STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034100	A. BUILDING: _____ B. WING _____	R 05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT AT UNIVERSITY PLACE	1635 EAST 5TH STREET WINSTON SALEM, NC 27101

(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	D 000		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure physician's orders were implemented for 1 of 5 sampled residents related to an order for laboratory blood tests (#5). The finding are: Review of Resident #5's current FL2 dated 03/31/26 revealed diagnoses included dementia, hypertension, and psychiatric disorder. Review of Resident #5's Resident Register revealed an admission date of 04/02/26. Review of Resident #5's Discharge Summary dated 4/2/26 revealed: -There was an order for a basic metabolic panel (a test for kidney function/electrolyte levels) (BMP) in 1 week. -Follow-up with primary care provider (PCP) in	D 276	Responses to cited deficiencies do not constitute an admission or agreement by the facility of truth of facts alleged or conclusions set forth in the Statement of Deficiencies or the Corrective Action Report. The Plan of Correction is prepared solely as a matter of compliance with state laws.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Executive Director (X6) DATE 5/29/26

Reviewed and acknowledged 6/1/26

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D 276	Continued From page 1 1-2 weeks. Review of Resident #5's record revealed there were no BMP laboratory test results available for review after 04/02/26. Interview with the Memory Care Coordinator (MCC) on 5/1/26 at 2:30pm revealed: -He was responsible for reviewing incoming paperwork including hospital discharge information to ensure orders are carried out and followed up on. -He was not aware of any orders for Resident #5. -He overlooked the order for Resident #5's BMP to be check in one week from 04/02/26. Interview with the Regional Clinical Director (RCD)on 4/29/26 at 10:00am revealed: -Resident #5 was a new admission to the facility on 04/02/26. -There was no order for Resident #5 to have a BMP. -There were no BMP completed for Resident #5. -She was unaware of the facility's process to obtain laboratory tests ordered for residents. Interview with Administrator on 5/1/26 at 11:22am revealed: - It was his and the MCC's responsibility to review incoming paperwork like discharge information to ensure orders, including request for laboratory values, are carried out and followed up on. - He was not aware of any orders for Resident #5 for a BMP to be done one week from 04/02/26.	D 276	10A NCAC 13F .0902(c)(3-4) HealthCare Facility shall ensure referral and follow-up meet routine and healthcare needs of residents. Regional Clinical Director, RN in serviced and reviewed rule area .0902 with Executive Director and Special Care Coordinator Executive Director, Special Care Coordinator and/or designee audited discharge paperwork for the last 30 days to ensure orders were implemented. Executive Director and Special Care Coordinators will review hospital discharge documents on a weekly basis during morning meeting to ensure compliance with .0902 (c)(3-4)	06/12/26 05/06/26 06/01/26 06/12/26
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 358		

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D 358	Continued From page 2 (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 2 of 5 sampled residents (#2, #5) related to medications for dementia with behaviors and a mood stabilizer (#5) and an antipsychotic (#2). The findings are: 1. Review of Resident #5's FL2 dated 3/31/26 revealed a diagnosis of dementia with behavioral problems. Review of Resident #5's hospital progress notes dated 03/31/26 and 04/01/26 revealed an active problem of dementia with behavioral disturbance with superimposed delirium and recent aggressive behavior. a. Review of Resident #5's FL2 dated 03/31/26 revealed: -There was an order for divalproex sodium (a mood stabilizing medication) 125mg two times a day at breakfast and lunch. -There was an order for divalproex sodium 250 mg at bedtime. Review of Resident #5's hospital discharge	D 358	10A NCAC 13F .1004 Medication Administration Facility will ensure compliance with rule area 10A NCAC 13F .1004 Medication Administration. Community Care Coordinator, Executive Director and/or designee completed resident records review, EMAR, to Physician orders, to medications cart audit. SCC and/or designee will conduct weekly EMAR to medication cart audits. Cart audit will be reviewed by ED during stand-up meetings. Orders, medications and/or treatments that need refill or have been missed, the CC and/or designee (Medication aides/SICs) will contact pharmacy and/or PCP. Regional Clinical Director, RN conducted training on .1004 Medication Administration with medication staff, special care coordinator and ED.	06/12/26 06/01/26 06/12/26 06/12/26 05/06/26

