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
	HAL080030	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA SALISBURY	1915 MOORESVILLE ROAD SALISBURY, NC 28147

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D 000	Initial Comments The Adult Care Licensure Section completed a annual and follow-up survey on 04/28/26 though 04/30/26.	D 000		6-14-26
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 5 sampled medication aides (MA) (Staff B and Staff F) completed the 5-hour and 10-hour, or 15-hour MA training and completed Medication Skills Competency Validation prior to administering medications. The findings are: 1. Review of Staff B's personnel record revealed: -Staff B was hired as an MA on 02/10/26. -Staff B had no pass date for the State written MA examination test. -There was no documentation Staff B completed the 5-hour and 10-hour or 15-hour training course. -Staff B completed the Medication Clinical Skills	D 125	Director of Health and Wellness (DHW)/ Business Office Manager (BOM) or designee will audit all Medication Aide (MA) files to identify any unmet requirements. Any identified issues will be immediately scheduled for completion. DHW/designee will utilize the Clinical New Hire Checklist to ensure all new employees meet qualification requirements prior to being placed on the schedule to work independently. BOM/designee will maintain the employee tracker to monitor annual requirements. BOM/designee will send report to Executive Director (ED) and Department Managers monthly.Department Managers and ED will review to ensure ongoing compliance.	

" Reviewed and Acknowledged " 05/28/2026 CPP

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D 125	Continued From page 1 Validation checklist on 03/16/26. Review of a resident's March 2026 electronic medication administration records (eMAR) revealed there was documentation Staff B administered medications on 03/26/26. Review of a resident's April 2026 electronic medication administration records (eMAR) revealed there was documentation Staff B administered medications on 04/02/26, 04/05/26 and 04/24/26. Attempted telephone interview with Staff B in on 04/30/26 at 10:15am was unsuccessful. Refer to the interview with the Resident Care Coordinator (RCC) on 04/30/26 at 9:20am. Refer to the interview with the Interim Health and Wellness Director (IHWD) 04/30/26 at 9:54am. Refer to the interview with the Executive Director on 04/30/26 at 9:46am. 2. Review of Staff F 's personnel record revealed: -Staff F was hired as an Medication Aide (MA) on 03/25/26. -There was documentation that Staff F had completed the 10-hour MA course on 04/05/26. -There was documentation that Staff F had completed the 5-hour MA course during the survey on 04/29/26. -There was no documentation that Staff F had completed the 15-hour MA training course. -Staff F completed the Medication Clinical Skills Validation checklist on 04/02/26 and had a pass date of 09/20/2007 for the State written MA examination test.	D 125		

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D 125	Continued From page 2 Review of a resident's April 2026 electronic medication administration record (eMAR) from 04/01/26 to 04/29/26 revealed there was documentation Staff F administered medications on 04/11/26. Attempted telephone interview with Staff F on 04/30/26- at 10:17 am was unsuccessful. Interview with the Human Resources Director on 04/30/26 at 9:41am revealed: -She was not aware of Staff F's missing training certificates but was aware that she had completed the 5-hour training on 04/29/26. -She maintained employee files and ensured staff members were aware of trainings that were due. -All staff training occurred online and it was each employee's responsibility to complete required training courses. -The facility's contracted pharmacy provided 5-hour, 10-hour and 15-hour MA training courses and diabetic training. -She sent a spreadsheet containing a list of all staff who were missing required trainings to the Health and Wellness Director (HWD) via email or paper at least monthly. -She sent an internal message to each employee who was out of compliance with required trainings. Interview with the Resident Care Coordinator (RCC) on 04/30/26 at 9:20am revealed: -She was aware of the trainings required for MAs. -She was not aware of Staff F's missing training certificates or that she had completed the 5-hour training on 04/29/26. -She was responsible for training MAs on the medication carts but not responsible for ensuring their required trainings were complete.	D 125		

