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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 05/28/25 - 05/30/25 with an exit conference via telephone on 05/30/25.	D 000		
D 067	10A NCAC 13F .0305 (h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) in facilities with at least one resident who is determined by a physician or is otherwise observed by staff to be disoriented or exhibits wandering behavior, a continuously sounding device that is activated when the door is opened shall be located on each exit door that opens to the outside. The sound shall be audible in the facility. If a central system of remote sounding devices is provided, the control panel shall be powered by the facility's electrical system, and be in a location accessible by staff to operate the control panel. Notwithstanding the requirements of Rule .0301, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure 8 of 8 sampled exit doors had a sounding device engaged that was audible throughout the facility at all times when the doors were opened which were accessible to 5 of 6 sampled residents (#2, #3, #4, #5, #8) who were documented as	D 067		

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disoriented including a resident (#2) who exited the facility without staff's knowledge and was found lying in the driveway after a fall with injuries requiring hospitalization and rehabilitation.

The findings are:

Review of the facility's current license effective 01/01/25 revealed the facility was licensed for 122 assisted living (AL) beds.

Review of the facility's census on 05/28/25 revealed there were 79 residents residing in the AL facility.

Review of the facility's Resident Exiting and Wandering Policy dated 02/02/21 revealed:
-The purpose of the policy was to establish a lawful, ethical, and resident-centered approach to managing residents' access to and from the facility, movement throughout the facility, in accordance with North Carolina (NC) laws and regulations.
-The facility supported the right of competent residents to exit and re-enter the facility freely.
-Residents may only be prevented from exiting if: a physician had provided a written order indicating the resident required secure memory care due to cognitive impairment and was a safety risk if allowed to leave unsupervised; the resident had been legally adjudicated incompetent and a court had assigned a guardian with authority to limit movement; the resident was in clear, immediate, and documentable danger (e.g. attempting to walk into traffic), justifying temporary emergency intervention.
-Door alarms shall be installed and activated only when required under 10A NCAC 13F .0305(h)(4), which applied to facilities with at least one resident known to be disoriented.

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-Alarms were intended as alerts, not barriers.
-Staff may respond, observe, and engage - but not restrain unless immediate safety was at risk.
-Doors shall remain accessible to exit.

Observation of the facility's main entrance door on 05/28/25 at 8:45am revealed the door was unlocked and did not alarm when the survey team entered the facility.

Observation during initial tour of the facility on 05/28/25 at 9:15am on the 100 hall revealed:
-The exit door near the laundry room was unlocked.
-There was no audible alarm sound when opened.

Observation during initial tour of the facility on 05/28/25 at 10:13am on the 100 hall revealed:
-The exit door near the activity room was unlocked.
-There was no audible alarm sound heard when the door was opened.
-The exit led to a side patio that was part of the front side of the facility.

Observation during initial tour of the facility on 05/28/25 at 9:20am on the 200-hall revealed:
-The exit door near the small dining room was unlocked and did not alarm when opened.
-The exit door led into a porch with a metal gate that was unlocked and did not alarm when opened.

Observation during initial tour of the facility on 05/28/25 at 9:21am on the 300 hall revealed:
-The exit door near resident room 305 was unlocked and did not alarm when opened.
-The exit door led into a courtyard with a metal gate that was unlocked and did not alarm when

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opened.

Observation during initial tour of the facility on 05/28/25 at 9:46am on the 300 hall revealed:
-The exit door near resident room 300 was unlocked and did not alarm when opened.
-The exit door led into an outside area near the main driveway for the facility that was enclosed with 2 metal gates on each side.
-Both metal gates were unlocked and did not alarm when opened.

Observation during initial tour of the facility on 05/28/25 at 9:47am in the great room revealed:
-The exit door to the left side of the great room was unlocked and did not alarm when opened.
-The exit door led into an outside area with a fence 3'- 4' in height.
-The walkway led down to a gate near a parking lot for the facility.
-There were 2 patio areas with latched but not locked gates which led into residents' rooms from their patios.
-The metal gates into the residents' patios and that led out into the parking lot were unlocked and did not alarm when opened.