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D 358	Continued From page 3 summary dated 04/02/26 and 04/10/26 revealed an order to continue divalproex sodium 125mg after breakfast and lunch and 2 capsules (250mg) at bedtime. Review of Resident #5's April 2026 electronic medication administration record (eMAR) from 04/03/26 to 04/29/26 revealed: - There was an entry for divalproex sodium 125mg 1 capsule by mouth three times per day, after two meals, and at bedtime. Give 2 capsules at bedtime. -Divalproex sodium 125mg was scheduled for administration at 10:00am, 2:00pm, and 7:00pm. -Divalproex sodium 125mg was documented as administered one capsule 3 times a day for 78 of 78 opportunities from 04/03/26 at 7:00pm to 04/29/26 at 2:00pm. -There was no documentation divalproex sodium 250mg at bedtime was administered. Observation of Resident #5's medications on hand on 04/29/26 at 4:00pm revealed: -There was a partial bottle of divalproex sodium 125mg capsules DR dispensed from a local hospital outpatient pharmacy on 04/01/26 for 109 capsules. -The divalproex sodium 125mg bottle was labeled to take 1 capsule by mouth after breakfast and lunch and 2 capsules at bedtime. -Based on administration of 4 capsules daily for 25 days plus 2 capsules on 04/03/26 and two capsules on 04/29/26, Resident #5 should have received 104 capsules leaving a remainder of 5 capsules. -There were 31 of 109 capsules dispensed on 04/01/26 available for administration. Interview with a medication aide (MA) on 04/29/26 at 4:10pm revealed:	D 358	Community has re-implemented the order processing system. The order processing system shall be checked no less than twice daily by CC. ED will check order processing system no less than weekly to assure orders have been properly and timely implemented. Regional VP and/or Regional Clinical Nurse Director, RN will check order processing system during onsite visits. Regional VP and/or Regional Clinical Nurse will monitor medications dashboards no less than weekly for next 30 days to ensure compliance with .1004 Medication Administration.	06/12/26 06/12/26 06/12/26

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D 358	Continued From page 4 -She read from Resident #5's eMAR entry and label for divalproex sodium while being interviewed and they did not match. -The eMAR only allowed documentation for a quantity of 1 for the 7:00pm entry. -The facility's contracted pharmacy entered residents' orders into the eMAR. Interview with the a pharmacist at the facility's contracted pharmacy on 04/30/26 at 4:20pm revealed: -The pharmacy staff entered Resident #5's order for divalproex sodium 125 mg twice daily, after breakfast and lunch, and 2 capsules at bedtime on the facility's eMAR on 04/03/26. -The facility was able to change resident's eMAR entries as well as the pharmacy. -There was no documentation staff at the contracted pharmacy changed the directions on Resident #5's divalproex 125mg capsules. -The entry was later changed by facility staff in the eMAR system. -The pharmacy had not dispensed divalproex sodium 125mg DR capsules because the facility requested the pharmacy to hold on sending the medication until the resident's current supply was used. Interview with the Memory Care Coordinator (MCC) on 05/01/26 at 2:30pm revealed: -Both the pharmacy and facility could make changes to the eMAR. -New orders were sent to the pharmacy to be placed into the eMAR by pharmacy staff. -The pharmacy was to be notified if any changes were made in a resident's eMAR. -He was responsible to review all orders and ensuring orders are correct in the eMAR. -Medication carts were audited weekly by the MAs and the MCC provides oversight.	D 358		