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D 125	Continued From page 3 Interview with the Interim Health and Wellness Director (IHWD) on 04/30/26 at 9:54am revealed: -She was aware of the trainings required for MAs. -She was not aware of Staff F's missing training certificates or that she had completed the 5-hour training on 04/29/26. -She was not responsible for the 5-hour, 10-hour or 15-hour trainings because she was only serving as the IHWD until a new HWD was hired. Interview with the Executive Director (ED) on 04/30/26 at 9:46am revealed: -The previous HWD was recently terminated for not performing her job duties. -She was not aware of Staff F's missing training certificates but was aware that she had completed the 5-hour training on 04/29/26. -There was a new hire checklist that was to be used to ensure all required trainings had been completed. -She expected a designated employee to ensure the use of an internal checklist be completed before new hires are placed on the schedule to work.	D 125		
D 285	10A NCAC 13F .0904(a)(4) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (a) Food Procurement and Safety in Adult Care Homes: (4) There shall be a three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the menus established in Paragraph (c) of this Rule for both regular and therapeutic diets. For the purpose of this Rule "perishable food" is food that is likely to spoil or decay if not kept refrigerated at 40 degrees Fahrenheit or below, or frozen at zero	D 285	Director of Culinary Services (DCS) was hired on 5-4-26. DCS/designee will place food orders twice weekly and maintain PAR levels to ensure 3-day perishable and 5-day nonperishable supply on hand at all times. ED/designee will conduct random monthly inspections to ensure ongoing compliance.	6-14-26

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D 285	Continued From page 4 degrees Fahrenheit or below and "non-perishable food" is food that can be stored at room temperature and is not likely to spoil or decay within seven days. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure the kitchen had a 3-day supply of perishable foods and a 5-day supply of nonperishable foods in the pantry available based on their census. The findings are: Review of the facility's census for 04/28/26 revealed there were 52 residents in the facility. Observations of the kitchen refrigerator on 04/29/26 between 9:30am and 10:15am revealed: -There were 16 gallons of milk with 32 servings per gallon; which is enough for 3 days for 52 residents. -There were two cases of pork sausage with 128 servings per case. -There was one container of concentrated cranberry juice with 89 (4-ounce) servings. -There was one 20-pound case of carrots with 80 (4-ounce) servings. -There was a half case of cabbage with 12 heads remaining with 60 (4-ounce) cooked servings. -There were 6 (one-pound) containers of molded strawberries. -There was one-half of a watermelon.	D 285		

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D 285	Continued From page 5 -There were 10 tomatoes. -There were 20 oranges. -There was a full sheet pan of salad with 50 (4-ounce servings). -There were 6 pounds of butter. -There were 2 (3-pound) containers of ricotta cheese 48 (2-ounce) servings. -There were 3 (5-pound bags) of grated cheese with 30) 4-ounce) servings. -There were not enough perishable food items to last 3 days. -According to the census of 52, the facility would need 52 one-half cups serving of fruit or fruit juice per day. -According to the census of 52, the facility would need 104 one-half cups serving vegetables per day. -There were not enough fresh fruit, fruit juice or vegetables to serve 52 residents for three days. Observations of the dry storage on 04/29/26 between 9:30am and 10:15am revealed: -There were 5 #10 cans of carrots with 24 one-half cup servings per can. -There were 3 #10 cans of black beans with 24 one-half cup servings per can. -There were 2 #10 cans of refried beans with 24 one-half cup servings per can. -There were 2 #10 cans of cranberry sauce with 24 one-half cup servings per can. -There were 7 cans of 50 ounces cream of mushroom soup with 80 one-half cup servings per can. -There were 5 #10 cans of green peas with 24 one-half cup servings per can. -There were 5 #10 cans of beets with 24 one-half cup servings per can. -There were 4 #10 cans of peaches with 24 one-half cup servings per can. -There were 4 #10 cans of corn with 24 one-half	D 285		

