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
	HAL054070	A. BUILDING: _____ B. WING _____	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY MEMORY CARE AT KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 Lenoir County Department of Social Services conducted an annual survey on 03/04/26 through 03/05/26.	D 000	The Statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with state regulations. The facility has taken or will take the action set forth in the plan of correction. The following plan of correction constitutes the facilities allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.	
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: TYPE B VIOLATION Based on observations, interviews and record reviews the facility failed to administer medications as ordered for 3 of 3 sampled residents (#1, #2, #3) related to medication used to treat infection, high blood pressure and diabetes (#2), medications used to treat infection and insomnia (#3) and a medication used to treat seasonal allergies (#1). The findings are: Review of the facility's undated Medication Administration policy revealed medications were to be administered in accordance with the provider's orders. 1. Review of Resident #2's current FL-2 dated 01/08/26 revealed: -Diagnoses included high blood pressure and	D 358		

Reviewed & Acknowledged DB 04/01/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054070	A. BUILDING: _____ B. WING _____	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY MEMORY CARE AT KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 1 type II diabetes. -He was semi-ambulatory and intermittently disoriented. Review of Resident #2's Resident Register revealed he was admitted on 09/08/25. a. Review of Resident #2's physician's order dated 02/12/26 revealed: -Resident #2 had a rash. -Omnicef 300mg was to be administered twice daily for 10 days to treat the rash. (Omnicef is a medication used to treat infection.) Review of Resident #2's physician's order dated 02/19/26 revealed: -Resident #2 had a upper respiratory infection (URI). -Omnicef 300mg was to be administered twice daily for 10 days to treat the URI. Review of Resident #2's electronic medication administration record (eMAR) for February 2026 revealed: -There was an electronic entry for Omnicef 300mg to be administered twice daily for 10 days and scheduled for 8:00am and 8:00pm. -There was documentation Omnicef was administered at 8:00pm on 02/25/26 and at 8:00am and 8:00pm from 02/26/26 through 02/28/26. Observation of Resident #2's medications on hand on 03/05/26 at 9:50am revealed: -There was a bottle labeled Omnicef 300mg with instructions to administer twice daily for 10 days. -There were 20 tablets dispensed on 02/19/26 with 9 tablets remaining. Review of Resident #2's eMAR for March 2026	D 358	a On 3/06/2026, the Administrator contacted a Registered Nurse to provide re-education/ competency with return demonstration for all staff responsible for medication administration, on medication administration policies, emphasizing the importance of timely medication administration and adherence to physician orders. On 3/06/2026, the Administrator and RCC implemented 100% audit of all resident charts, including physician orders, MAR's and medication supply for four(4) weeks the monthly On 3/13/2026, Administrator implemented a Medication tracking log to monitor deliveries, follow-ups and delays to prevent missed or Late medications.	Completed 3/26/2026 3/9/2026 and Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054070	A. BUILDING: _____ B. WING _____	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY MEMORY CARE AT KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 2 revealed: -There was an electronic entry for Omnicef 300mg to be administered twice daily for 10 days and scheduled for 8:00am and 8:00pm. -There was documentation Omnicef was administered each day at 8:00am and 8:00pm from 03/01/26 through 03/03/26 and at 8:00am on 03/04/26. Telephone interview with a pharmacist for the facility's contracted pharmacy on 03/04/26 at 11:57am revealed: -They had not received an order for Omnicef dated 02/12/26 for Resident #2. -They received an order for Omnicef dated 02/19/26 for Resident #2 to treat an URI and that was sent to the back up pharmacy the same day. -A delay in or not administering an antibiotic could cause worsening infections. -A URI could extend into a lower respiratory infection such as pneumonia and not all antibiotics that treat URI would treat a lower respiratory infection. Interview with Resident #2's primary care provider (PCP) on 03/05/26 at 9:30am revealed: -Omnicef was prescribed for Resident #2 on two separate occasions due to an URI and skin papules that she thought may have been folliculitis. (Folliculitis is inflammation or infection of hair follicles.) -Blood sugars could increase due to infection. -Resident #2 was prescribed an antibiotic to treat the URI because he was diabetic and his blood sugar levels were not well controlled. -Antibiotics should begin within 3 days of prescribing in order to treat the infection and prevent worsening of the infection. -She assumed medications were administered when they were prescribed.	