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D 358	Continued From page 5 -He did not know that the entry on the eMAR, the physician's order, and medication label for Resident #5's divalproex sodium 125mg did not match. -He did not have a system in place to routinely audit medication orders compared to the entries of medications in the eMAR system. Interview with the Administrator on 05/01/26 at 11:30am revealed: -Resident #5's medication orders were from FL2 and the hospital discharge summary. -The pharmacy placed the medication orders into the eMAR. -Facility staff did not input orders or make changes to the eMAR. -The Administrator and the MCC were responsible to review discharge orders and to ensuring orders were correct and medications were administered as ordered. -He did not know that the eMAR and label for Resident #5's divalproex sodium did not match and the resident had received the incorrect dose of divalproex. Attempted telephone interview with Resident #5's primary care provider (PCP) on 05/01/26 at 11:14am was unsuccessful. Based on observations, interviews, and record reviews, it was determined Resident #5 was not interviewable. b. Review of Resident #5's FL2 dated 03/31/26 revealed: -There was an order for olanzapine (a mood stabilizing medication) 2.5 mg daily with breakfast. -There was an order for olanzapine 5mg at supper and at bedtime.	D 358		

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D 358	Continued From page 6 Review of Resident #5's hospital discharge summary dated 04/02/26 revealed: -There was an order for olanzapine 5mg tablet: take one half tablet (2.5 mg dose) by mouth with breakfast and 1 tablet at supper and 1 tablet at bedtime. -There was an order for olanzapine 5 mg tablet: take one half tablet (2.5 mg) every 6 hours as needed (PRN) for agitation. Review of Resident #5's April 2026 eMAR from 04/03/26 to 04/29/26 revealed: -There was an entry for olanzapine 2.5 mg (5mg one half tablet): two times a day with meals schedule at 8:00am and 5:30pm. Please break tablet in half and give with breakfast and dinner. -Olanzapine 2.5mg was documented as administered for 52 of 52 opportunities for one-half of 5mg tablets. -There was an entry for olanzapine 2.5mg (5mg one half tablet) PRN. -Olanzapine 2.5mg (5mg one half tablet) PRN was documented as administered on 04/11/26 at 1:16pm, 04/23/26 at 10:36pm, 04/27/26 at 10:57pm and 04/27/26 at 2:19am for a total of 4 doses (2 tablets). -There was no entry for olanzapine 2.5mg (5mg one half tablet) with breakfast, and one tablet with supper and one tablet at bedtime as ordered on 04/02/26. Observation of Resident #5's medication on hand on 04/29/26 at 4:00pm revealed: -There was a partially full medication bottle of olanzapine 5mg dispensed from a local hospital on 04/01/26 for 45 tablets. -The bottle was labeled take ½ tablet (2.5 mg) by mouth with breakfast and 1 tablet at supper and 1 tablet at bedtime.	D 358		

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D 358	Continued From page 7 -There were 23 of 45 olanzapine 5mg labeled to take one half tablet (2.5 mg dose) daily with breakfast and 1 tablet at supper and 1 tablet at bedtime dispensed 04/01/26. -There was a partially full medication bottle dispensed from a local hospital pharmacy dispensed on 04/01/26 for a quantity of 30 tablets containing 19 half tablets. -The bottle was labeled olanzapine 5 mg one half tablet (2.5 mg) every 6 hours as needed for agitation. Interview with a medication aide (MA) on 04/29/26 at 4:33pm revealed: -She did not know that Resident #5's olanzapine order was incorrect on the eMAR. -The pharmacy entered the information into the eMAR. -MAs must have used the split olanzapine 5mg PRN tablets for some daily administrations. Interview with the a pharmacist at facility's contracted pharmacy on 04/30/26 at 4:20pm revealed: -The pharmacy staff entered Resident #5's order for olanzapine into the eMAR for 2.5 mg at breakfast and 5 mg at supper and bedtime. -She was not aware Resident #5's eMAR had directions for olanzapine 2.5 mg take one half tablet by mouth two times a day with meals schedule at 8:00am and 5:30pm. Please break tablet in half and give with breakfast and dinner. -The order was changed by facility staff in the eMAR, according to electronic time stamps that she reviewed. -The facility could make changes to the eMAR as well as the pharmacy. -The facility should notify the pharmacy for changes made to the residents' eMARs. -The pharmacy had not dispensed olanzapine	D 358		