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D 285	Continued From page 6 cup servings per can. -There was 1 #10 can of baked beans with 24 one-half cup servings per can. -There was 1 #10 can of black-eyed peas with 24 one-half cup servings per can. -There were 2 (2-pound) bags of vanilla wafers with 32 servings per bag. -There were 16 cups of pudding. -There were 12 cups of Jello. -There were 6 cups of applesauce. -There was one half case of fortune cookies. -There was one half case of saltine crackers with 500 single serve packs per case. -There were 3 (16-ounce) bags of potato chips with 24 servings of 8 chips per bag. -There were 3 large bags of cereal. -There were 2 cases of dried pasta. -There were 10 cartons of thickened dairy drink. -There were 6 cartons of thickened sweet tea. -There were 2 quarts of mixed berry juice. -There were no canned meats. -According to the census of 52, the facility would need 5 cans of vegetable per day. -The facility needed 25 cans of vegetables to last for five days. -The facility had 17 cans of vegetables. Review of the observation of facility's lunch meal service on 04/28/26 at 12:00pm revealed: -There were 33 residents in the dining room. -There were four staff who served beverages and took orders for the lunch meal service. -The main menu entrée was ham and beans, tomatoes with cheese, a roll and cake. -The alternate items offered were hotdogs, hamburgers, grilled cheese, bacon, lettuce and tomato (BLT) sandwich, chips and fries. -The residents who requested fries were told they did not have any fries and were served chips. -The kitchen ran out of the main entrée before all	D 285		

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D 285	Continued From page 7 the residents' orders were taken. -The last two residents that placed their orders were told there were no hot dogs or hamburgers. -The last two residents were offered a choice of grilled cheese, pimento cheese or a BLT sandwich with chips. Interview with a resident on 04/28/26 at 12:35pm revealed: -The kitchen ran out of food often. -Her table was always the last to be seated in the dining room. -By the time she placed her order there were usually only sandwiches, hot dogs and burgers left to choose from. -Her only choice today was grilled cheese, pimento cheese or a BLT sandwich. Interview with the Kitchen Manager (KM) on 04/29/26 at 2:35pm: -He was pulled from another facility today to cover because they did not have a KM. -He was aware there needed to be a 3-day perishable and 5-day nonperishable food supply in the case of a disaster. -He was aware there was not a 5-day supply of food in the dry storage to feed 52 residents -He was aware there was not a 3-day supply of nonperishable food to feed 52 residents. -He had enough snacks to serve residents today on 04/29/26 at 3:00pm and 7:00pm. -He did not have enough snacks to serve tomorrow on 04/30/26 at 10:00am, 2:00pm and 7:00pm. -The Executive Director (ED) was responsible for placing the food orders. -The food budget was $7.90 per day per resident. -The facility received a delivery truck today on 04/29/26. -The next delivery truck was scheduled for Friday	D 285		

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D 285	Continued From page 8 05/01/26. Interview with the Interim Health and Wellness Director (IHWD) on 04/30/26 at 10:00am revealed: -She was not aware the food supply was low. -She was aware the snack supply was low because of the staff eating the snacks. -There was a meeting with staff on 04/16/26 to address the staff about not eating the snacks purchased for residents. -The ED was responsible for ordering food for the facility. -She would expect the facility to have enough food to feed the residents and have a 3-day perishable and a 5-day nonperishable food supply. Interview with the ED on 04/30/2026 at 10:30am revealed: -She was aware there needed to be a 3-day perishable and 5-day nonperishable food supply in the kitchen in case there was a disaster. -She was not aware there was not a 3-day perishable and 5-day nonperishable supply of food in the refrigerator or the dry storage. -She was not aware the kitchen did not have enough food to serve the main entrée during lunch meal service on 04/28/26. -She was not aware the kitchen did not have enough snacks to serve today on 04/30/26 at 10:00am, 2:00pm and 7:00pm. -She ordered snacks that had to be prepared versus prepackaged snacks of convenience to save money. -She was responsible for placing the food orders. -Her expectation would be for there to be a 3-day perishable and 5-day nonperishable food supply in the kitchen in case there was a disaster.	D 285		

