Care Plan dated 04/23/26 revealed the resident was totally dependent with eating, toileting, ambulation, bathing, dressing, grooming and transfers. Review of Resident #2's record revealed there was no pre-admission screening assessment prior to her admission to the SCU. Interview with the Administrator on 05/06/26 at 4:39pm revealed no pre-screening assessment was completed for Resident #2 prior to her admission to the SCU. Refer to the interview with the Special Care Coordinator (SCC) on 05/06/26 at 4:39pm. Refer to the interview with the Administrator on 05/06/26 at 4:39pm. Attempted telephone interview with Resident #2's guardian on 05/06/26 at 4:52pm was unsuccessful. 3. Review of Resident #4's current FL2 dated 01/15/26 revealed: -Diagnoses included Alzheimer's disease and diabetes type 1. -Resident #4's recommended level of care was "Memory Care" -Resident #4 was intermittently disoriented.	D 463		

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D 463	Continued From page 10 Review of resident #4 Resident Register revealed an admission date of 01/23/26. Review of Resident #4's Care Plan dated 02/02/26 revealed: -Resident #4 required limited assistance with toileting, bathing, dressing and grooming. -The resident was independent with eating, ambulation and transfers. Review of Resident #4's record revealed there was no pre-admission screening assessment prior to his admission to the SCU. Interview with the Administrator on 05/06/26 at 4:39pm revealed no pre-screening assessment was completed for Resident #4 prior to his admission to the SCU. Refer to the interview with the Special Care Coordinator (SCC) on 05/06/26 at 4:39pm. Refer to the interview with the Administrator on 05/06/26 at 4:39pm. Interview with the Special Care Coordinator (SCC) on 05/06/26 at 4:39pm revealed: -She was not aware a pre-screening needed to be completed on the residents in the SCU. -It was her responsibility to complete the pre-screening. -She kept a notebook that had brief interview for mental status (BIMS) on each resident, but she did not have a pre-screening. -She did not complete pre-screening assessments because she was never told to complete them. Interview with the Administrator on 05/06/26 at	D 463		

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D 463	Continued From page 11 4:39pm revealed: -She was not aware a pre-screening assessment was required prior to a resident's admission to the SCU. -She was responsible for completing pre-admission paperwork for the facility.	D 463		