D 358	The Administrator or designee will conduct weekly medication administration audits for four (4) weeks to ensure medications are administered as ordered and on time. On 3/10/2026, [redacted] Pharmacy was provided 30 day notice for service termination after an Medication Error Root Cause Analysis was performed and revealed Pharmacy delivery delays, Orders not transcribed to MAR, Pharmacy clarification delay and Physician orders unclear without clarification.	3/9/26 and ongoing 3/10/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054070	A. BUILDING: _____ B. WING _____	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY MEMORY CARE AT KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 3 -Resident #2's rash had resolved. Interview with the Resident Care Coordinator (RCC) on 03/05/26 at 3:25pm revealed: -She stepped into the RCC role when the Administrator was out on leave. -She was not aware the PCP had written an order on the pharmacy review for Resident #2. -She was not aware there could be a physician's order in the physician's visit reports that were electronically signed. -Providers sent orders to the pharmacy themselves and sometimes left them in a folder to be sent by the facility. -The RCC was responsible for ensuring orders were sent to the pharmacy when they were left in the new order folder. -There was no process in place for reviewing resident records for orders. Interview with the Administrator on 03/05/26 at 10:55am revealed: -She did not think Resident #2's order for Omnicef dated 02/12/26 had been sent to the pharmacy and she did not know why it was not sent. -The order for Omnicef dated 02/19/26 was sent to the back-up pharmacy and they did not deliver medications. -The RCC was responsible for picking up the medication from the back-up pharmacy and should have picked it up as soon as it was filled. -The RCC was responsible for faxing orders to the pharmacy. b. Review of Resident #2's pharmacy review dated 02/12/26 revealed: -There were recommendations to restart an ACE inhibitor due to blood pressure reading of 167/90. (ACE inhibitors are a certain type of medication	D 358	Administrator contracted 3/17/26 with [redacted] Pharmacy to, start servicing facility on 4/15/2026, in an effort to address Medication delivery delays Pharmacy refill delays and Emergency medication supplies. Administrator contacted 3/6/26 [redacted] Management to request new Provider for Primary Care Services in efforts to correct Communication Issues, Delay in order Communication, Pharmacy Clarification delay and delay in prior authorization for medications for residents. New Provider Started on 3/11/2026.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054070	A. BUILDING: _____ B. WING _____	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY MEMORY CARE AT KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 4 used to treat high blood pressure.) -There was a physician's response documented on the pharmacy review to start lisinopril 5mg each day and signed by the physician on 02/19/26. (Lisinopril is a medication used to treat high blood pressure.) Review of Resident #2's electronic medication administration record (eMAR) for February 2026 revealed there was no entry for lisinopril 5mg. Review of Resident #2's eMAR for March 2026 revealed there was no entry for lisinopril 5mg. Observation of Resident #2's medications on hand on 03/05/26 at 9:50am revealed there was no lisinopril 5mg available for administration. Interview with Resident #2's primary care provider on 03/05/26 at 9:30am revealed: -Lisinopril was ordered to help control Resident #2's blood pressure based on pharmacy recommendations. -Resident #2 had occasional high blood pressure readings and was on another medication to help with blood pressure. -High blood pressures could cause a heart attack or stroke due to damage to blood vessels over time. -She assumed medications were administered when they were prescribed and should begin within 3 days of ordering. Interview with the Resident Care Coordinator (RCC) on 03/05/26 at 3:25pm revealed: -She stepped into the RCC role when the Administrator was out on leave. -She was not aware the PCP had written an order on the pharmacy review for Resident #2.	D 358	Administrator has implemented an Interdisciplinary Care Collaborative Meeting to improve medication safety and coordination of care by addressing medication administration errors, delays in medication delivery from pharmacy, communication gaps in physician orders, proper handling of new and discontinued medication orders and ensuring timely and accurate medication administration for residents which will include: • Pharmacy Coordination • Physician Communication • Hospice Coordination • Discontinued Medication Process • Strategies to Prevent Medication Errors • Staff training/retraining/In-Services	4/1/26, and Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054070	A. BUILDING: _____ B. WING _____	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY MEMORY CARE AT KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 5 Interview with the Administrator on 03/05/26 at 4:00pm revealed: -She was not aware of the order for lisinopril 5 mg. -Providers sent orders directly to the pharmacy or place orders in the new order folder to be faxed or tracked. -The RCC was responsible for ensuring new orders were processed. -There was no process for reviewing resident records for missed orders. A vitals signs report for Resident #2 was requested on 03/04/26 but was not provided. c. Review of Resident #2's current FL-2 dated 01/08/26 revealed there was a physician's order for Lantus Solostar, 48 units to be administered each day