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D 358	Continued From page 9	D 358		6-14-26
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments 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 ensure medications were administered as ordered by a licensed prescribing practitioner for 1 of 6 residents (#2) sampled for record review related to a medication for thinning the blood, and for 2 of 4 residents (#2 and #6) observed during the 8:00am medication pass on 04/29/26 related to a medication to treat vitamin B-12 deficiency (#2 and #6). The findings are: 1. Review of Resident #2's current FL2 dated 01/21/26 revealed diagnoses included atrial fibrillation, hypertension, and atherosclerotic heart disease. Review of Resident #2's signed physician's orders dated 02/24/26 revealed there was an order for warfarin (a medication used to thin the blood) 7mg every evening. Review of Resident #2's warfarin monitoring	D 358	Coumadin tracking log was immediately updated. DHW/designee will be responsible for reviewing log and following up throughout each week. ED/designee will review Coumadin log weekly to ensure ongoing compliance. DHW/designee will complete an order-to-MAR-to-cart audit to ensure all orders are current, accurately transcribed to MAR, and available for administration. Nurse Practitioner (NP) reviewed completed/audited med orders to verify accuracy on 5-19-26 Order Processing System was re-instituted. DHW/designee will review orders and System contents daily to ensure all orders are processed accurately and timely. DHW/designee will implement med-to-MAR audit to be completed for each resident monthly. Any issues will be reported to physician immediately for follow up orders. ED/designee will review audit results weekly during morning management meeting. Vitamin B order was obtained for Resident #6 to change route from SL to po per resident request. MA was re-educated regarding contacting physician whenever a resident requests a different form of medication or refuses the currently ordered form of medication.	

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D 358	Continued From page 10 results revealed: -On 02/19/26, the International Normalized Ratio (INR) test results were 1.99 (INR therapeutic goal was identified as 0.8-1.1). -On 03/10/26, the INR test results were 3.01. -On 04/02/26, the INR test results were 4.21. -On 04/09/26, the INR test results were 2.02. -Per the American Heart Association (AHA) and similar guidelines, the goal is to keep the INR at a therapeutic level to minimize stroke risk while preventing major bleeding. Review of Resident #2's signed physician's orders dated 04/02/26 revealed there was an order to hold warfarin 7mg on 04/03/26 for 48 hours, then resume at the same dosage. Review of Resident #2's April 2026 electronic medication administration record (eMAR) from 04/01/26 to 04/28/26 revealed: -There was an entry for warfarin 7mg every evening scheduled for administration at 5:00pm. -There was documentation that warfarin 7mg was administered from 04/01/26 to 04/05/26. -There was documentation that warfarin 7mg was held from 04/06/26 to 04/27/26. Observation of Resident #2's medication on hand on 04/28/26 at 2:00pm revealed: -There was a bubble pack medication card of warfarin 6mg dispensed on 03/11/26 for 28 tablets with 21 tablets remaining. -There was a bubble pack medication card of warfarin 6mg dispensed on 04/08/26 for 28 tablets with 28 tablets remaining. -There was a bubble pack medication card of warfarin 1mg dispensed on 03/11/26 for 28 tablets with 21 tablets remaining. -There was a bubble pack medication card of warfarin 1mg dispensed on 04/08/26 for 28	D 358		

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D 358	Continued From page 11 tablets with 28 tablets remaining. Interview with a medication aide (MA) on 04/29/26 at 1:50pm revealed: -She was aware of Resident #2's warfarin 7mg order. -She was not sure why Resident #2's warfarin 7mg was held from 04/06/26 to 04/27/26. -She never administered Resident #2's warfarin 7mg because it was not scheduled to be administered during her shift. -The MAs or the previous Health and Wellness Director (HWD) were in charge of processing new orders. -If she received a new order from a provider, she would fax the order to the facility's contracted pharmacy. -She did medication cart and eMAR audits twice a week. Interview with a second MA on 04/29/26 at 3:52pm revealed: -She was aware of Resident #2's warfarin 7mg order. -She had administered Resident #2's warfarin 7mg. -She was not aware of Resident #2's warfarin 7mg order to be held on 04/03/26 to 04/04/26. -She was not sure why Resident #2's warfarin 7mg was held from 04/06/26 to 04/27/26. -She never asked the previous HWD why Resident #2's warfarin 7mg was held from 04/06/26 to 04/27/26. Interview with the interim HWD on 04/29/26 at 3:30pm revealed: -She was not aware of Resident #2's warfarin 7mg hold order before being made aware on 04/28/26. -She was not sure why Resident #2's warfarin	D 358		