Observation during initial tour of the facility on 05/28/25 at 10:05am on the 400 hall revealed:
-The exit door near resident room 410 was unlocked and did not alarm when opened.
-The exit door led into a small fenced in area with a metal gate that was unlocked and did not alarm when opened.

Interview with a personal care aide (PCA) on 05/28/25 at 9:48am revealed:
-The alarms on all exit doors were turned off during the day.
-The exit door alarms were turned on at night at

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8:00pm and turned off the next morning around 7:00am when first shift staff arrived.
-If a door alarm sounded, there were switchboards on the walls at the nurses' stations for staff to turn the alarms off and reset them.
-She was not aware of any residents who had wandering behaviors.

Interview with a medication aide (MA) on 05/29/25 at 11:07am revealed:
-The facility door alarms were off from 8:00am to 8:00pm daily.
-She would turn off the door alarms around 7:45am when she arrived at work.
-The second shift staff were responsible for turning on the door alarms, but she did not know when the alarms were turned on.
-There were at least four residents whom she identified as "wanderers".

Interview with the Resident Care Director (RCD) on 05/28/25 at 3:50pm revealed:
-The alarms on the exit doors were not turned on during the day because the facility was not a memory care unit.
-The alarms on the exit doors were turned on every day from 8:00pm to 8:00am.
-That was a policy he inherited from the previous RCD.
-He thought the door alarms only had to be turned on at all times if the facility had "wanderers".
-They did not have any "wanderers" to his knowledge.
-There were residents in the facility who were disoriented but he was not aware door alarms needed to be turned on for residents who were disoriented.

1. Review of Resident #2's current FL-2 dated

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06/07/24 revealed:
-Diagnoses included type II diabetes, hypertension, hyperlipidemia, gastroesophageal reflux disease (GERD), history of transient ischemic attack (TIA), depression, irritable bowel syndrome, and cerebral infarction without residual.
-Resident #2 was ambulatory without an assistive device.
-Resident #2's was intermittently disoriented.

Review of Resident #2's progress note dated 01/28/25 at 7:51pm revealed:
-Resident #2 was seen walking out of her room wearing only one sock.
-Resident #2 stated she was going home, and staff could not keep her at the facility.
-Resident #2 was escorted back to her room and informed staff she had millions of dollars' worth of diamonds and asked staff to retrieve the jewelry.
-Resident #2 became agitated and accused the staff of taking her jewelry.

Review of Resident #2's progress note dated 01/28/25 at 8:43pm revealed:
-Resident #2 tried to leave the facility for a second time that evening.
-Staff was able to redirect Resident #2 before she could get to the door.

Review of Resident #2's progress note dated 01/29/25 at 1:32am revealed:
-Resident #2 kept coming out of her room stating she was going home.
-Staff redirected Resident #2 back to her room each time.

Review of Resident #2's progress note dated 02/02/25 at 10:37pm revealed:
-Resident #2 had been directed twice for trying to

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leave the facility stating that she was going home.
-The medication aide (MA) was able to get Resident #2 back in her room and settled in bed.
-Resident #2 was not found in her room after the final rounds.
-Resident #2 was found outside on the facility grounds.
-Resident #2 had fallen and possibly had a broken arm, head lacerations and face injuries.

Review of Resident #2's incident report dated 02/02/25 revealed:
-The date and time of the incident was 02/02/25 at 10:27pm.
-The type of incident was listed as "fall of unknown origin".
-The location of the incident was other: outside on community grounds.
-The signs of injuries were documented as a "cut on head and EMTs (emergency medical technicians) said a possible broken arm".
-Resident #2 was transported to a local hospital.
-It was documented the primary care provider (PCP) was notified on 02/03/25 at 8:00am.
-It was documented the Responsible Person was notified on 02/02/25 at 10:28pm.
-It was documented that the previous Resident Care Director (RCD) was the person who completed the report on 02/03/25 at 8:45pm.

