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

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] with history of multiple strokes and end of life care management. The Minimum Data Set (MDS) 5-day assessment dated [DATE] 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 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, 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 (continued on next page)

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#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.