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D 358	Continued From page 12 7mg was not held on 04/03/26 to 04/04/26. -She was not sure why Resident #2's warfarin 7mg was held from 04/06/26 to 04/27/26. -The facility was responsible for adding medication hold orders to the eMAR. -The previous HWD received and processed Resident #2's warfarin 7mg hold order. -When the previous HWD added Resident #2's warfarin 7mg hold order to the eMAR she did not enter an "end date". -The previous HWD no longer worked at the facility. -She did medication cart and eMAR audits were done twice a month. -She was not sure why this error was not caught during audits. Telephone interview with Resident #2's primary care provider (PCP) on 04/28/26 at 3:18pm revealed: -She was not aware Resident #2's warfarin 7mg was held from 04/06/26 to 04/27/26. -Resident #2 was ordered warfarin 7mg for management of atrial fibrillation. -Missed doses of warfarin for atrial fibrillation could cause an increased risk for stroke. -Resident #2 had no apparent signs of negative side effects from the missed doses of warfarin. -She expected the facility to ensure medications were administered and held as ordered. Interview with the Administrator on 04/30/26 at 4:45pm revealed: -She was aware of Resident #2's warfarin 7mg hold order on 04/03/26 to 04/04/26. -On 04/06/26, the previous HWD noticed that Resident #7's warfarin 7mg was not held from 04/03/26 to 04/04/26. -The previous HWD contacted Residents #2's PCP and was instructed to hold the warfarin 7mg	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080030	A. BUILDING: _____ B. WING _____	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 13 from 04/06/26 to 04/07/26, then resume at the same dosage. -On 04/06/26, the previous HWD added the hold order to eMAR but did not put an "end date". -On 04/28/26, when the surveyor made her aware that Resident #2's warfarin 7mg had been held from 04/06/26 to 04/27/26, she contacted Resident #2's PCP and was instructed to restart at the same dosage that evening. 2. The medication error rate was 5% as evidenced by the observation of 2 errors out of 36 opportunities during the 9:00am medication pass on 04/29/26. a. Review of Resident #2's current FL2 dated 01/21/26 revealed diagnoses included atrial fibrillation, hypertension, and atherosclerotic heart disease. Review of Resident #2's signed physician's orders dated 02/18/26 revealed an order to start vitamin B-12 (used to treat and prevent vitamin deficiency) 1000mcg daily. Observation of the morning medication pass on 04/29/26 at 8:53am revealed: -The medication aide (MA) prepared 7 oral medications for administration to Resident #2 from medications packaged in bubble medication cards. -Vitamin B-12 1000mcg was not prepared to be administered. -The MA administered the 7 prepared oral medications to Resident #2. Observation of Resident #2's medication on hand on 04/29/26 at 8:56am revealed there was no vitamin B-12 1000mcg available for administration.	D 358		

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D 358	Continued From page 14 Review of Resident #2's April 2026 electronic medication administration record (eMAR) from 04/01/26 to 04/29/26 revealed there was no entry or documentation for vitamin B-12 1000mcg one tablet daily. Interview with the MA on 04/29/26 at 2:42pm revealed: -She routinely worked the morning shift and administered Resident #2's morning medications. -She was not aware of Resident #2's vitamin B-12 1000mcg order. -The MAs or the previous Health and Wellness Director (HWD) were in charge of processing new orders. -If she received a new order from a provider, she would fax the order to the facilities contracted pharmacy. -She was not sure why Resident #2's vitamin B-12 1000mcg order was not implemented. Interview with the interim HWD on 04/29/26 at 3:30pm revealed: -She was not aware of Resident #2's vitamin B-12 1000mcg order. -New orders were faxed by the previous HWD to the facility's contracted pharmacy. -She was not sure why the previous HWD did not fax Resident #2's vitamin B-12 1000mcg order. Telephone interview with Resident #2's primary care provider (PCP) on 04/30/26 at 10:21am revealed: -She was not aware Resident #2's vitamin B-12 1000mcg order had not been implemented. -She had not assessed any adverse effects in Resident #2 due to not receiving her vitamin B-12 1000mcg as ordered. -She expected the facility to ensure medications	D 358		