after lunch. (Lantus is a long-acting insulin used to control blood sugar levels in people with diabetes.) Review of a physician's order dated 01/22/26 revealed there was an order to administer Lantus 56 units each day at lunch. Review of a physician's order dated 02/12/26 revealed there was an order to discontinue Lantus 56 units and to begin Lantus 58 units each day at lunch. Review of Resident #2's physician's order dated 02/19/26 revealed there was an order to administer Lantus 60 units each day at lunch. Review of Resident #2's physician's order dated 02/26/26 revealed there was an order to administer Lantus 64 units each day at lunch. Review of Resident #2's electronic medication	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054070	A. BUILDING: _____ B. WING _____	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY MEMORY CARE AT KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 6 administration record (eMAR) for February 2026 revealed: -There was an electronic entry for Lantus 56 units to be administered each day at lunch and scheduled for 11:30am. -There was no documentation on 02/01/26 to indicate Lantus 56 units was administered at 11:30am and there was no exception note entered. -There was documentation Lantus 56 units was administered each day on 02/02/26 through 02/23/26 and a notation to say the medication was discontinued. -There was an electronic entry for Lantus 60 units to be administered each day at lunch and entered as PRN (as needed) with no documentation of administration. -There was an electronic entry for Lantus 64 units to be administered each day at lunch and scheduled for 12:00pm. -There was documentation Lantus 64 units was administered each day at 12:00pm on 02/27/26 and 02/28/26. -There were 3 days in which no Lantus was administered at lunch time (02/24/26 through 02/26/26). Observation of Resident #2's medications on hand on 03/05/26 at 9:50am revealed there were 6 unopened Lantus injection pens available for administration. Telephone interview with a pharmacist for the facility's contracted pharmacy on 03/04/26 at 11:57am revealed they had not received an order for Lantus 58 units dated 02/12/26 for Resident #2. Interview with Resident #2's primary care provider (PCP) on 03/05/26 at 9:30am revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054070	A. BUILDING: _____ B. WING _____	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY MEMORY CARE AT KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 7 -She usually sent new prescriptions directly to the pharmacy and left the new orders in the new order folder for the facility. -She sometimes sent orders to the pharmacy, after her visits, later in the evening. -Resident #2 was diabetic and his blood sugars were not well controlled. -She was increasing Resident #2's Lantus gradually to not cause a sudden decrease in blood sugar levels. -She assumed medications were administered when they were prescribed. -Chronic high blood sugar levels could affect the kidneys, arteries and the retinas of the eyes. Interview with the Resident Care Coordinator (RCC) on 03/05/26 at 3:25pm revealed: -Providers sent orders to the pharmacy and there was no process for reviewing charts for orders. -She was not aware of the order for Lantus 58 units for Resident #2 and she did not know why the order was not sent to the pharmacy. -When the provider sent the order, the pharmacy entered the medication onto the eMAR. -The RCC was responsible for approving the medication on the eMAR once the medication arrived to the facility so that it shows on the eMAR for medication aides to administer. Interview with the Administrator on 03/04/26 at 10:55am revealed: -The RCC was responsible for faxing orders that were left by providers but the providers typically sent the orders to the pharmacy directly. -She did not know why the order was not sent the the pharmacy to be placed on the eMAR for administration. -There was no process in place for reviewing provider visit notes for physician's orders.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054070	A. BUILDING: _____ B. WING _____	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY MEMORY CARE AT KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 8 Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable. 2. Review of Resident #3's current FL-2 dated 01/08/26 revealed: -Diagnoses included high blood pressure and chronic kidney disease with heart failure. -He was ambulatory and constantly disoriented. a. Review of Resident #3's physician's order dated 02/28/26 revealed Keflex 500mg was to be administered twice daily for 10 days for a urinary tract infection (UTI). (Keflex is a medication used to treat infection.) Review of Resident #3's electronic medication administration record (eMAR) for February 2026 revealed there was no entry for Keflex 500mg. Review of Resident #3's eMAR for March 2026 revealed there was no entry for Keflex 500mg. Observations of medication on hand for Resident #3 on 03/05/26 at 9:50am revealed there was no Keflex 500mg available for administration. Telephone interview with a pharmacist for the facility's contracted pharmacy on 03/05/26 at 11:57am revealed: -They received the order for Keflex this morning (03/05/26) for Resident #3 to treat a UTI but the system for insurance showed the medication was dispensed on 03/02/26 at another pharmacy. -Not treating or delaying treatment for a UTI could cause a worsening infection or cause the infection to migrate to up into the kidney. -UTIs were a special concern in the elderly since they experienced mental status changes more than pain which increased their risk for falls.