Review of Resident #2's rehabilitation transfer/discharge report dated 03/19/25 revealed:
-Diagnoses included unspecified dementia, anxiety disorder, cognitive communication deficit, depression, displaced fracture of coronoid process of unspecified ulna, subsequent encounter for closed fracture with routine healing, essential hypertension, hypomagnesemia, muscle weakness, other mechanical complication

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of other internal orthopedic devices, primary osteoarthritis, unspecified abnormalities of gait and mobility, unspecified fracture of the lower end of right radius, cerebral infraction, coronavirus infection, encephalopathy, hyperlipidemia, influenza, personal history of (healed) traumatic fracture, type 2 diabetes, and unspecified intracranial injury without loss of consciousness.
-Resident #2 had been admitted to the rehabilitation facility on 02/03/25 and discharged on 03/19/25.
-Resident #2 would be discharged back to the assisted living facility.

Interview with Resident #2 on 05/29/25 at 6:50pm revealed she remembered falling and breaking her arm but did not remember when and where the fall occurred.

Interview with a personal care aide (PCA) on 05/29/25 at 1:10pm revealed:
-The door alarms were turned on during the day most of the time.
-The MAs would turn off the door alarms when they arrived at 7:00am.
-Resident #2 would not always remember where she was but she was easily redirected.
-Resident #2 had come to the nurses' station on 05/27/25 and she did not know where she was.

Interview with a second PCA on 05/29/25 at 6:02pm revealed:
-Resident #2 had come to her on the evening of 02/02/25 asking where her room was; the PCA escorted Resident #2 back to her room.
-Resident #2 had come out of her room for a second time on 02/02/25 asking for snacks; the PCA provided Resident #2 with snacks and escorted her back to her room.
-During the rounds on 02/02/25, between 9:00pm

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and 10:00pm, the PCA checked on Resident #2 and found that she was not in her room.
-The assigned MA was notified immediately.
-Resident #2 was found outside in the side circle driveway nearest the 100 hall.
-Resident #2 had a visible head injury and she was bleeding from her head and knee.
-Resident #2 was confused and crying, saying she wanted to go home.
-Resident #2 complained that her arm was hurting.
-The door alarms were to be turned on by the third shift staff.
-The MAs were responsible for turning on the door alarms.
-She did not remember if the door alarms had been turned on during the second shift on 02/02/25.
-The doors had not been locked during the second shift on 02/02/25 because she was able to enter the building after being asked to further assist in aiding Resident #2.
-She did not remember how long Resident #2 had not been in her room when she was found outside.

Interview with a MA on 05/29/25 at 10:46pm revealed:
-Resident #2 would at times walk towards the front door saying she was leaving and going to her car.
-Resident #2 did not have a car.
-She noticed Resident #2 had gone outside last week (date not provided) and sat thinking her family member was coming to take her to lunch.
-She went outside and asked Resident #2 to come back inside for lunch.
-She called Resident #2's family member and had the family member tell the resident that the family member could not take the resident out for lunch

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because the family member had to work.
-Resident #2 would wander around almost daily around 3:00pm.

Interview with a second MA on 05/29/25 at 5:18pm revealed:
-She had learned Resident #2 was not in her room on 02/02/25 by a PCA around 8:30pm.
-She immediately gathered all of the staff, and a search began.
-She found Resident #2 outside lying on the ground in the side circle driveway nearest the 100 hall.
-Resident #2 had fallen and had a head injury and facial bruises.
-Resident #2 was crying and said her arm was hurting.
-When the EMTs arrived, they assessed Resident #2 for a possible broken arm due to the fall.
-Resident #2 was wearing a pajama set, one bedroom shoe and no socks.
-She did not know which door Resident #2 had exited out of.
-She had turned on the exit door alarms for the 100 and 200 halls but the door alarms for the 300 and 400 halls had been disarmed.
-She did not know who had turned off the door alarms.
-She completed an incident report on 02/02/25 and placed the report in the previous RCD's folder.
-Resident #2 wandered a lot since she had been admitted to the facility and always stated she was going home.
-She did not know why Resident #2 wanted to leave the evening of 02/02/25.
-The weather on the evening of 02/02/25 was windy, light drizzle and cold.