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D 358	Continued From page 8 2.5mg or 5mg tablets for Resident #5 because the facility requested the pharmacy to hold on sending until the resident's current supply was used. Interview with the MCC on 05/01/26 at 2:30pm revealed: -Both the pharmacy and facility staff could make changes to the residents' eMAR. -New orders were sent to the pharmacy to be entered into the eMAR system. -The pharmacy was to be notified if any changes were made in the eMAR. -He was in charge of reviewing all discharge orders and ensure orders were correct in the eMAR. -Medication carts were audited weekly by the MAs and he provided oversight. -He did not know that Resident #5's olanzapine order was incorrect on the eMAR. -He did not currently have a system in place to routinely audit medication orders compared to the entries of medications in the eMAR system. Interview with the Administrator on 05/01/26 at 11:30am at revealed: -Resident #5's medication orders were from the FL2 and the hospital discharge summary. -The pharmacy entered medication orders into the eMAR. -Facility staff did not enter orders or make changes in the eMAR. -It was his and the MCC's responsibility to review incoming paperwork including discharge information to ensure orders were correct. -He did not know that Resident #5's olanzapine order was incorrect on the eMAR. -He expected medications to be administered as ordered.	D 358		

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D 358	Continued From page 9 Attempted telephone interview with Resident #5's primary care provider (PCP) on 05/01/26 at 11:14am was unsuccessful. Based on observations, interviews, and record reviews, it was determined Resident #5 was not interviewable. 2. Review of Resident #2's current FL2 dated 10/06/25 revealed diagnoses included unspecified dementia, hypertension, and low back pain. Review of Resident #2's Resident Register revealed an admission date to the facility on 08/18/25. Review of Resident #2's hospice physicians orders dated 02/09/26 revealed: -There was an order for quetiapine (used to psychotic behaviors) 25mg every morning. -There was an order for quetiapine 50mg at bedtime. Review of Resident #2's signed physician order review dated 03/02/26 revealed an order for quetiapine 25mg in the morning and quetiapine 50mg at bedtime Review of Resident #2's hospice visits note dated 04/14/26 revealed there was documentation to increase quetiapine to 50mg in the morning and 75mg at bedtime. Observation of medication on hand for administration on 05/01/26 revealed: -There were 2 of 7 quetiapine 25mg dispensed for 7 tablets on 04/27/26. -There were 3 of 7 quetiapine 50mg dispensed for 7 tablets on 04/27/26.	D 358		

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D 358	Continued From page 10 Review of Resident #6's February 2026 and March 2026 electronic medication administration records (eMARs) revealed: -There was an entry for Seroquel (quetiapine is generic) 25mg every morning scheduled for administration at 8:00am daily. -There was an entry for quetiapine 50mg at bedtime scheduled for administration at 8:00pm daily. -There was documentation quetiapine 25mg was administered daily at 8:00am from 02/01/26 to 03/31/26. -There was documentation quetiapine 50mg was administered daily at 8:00pm from 02/01/26 to 03/31/26. Review of Resident #2's April 2026 eMAR from 04/01/26 to 04/29/26 revealed: -There was an entry for quetiapine 25mg every morning scheduled for administration at 8:00am daily. -There was an entry for quetiapine 50mg at bedtime scheduled for administration at 8:00pm daily. -There was documentation quetiapine 25mg was administered daily at 8:00am from 04/01/26 to 04/29/26. -There was documentation quetiapine 50mg was administered daily at 8:00pm from 04/01/26 to 04/28/26. -There was entry for quetiapine 50mg every morning beginning 04/14/26. -There was no entry for quetiapine 50mg at bedtime beginning 04/14/26. Telephone interview with a pharmacist with the facility's contracted pharmacy on 04/30/26 at 4:45pm revealed: -The contracted pharmacy entered medications orders on the facility's eMARs based on current	D 358		