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054070	A. BUILDING: _____ B. WING _____	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY MEMORY CARE AT KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 9 Telephone interview with the pharmacist for the facility's back-up pharmacy on 03/05/26 at 2:27pm revealed: -They dispensed 20 tablets of Keflex 500mg on 03/02/26 from a hospice order for Resident #3. -The facility picked up the medication on 03/05/26. Interview with the Resident Care Coordinator (RCC) on 03/05/26 at 3:25pm revealed: -Resident #3's order for Keflex 500mg dated 02/28/26 was written by hospice after hours. -The hospice nurse sent the order to another pharmacy and not to the facility's contracted pharmacy or their regular back up pharmacy. -The nurse put the order back in the chart so she was not aware the provider had ordered Keflex for Resident #3 since there was no process in place for reviewing resident records for orders. Interview with the Administrator on 03/04/26 at 10:55am revealed: -The hospice nurse sent the order to another pharmacy and not to the facility's contracted pharmacy or their regular back up pharmacy. -Resident #3's Keflex 500mg dated 02/28/26 was ordered by hospice and was placed back in the chart instead of in the new order folder. -There was no process in place for reviewing provider visit notes for physician's orders so no one was aware of the order. Attempted telephone interview with Resident #2's hopice nurse on 03/05/26 at 2:51 was unsuccessful. b. Review of Resident #3's current FL-2 dated 01/08/26 revealed there was an order to administer trazodone 50mg each night at	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054070	A. BUILDING: _____ B. WING _____	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY MEMORY CARE AT KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 10 bedtime.(Trazodone is a medication used to treat insomnia.) Review of Resident #3's physician's order dated 01/29/26 revealed trazodone 25mg was to be administered each night at bedtime. Review of Resident #3's electronic medication administration record (eMAR) for January 2026 revealed: -There was an electronic entry for trazodone 50mg to be administered each night at bedtime and scheduled for 8:00pm. -There was documentation trazodone 50mg was administered at 8:00pm from 01/01/26 to 01/22/26 and from 01/24/26 to 01/31/26. -There was no documentation on 01/23/26 to indication trazodone 50mg was administered and there was no exception note. -There was no entry for trazodone 25mg to be administered. Review of Resident #3's eMAR for February 2026 revealed: -There were two electronic entries for trazodone 50mg to be administered each night at bedtime and scheduled for 8:00pm. -There was documentation trazodone 50mg was administered at 8:00pm from 02/02/26 to 02/23/26 and from 02/26/26 to 02/28/26. -There was no documentation on 02/01/26 and on 02/24/26 to 02/26/26 to indication trazodone 50mg was administered and there was no exception note. -There was no entry for trazodone 25mg to be administered. Review of Resident #3's eMAR for March 2026 revealed: -There was an electronic entry for trazodone	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054070	A. BUILDING: _____ B. WING _____	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY MEMORY CARE AT KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 11 50mg to be administered each night at bedtime and scheduled for 8:00pm. -There was documentation trazodone 50mg was administered at 8:00pm from 03/01/26 to 03/03/26. -There was no entry for trazodone 25mg to be administered. Observations of medication on hand for Resident #3 on 03/05/26 at 9:50am revealed there was no trazodone 25mg available for administration. Telephone interview with a pharmacist at the facility's contracted pharmacy revealed they had not received an order dated 01/29/26 to decrease Resident #3's trazodone from 50mg to 25mg nightly. Interview with Resident #3's primary care provider (PCP) on 03/05/26 at 9:30 revealed: -She usually sent orders to pharmacy by electronic prescription and may have forgotten to send the order to decrease Resident #3's trazodone. -Resident #3 was on several medications that could cause sedation and had fallen due to decline in condition. -She decreased Resident #3's trazodone because it was a medication that could cause sedation and thought it might decrease the risk of falling. Interview with the Resident Care Coordinator (RCC) on 03/05/26 at 3:25pm revealed: -Resident #3 had falls due to a decline and was placed on hospice. -She did not review provider visit notes and she did not know provider visit notes contained physicians orders so she was not aware the order to decrease Resident #3's trazodone had been	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054070	A. BUILDING: _____ B. WING _____	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY MEMORY CARE AT KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 12 written. Interview with the Administrator on 03/04/26 at 10:55am revealed: -The RCC was responsible for faxing orders that were left by providers but the providers typically sent the orders to the pharmacy directly. -The PCP came to the facility weekly and emailed the visit notes to her the following week. -She was not aware physician's orders were in the PCP visit notes. -There was no process in place for reviewing provider visit notes for physician's orders. Attempted interview with Resident #3's hospice nurse on 03/05/26 at 2:51pm was unsuccessful. 