Telephone interview with Resident #2's power of

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attorney (POA) on 05/29/25 at 2:43pm revealed:
-She received a call from the facility staff on 02/02/25 around 10:30pm that Resident #2 tried to leave the facility and had a bad fall and was found outside at the end of the first circle driveway.
-She had been informed the door alarm had not been set.
-Resident #2 had suffered a head injury, broken arm and facial bruises.
-The weather on the night of 02/02/25 was in the low to mid 40s.
-Resident #2 had a diagnosis of dementia and the facility was aware of the diagnosis.
-Staff would inform her of Resident #2's wandering behavior and said they were able to redirect her but had not provided any additional interventions.
-She had inquired with the Administrator when the door alarms were to be set at night but was never provided a clear answer.

Telephone interview with Resident #2's family member on 05/29/25 at 2:43pm revealed:
-The family member had been informed by the Administrator that Resident #2 had been outside for 30 to 45 minutes before she was found outside.
-Resident #2 had tried to leave the facility a couple days before she was found outside on the evening of 02/02/25.

Telephone interview with Resident's #2's current PCP on 05/30/25 at 1:30pm revealed:
-Resident #2 was a new patient and was last seen on 05/13/25.
-Resident #2 had a diagnosis of dementia.
-The outside door alarms should be activated at all times for the safety of residents who had wandering issues.

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D 067	Continued From page 11 Interview with the Administrator on 05/29/25 at 3:43pm revealed: -Resident #2 had gone outside and fell and was brought back inside of the facility on the 02/02/25 incident. -The 02/02/25 incident occurred around 10:30pm. -Resident #2 was found outside along at the end of the circle driveway. -He had reviewed the surveillance camera footage and Resident #2 had been outside for about 5 minutes. -He could not remember the type of injuries Resident #2 had sustained. -He no longer had access to the 02/02/25 surveillance camera footage. -He was not sure if the front door alarm had been turned on the evening of the 02/02/25 incident, but did not see a reason why the front alarm had not been turned on. -The front door alarm was turned on by the last front office staff to leave for the day. -There was a panel box that specified the exact door and gate when the alarm was triggered. 2. Review of Resident #8's current FL-2 dated 05/06/25 revealed: -Diagnosis included Alzheimer's disease. -Resident #8 was constantly disoriented and ambulatory without any assistive devices. Observation of Resident #8 on 05/28/25 at 1:35pm revealed: -The resident was in the hall near the front intersecting hallways. -The resident was looking around and appeared disoriented. Review of Resident #8's progress notes revealed: -On 04/27/25 at 2:48pm, Resident #8 was a little	D 067		

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confused that morning and needed help getting dressed.
-On 04/27/25 at 7:02am, Resident #8 appeared confused and unsteady that morning; he went into the hallway and urinated on the hall floor.
-On 04/24/25 at 4:50pm, Resident #8 followed another resident out of an exit door on the 400 hall and had to be redirected to go back inside.
-On 03/02/25 at 6:40am, Resident #8 had packed his bags wanting to leave, and he said his roommate was annoying him and they had been "feuding" since 6:15am and he made one attempt to leave.

Interview with the Resident Care Coordinator (RCC) on 05/28/25 at 12:54pm revealed:
-Resident #8 had wandering behaviors.
-Resident #8 would go outside to jog around the facility.
-Resident #8 left the facility without staff knowledge.
-The Administrator noticed the resident walking toward the street and went outside to check on him.
-Resident #8 now had to have an escort when leaving the facility.

Telephone interview with Resident #8's primary care provider (PCP) on 05/30/25 at 1:19pm revealed:
-Resident #8 had a diagnosis of dementia.
-She had only seen Resident #8 on one occasion but was not aware of any problems with him exit seeking.

Telephone interview with the Administrator on 05/30/25 at 2:13pm revealed:
-He was not aware of Resident #8 exit seeking.
-Resident #8 normally stayed up at the front area where the 100 and 200 halls met.

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-Resident #8 liked to jog and would go out for a jog and return to the facility without leaving the property.
-He and the Managing Director were outside one day (did not state the date) and they saw Resident #8 out for a jog.
-The Managing Director noticed Resident #8 was a little further down the road than was his normal jogging path, so he went and had to redirect Resident #8 back into the facility.
-Since then, Resident #8 had not been allowed to go outside unattended.

Based on observations, interviews, and record reviews, it was determined that Resident #8 was not interviewable.

