STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345479	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salemtowne	**1550 Babcock Drive , Winston-Salem, North Carolina, 27106**

(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) COMPLETION DATE
F0000	INITIAL COMMENTS A complaint investigation survey was conducted on 3/26/26. Event ID# 22C285-H1. The following intakes were investigated: 2807905 and 2785711. 1 of 5 complaint allegations resulted in deficiency.	F0000		04/01/2026
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and staff, Hospice Nurse, and Nurse Practitioner interviews, the facility failed to prevent a significant medication error when Medication Aide #1 (MA #1) administered Resident #1 Morphine 50 milligrams (mg) instead of the ordered 5 mg (Morphine is an opioid pain medication used in hospice care to relieve moderate-to-severe pain, anxiety, and severe breathlessness at the end of life). This deficient practice affected 1 of 3 residents reviewed for significant medication errors. The findings included: Resident #1 was admitted to the facility on 2/24/26 with history of multiple strokes and end of life care management. The Minimum Data Set (MDS) 5-day assessment dated 3/2/26 revealed Resident #1 was severely cognitively impaired. Resident #1 was dependent on staff for all activities of daily living and received hospice care. Review of physician orders showed an order dated 2/24/26 for Morphine 20 mg/milliliters (ml) take 0.25 ml every 4 hours as needed for pain and shortness of	F0760	Medication Aide administered incorrect dose of PRN liquid morphine to the resident on 3/4/2026 at 1:55pm, this did not result in harm to the resident, and resident remained at the facility on hospice services. The resident was to receive .25ml of liquid morphine and received 2.5ml of liquid morphine. The Medication Aide failed to check the medication label against the eMAR (concentration) and verify the dose was correct and within a safe range. The “why” for deficient practice was identified as the Medication Aide failed to follow the 6-rights of administering medication, #2 “Right Medication: check the medication label against the medication administration record (eMAR) three times to ensure it is the correct, prescribed medication” and #3 “Right Dose: verify the dose is correct, within a safe range, and that any required, calculations are double-checked.” Immediately upon being notified of the medication error, the DON confirmed the resident was stable with the Nursing Supervisor and Clinical Lead and then contacted the HPOA to notify him of the medication error. Physician assessed resident on 3/6/2026, no new orders were given. 2. The facility identified all residents with orders for liquid morphine that could be at risk for a medication error with the wrong dose being administered. The DON conducted a full facility audit on 3/6/2026 of all residents identified to be on liquid morphine to	04/01/2026

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F0760 SS = D	Continued from page 1 breath. Review of narcotic record showed the pharmacy supplied the ordered Morphine 20 mg/ml in a 30ml bottle. Further review showed MA #1 documented on 3/4/26 at 1:55 pm she administered 2.5ml to Resident #1 with 27.50ml remaining in the bottle. During an interview on 3/26/26 at 2:28pm with MA #1 she stated she had worked with Resident #1 several times since his admission. MA #1 reported on 3/4/26 shortly after lunch, a family member came out of Resident #1's room and stated to her that it appeared Resident #1 was having pain or discomfort. MA #1 stated when she entered the room, Resident #1 did appear restless, which was not usual for him. MA #1 reported she returned to the medication cart to retrieve the bottle of Morphine. MA #1 stated she was sure she looked at the bottle label and checked the directions before pouring out 2.5 ml and administering it to Resident #1. MA #1 stated she returned to check on Resident #1 about an hour later and noted he was sleeping and resting comfortably. MA #1 reported Resident #1's chest was rising and falling with no breathing issues and his skin was dry and warm with no discolorations to his lips or fingertips. MA #1 stated she did not realize she had read the instructions on his Morphine order incorrectly until it was brought to her attention 2 days later when Nurse #1 went to administer a second dose to Resident #1. Multiple attempts to reach Nurse #1 were unsuccessful. During an interview with Hospice Nurse #1 on 3/26/26 at 3:44pm, she stated that she arrived at the facility on 3/4/26 at approximately 9:30pm for a routine assessment of Resident #1. Hospice Nurse #1 stated they do not routinely gather vital signs other than oxygen saturation which was 97% on room air when she tested. Hospice Nurse #1 stated she found Resident #1 to be resting comfortably in bed. She noticed no labored breathing and his chest was rising and falling with ease. Hospice Nurse #1 also stated that Resident's skin was dry and warm and there were no discolorations to his lips or fingertips that would indicate he was not getting enough oxygen. Hospice Nurse #1 stated she was not made aware of the medication error until she was contacted by the facility around midnight on 3/6/26 and asked to come out and reassess Resident #1 (she works 5:00pm to 5:00 am) and at that time he was alert,	F0760	Continued from page 1 confirm orders and concentrate matched. Facility's EHR report of residents on liquid morphine on 3/6/2026 was used to conduct audit. All 5 medication carts and resident orders for liquid morphine were audited for compliance. 100% compliance noted on 3/6/2026. The facility identified residents with orders for all oral liquid medication that could be at risk for a medication error with the wrong dose being administered. DON conducted a full facility audit on 3/9/2026 of all residents on all oral liquid medications to confirm orders and medication labels matched. Facility's EHR report of residents on all oral liquid medication on 3/6/2026 - 3/9/2026 used to conduct audit. All 5 medication carts and resident orders for all oral liquid medication were audited for compliance. 100% compliance noted on 3/9/2026. The facility identified residents receiving medication could be at risk for a medication error if the Nurse/Medication Aide does not follow the 6-Rights of Medication Administration. The Staff Development Coordinator (SDC) provided Nurses and Medication Aides in person education on the 6-rights of medication administration. Validation of understanding was conducted through return demonstration and verbal acknowledgement. The education was conducted on 3/9/2026 through 3/13/2026. 3. Nurses and Medication Aides were re-educated on the 6-Rights of Medication Administration from 3/9/2026 through 3/13/2026 by the Staff Development Coordinator. The Staff Development Coordinator will provide education during the orientation program for new hires, annual training and added to the agency communication binders. Validation of understanding was conducted through	