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D 358	Continued From page 11 physician's orders received from the facility. -The pharmacy dispensed weekly cycle filled medications to the facility. -The cycle filled medications were packaged in multi-dose bubble packages with the medications separated by time of day scheduled for morning, noon, afternoon and bedtime. -The current order for Resident #2's quetiapine was 25mg in the morning and 50mg at bedtime as ordered on 02/09/26. -On 04/16/26, the facility faxed hospice visit notes dated 04/14/26 with documentation to increase quetiapine to 50mg in the morning and 75mg at bedtime. -The pharmacy did not receive physician's order written or electronically prescribed for the quetiapine 50mg in the morning and 75mg at bedtime dated 04/14/26. -There was no documentation that the pharmacy had corresponded with the facility regarding needing the physician's order. -The facility was responsible to send all orders to the pharmacy for processing. Telephone interview with Resident #2's Hospice Nurse(HN) on 05/01/26 at 11:50am revealed: -She saw Resident #2 in the facility on 04/14/26. -The HN had consulted with the Hospice primary care provider (PCP) and was instructed to increase Resident #2's quetiapine to 50mg in the morning and 75mg at night. -The HN had documented the change to the quetiapine on the visit notes and written an order for the change per the PCP's instruction. -The facility, not the HN, was responsible for sending the orders to the residents' pharmacy. -She saw Resident #2 on 04/30/26 and reviewed the resident's eMAR. -She reordered the quetiapine 50mg in the morning and 75mg at bedtime on 04/30/26 when	D 358		

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D 358	Continued From page 12 she discovered the resident's quetiapine had not been changed. -Not receiving the increased quetiapine could add to the resident's anxiety and affect her behaviors. Interview with the Memory Care Coordinator (MCC) 05/01/26 at 12:00pm revealed: -He knew Resident #2's quetiapine was changed to 50mg in the morning and 75mg at bedtime on 04/14/26. -He faxed the HN visit information to the contracted pharmacy on 04/16/26. -He did not realize there was no signed order for the quetiapine 50mg and 75mg change along with the information faxed to the contracted pharmacy. -There was no current order tracking system in place to audit physician's orders, hospice notes for orders, compared to the resident's eMAR and medications on hand for administration. -He did not know Resident #2's quetiapine was incorrectly administered from 04/14/26 to 04/30/26. Interview with a medication aide (MA) on 05/01/26 at 2:00pm revealed: -She administered medications according to the eMAR after comparing the medications listed on the eMAR and the medications pre-packed by the contracted pharmacy. -The contracted pharmacy sent resident's medication in multi-dose packages dispensed for one week at a time. -She did not have access to resident's medication orders. -Resident #2's quetiapine order and medication available was currently 25mg in the morning and 50mg at bedtime. -The MCC was responsible for ensuring medication orders were processed.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034100	A. BUILDING: _____ B. WING _____	R 05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET COURT AT UNIVERSITY PLACE	1635 EAST 5TH STREET WINSTON SALEM, NC 27101

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D 358	Continued From page 13 Interview with the Administrator on 05/01/26 at 4:50pm revealed: -He expected medications to be administered as ordered. -The medications were supposed to be audited weekly by the MCC to ensure the residents' eMAR and medications on the cart matched. -The MCC was responsible for ensuring all medication orders were faxed to the contracted pharmacy and were correct on the eMAR and matched the medications on the cart for administration. -The facility did not currently have a system in place for tracking medication orders other than the MCC reviewing orders. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable. Attempted interview with Resident #2's Hospice PCP on 05/01/26 at 12:00pm was unsuccessful. The facility failed to ensure medications were administered as ordered for 2 of 5 residents (#2 and #5), related to administering medications for behavior control to a resident with dementia and behavioral problems (#5) and to a resident with dementia to treat anxiety and behaviors (#2) placing the residents at risk for depression (#2) and adverse behaviors (#2 and #5). This failure was detrimental to the health, safety and welfare of the residents which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/01/2026 for this violation.	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 14 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 15, 2026.	D 358		