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 358	Continued From page 15 were administered as ordered. Interview with the Administrator on 04/30/26 at 10:15am revealed: -The previous HWD was responsible to ensure residents received medications as ordered. -She did not know Resident #2's vitamin B-12 1000mcg order had not been implemented. -A process to check behind the previous HWD was not in place to ensure all orders were being implemented. -She expected all medications to be administered as ordered. b. Review of Resident #6's current FL2 dated 05/08/25 revealed diagnoses included atrial fibrillation, chronic heart failure, and hyponatremia. Review of Resident #6's signed physician's order dated 12/09/25 revealed there was an order for vitamin B-12 (used to treat and prevent vitamin deficiency) sublingual 1000mcg, take 1 tablet under tongue once daily. Observation of the morning medication pass on 04/29/26 at 8:42am revealed: -The MA prepared 7 oral medications for administration to Resident #6 from medications packaged in bubble medication cards. -Resident #6's vitamin B-12 1000mcg was in the medication cup with other medications the MA prepared. -The MA did not separate the vitamin B-12 tablet from the other tablets. -The MA administered the 7 prepared oral medications to Resident #6. -Resident #6 swallowed the 7 oral medications. -The MA did not instruct Resident #6 to place the vitamin B-12 tablet under her tongue.	D 358		

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 358	Continued From page 16 Observation of Resident #6's medication on hand on 04/29/26 at 8:51am revealed -There was a bubble pack medication card of vitamin B-12 1000mcg available for 28 tablets with 9 tablets remaining. -The bubble pack medication card of vitamin B-12 1000mcg had instructions to place the tablet under the tongue. Review of Resident #2's April 2026 eMAR from 04/01/26 to 04/29/26 revealed: -There was an entry for vitamin B-12 1000mcg, take one tablet under tongue daily. -There was documentation vitamin B-12 1000mcg, take one tablet under tongue daily had been administered from 04/01/26 to 04/29/26. Interview with a MA on 04/29/26 at 2:49pm revealed: -She routinely worked the morning shift and administered Resident #6's morning medications. -She was aware of Resident #6's vitamin B-12 1000mcg take one tablet under tongue daily order. -Resident #6 did not like to place vitamin B-12 1000mcg tablet under her tongue to due the taste. -She had not contacted Resident #6's PCP about Resident #6 not wanting to place the vitamin B-12 1000mcg tablet under her tongue. -She expected medications to be administered as ordered. Interview with the interim HWD on 04/29/26 at 3:32pm revealed: -She was not aware of Resident #6's vitamin B-12 1000mcg order. -She was aware that some medications were to	D 358		

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D 358	Continued From page 17 be put under the tongue for administration. -She expected MAs to administer medications per their instructed route. Telephone interview with Resident #6's PCP on 04/30/26 at 10:21am revealed: -She was not aware Resident #6's vitamin B-12 1000mcg order had not been administered sublingually as ordered. -She had not assessed any adverse effects and did not have any concerns about Resident #6 not receiving her vitamin B-12 1000mcg as instructed. -She expected the facility to ensure medications were administered as ordered. Interview with the Administrator on 04/30/26 at 10:15am revealed: -She did not know Resident #6's vitamin B-12 1000mcg order had not been administered as ordered. -She expected MAs to administer medications per their instructed route. _____ The facility failed to ensure medications were administered as ordered to Resident #2 who had a diagnoses of atrial fibrillation and was not administered a medication for thinning the blood (warfarin), placing the resident at risk for a stroke. 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. 131D-34 on 04/28/26 for this violation. CORRECTION DATE FOR THE TYPE B	D 358		

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D 358	Continued From page 18 VIOLATION SHALL NOT EXCEED JUNE 14, 2026.	D 358		