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F0760 SS = D	Continued from page 2 responded to his name being called but did not respond to any of her questions. Hospice Nurse #1 added that Resident #1 seemed to be gradually declining since she had first seen him the week prior, which she had expected. During an interview with the Director of Nursing (DON) on 3/26/26 at 4:05 pm, she stated that Nurse #1 alerted her on 3/6/26 around midnight that Resident #1 was given an incorrect dose of Morphine on 3/4/26. The DON stated she arrived at the facility and assessed Resident #1 to be resting comfortably, skin was dry and warm, and vital signs were stable. The DON stated that when she looked at Resident #1's narcotic sheet with Nurse #1, she saw that MA #1 had documented giving the only dose out of the 30 ml bottle on 3/4/26 and there was 27.50ml remaining in the bottle. Comparing to the order, she stated she could see that Resident #1 should have only received 0.25ml but was administered 2.5ml instead. The DON stated that the current process for counting narcotics was for two staff members to count during each shift change. She stated the nurses will look at the beginning amount, the amount given, and the amount remaining so the error wasn't noted during shift change counts. The DON stated that the error was only discovered because Nurse #1 saw the amount documented as administered on 3/4/26 was 2.5ml and she was getting ready to administer 0.25ml per the order. During an interview with the Nurse Practitioner (NP) on 3/26/26 at 4:30 pm, she stated she assessed Resident #1 on 3/5/26 after the medication error and found him to be alert and responsive to his name but did not respond to her questions. She stated he did not appear to be in any discomfort; his skin was dry and warm with no discolorations. The NP stated that Resident #1 was receiving end of life services and had been gradually declining over the last week, so she expected him to not be very alert or responsive to her questions. The NP stated that even though Resident #1 received a much higher dose of Morphine on 3/4/26 than he should have been administered per the order, it did not affect his outcome and Resident #1 passed away peacefully on 3/7/26. During an interview with the Administrator on 3/26/26 at 5:00pm, she stated the DON made her aware of the medication error on 3/6/26 when it was discovered.	F0760	Continued from page 2 return demonstration and verbal acknowledgement. Staff Development Coordinator is responsible for providing the education. 4. The person responsible for the auditing and monitoring completion is the Staff Development Coordinator. The Staff Development Coordinator (SDC) or designee will be auditing Nurses and Medication Aides for execution of and accuracy of the 6-Rights to Medication Administration (1. Right Patient 2. Right Medication 3. Right Dose 4. Right Time 5. Right Route 6. Right Documentation). An auditing tool was developed by the Director of Nursing titled, Medication Administration Observation Tool - 6 Rights Audit to be used by the SDC or designee. The SDC or designee will randomly audit through observation of medication administration with proper use of the 6-Rights to Medication Administration. The audits will include residents with and without liquid medication. The SDC or designee will conduct random daily audits for four (4) weeks, then weekly for four (4) weeks, then monthly for four (4) consecutive months. The SDC will report the findings to the QAA/QAPI Committee for review and approval monthly. This investigation and Plan of Correction was presented to and approved by the QAA/QAPI Committee on 3/19/2026. 5. Plan of Correction Completion Date: 4/01/2026.	