3. Review of Resident #1's current FL-2 dated 01/08/26 revealed: -Diagnoses included cognitive impairment, dementia, hypotension, failure to thrive, vitamin D deficiency, chronic pain, recurrent urinary tract infection, and asthma. -There was no order for Allegra (used to treat allergies). Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 03/07/25. Review of a routine physician consultation report for Resident #1 dated 09/18/25 revealed: -There was a diagnosis for chronic rhinitis (Rhinitis is an inflammation of the nasal lining causing congestion, runny nose, sneezing, and itching. -There was a physician's order to start Allegra (used to treat allergies) 180mg tablet in the morning.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054070	A. BUILDING: _____ B. WING _____	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY MEMORY CARE AT KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 13 Review of Resident #1's physician orders from 09/18/25 through 12/15/25 revealed there was no physician's order to discontinue the Allegra 180mg. Review of Resident #1's physician orders dated 12/15/25 revealed: -There was a hospice plan of care initiated. -There was no order for Allegra. Interview with Resident #1 on 03/05/26 at 3:30pm revealed: -Since she was a child, she had allergies. -She "just sniff(ed) sometimes". -She was administered some medications but did not know what kind of medications. Review of Resident #1's electronic medication administration records (eMARs) from 09/18/25 through 12/30/25 revealed there was no entry for Allegra 180mg tablet printed to the eMARs. Interview with a medication aide (MA) on 03/05/26 at 2:01pm revealed: -The Resident Care Coordinator (RCC) normally managed new orders. -The RCC gave her the new medication upon delivery to the facility. -She put the new medications in the medication cart. -She administered medications to residents based on what populated on the eMAR. Interview with the RCC on 03/05/26 at 2:07pm revealed: -She was responsible to ensure residents medications were received at the facility. -She sent physician orders to the pharmacy. -She had only been the RCC for about two months.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054070	A. BUILDING: _____ B. WING _____	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY MEMORY CARE AT KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 14 -The previous RCC was no longer at the facility. Interview with the Administrator on 03/05/26 at 11:00am revealed: -Resident #1 was never administered the Allegra 180mg tablet every morning. -The contracted provider pharmacy input new orders to the eMARs. -The contracted provider pharmacy did not have an order for Allegra for Resident #1. -She had never reviewed physician/PCP reports. -The PCP usually wrote orders on a physician order sheet. -She never knew to review PCP printed notes for orders. Telephone interview with a pharmacist at the provider contracted pharmacy on 03/05/26 at 12:14pm revealed: -The pharmacy had never dispensed Allegra for Resident #1. -The pharmacy had never received an order for Allegra for Resident #1. -Resident #1 was prescribed another medication used for allergies. -Most people only needed one medication used to treat allergies, but some people did do better with multiple medications used to treat allergies. -She would not be concerned about the Allegra for Resident #1 as long as the resident was symptom free, but if Resident #1 was routinely having a runny nose, coughing, sneezing, or itchy eyes, there would be concern. The facility failed to ensure medications were administered as ordered to Resident #2 who was prescribed an antibiotic for folliculitis in which the antibiotic was not started and was then ordered a second course of antibiotic therapy for an upper respiratory infection was ordered but the facility	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054070	A. BUILDING: _____ B. WING _____	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY MEMORY CARE AT KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 15 failed to administer the first dose of the antibiotic until six days later which placed him at risk for worsening of infections including pneumonia. Resident #2 was also ordered medications to help control blood glucose levels including a long acting insulin that was not increased in dose and the previous dose continued the be administered for 10 days and 4 days in which no long acting insulin was administered. The facility failed to administer an antibiotic to Resident #3 that was ordered to treat a urinary tract infection which placed the resident at risk for worsening infection including infection of the kidney for Resident #3 who was diagnosed with chronic kidney disease. The facility also failed to decrease a medication dosage as ordered for a medication that caused sedation and was decreased in dosage in an effort to decrease fall risk in Resident #3 who had previous falls. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131-34 on 03/05/26 for this violation. CORRECTION DATE FOR TYPE B VIOLATION SHALL NOT EXCEED APRIL 19, 2026	D 358		