Attempted telephone interview with Resident #8's power of attorney (POA) on 05/29/25 at 5:25pm was unsuccessful.

3. Review of Resident #4's current FL-2 dated 02/21/25 revealed:
-Diagnoses included malignant neoplasm of overlapping sites of bronchus, anemia, hypertensive heart disease with heart failure, and chronic diastolic congestive heart failure.
-Resident #4 was intermittently disoriented and ambulatory with a wheelchair.

Observation of Resident #4 on 05/28/25 at 10:35am revealed:
-He was in his room in bed.
-He was looking around his room and asked to have his banana peel thrown away from his overbed table.

Second observation of Resident #4 on 05/29/25 at 12:10pm revealed:
-He was seated in his wheelchair in the dining

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room eating lunch.
-He did not remember the previous day or asking to have the banana peel thrown away.

Review of Resident #4's care plan dated 02/27/25 revealed:
-He required extensive assistance in transferring and ambulation.
-All of the other activities of daily living (ADLs) were documented that Resident #4 was totally dependent for those ADLs of bathing, dressing, and toileting.

4. Review of Resident #3's current FL-2 dated 03/28/25 revealed:
-Diagnoses included hypertension, hyperlipidemia, depression without behavior, anxiety disorder, insomnia, degeneration macular, atherosclerotic heart disease of native coronary artery without heart failure, chronic obstructive pulmonary disease, age-related cognitive disease decline, and history of falls.
-Resident #3 was ambulatory with the use of a walker.
-Resident #3 was intermittently disoriented.

Review of Resident #3's care plan dated 03/28/25 revealed Resident #3 did not require assistance with activities of daily living (ADLs).

5. Review of Resident #5's current FL-2 dated 10/02/24 revealed:
-Diagnoses included vascular dementia with anxiety, cerebrovascular atherosclerosis, coronary artery disease, sick sinus syndrome, aortic stenosis status post valve replacement, essential hypertension, type 2 diabetes mellitus, hyperlipidemia, and gastroesophageal reflux disease.
-The resident was documented as constantly

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disoriented.
-The resident was ambulatory.

Review of Resident #5's Resident Register revealed:
-The resident's date of admission to the facility was 10/14/24.
-The resident was forgetful and needed reminders.

Review of Resident #5's current assessment and care plan dated 10/15/24 revealed:
-The resident was ambulatory with no problems and used a cane or walker if needed.
-The resident was documented as sometimes disoriented, forgetful, and needed reminders.
-The resident was documented as independent with toileting, ambulation, grooming, and transferring.

Review of Resident #5's facility progress note dated 10/29/24 at 6:21am revealed:
-The resident seemed "a bit confused" in the night but was redirected each time.
-The resident was monitored throughout the night.

Review of Resident #5's facility progress note dated 11/04/24 at 6:32am revealed the resident was redirected to his room multiple times in the night.

Review of Resident #5's facility progress note dated 11/13/24 at 3:41pm revealed:
-The resident was getting more confused.
-The resident said he wanted to move out and call his family member.
-The resident was seen by staff trying to use the phone in the hallway to call his family member.
-The resident was told by staff that he could not

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D 067	Continued From page 16 call his family member until after 5:00pm due to the family member being at work. Interview with a medication aide / personal care aide (MA/PCA) on 05/29/25 at 2:45pm revealed: -Resident #5 was confused every day. -Resident #5 would get lost and could not find his room on his own. -Staff redirected the resident to his room. -If another resident tried to go into Resident #5's room, Resident #5 became paranoid and thought someone was trying to get him. Interview with a second MA/PCA on 05/29/25 at 6:00pm revealed: -Resident #5 was confused. -The resident did not know the difference between night and day; he had sundowning (dementia-related symptoms that can include increased confusion, agitation, and anxiety in the late afternoon or early evening) behaviors. -The resident talked about leaving the facility, but she had not observed the resident trying to leave the facility. -Staff had to direct the resident to his room and to the dining room for meals because the resident did not know where to go. Attempted telephone interview with Resident #5's family member on 05/29/25 at 5:45pm was unsuccessful. _____ The facility failed to ensure 8 of 8 sampled exit doors were engaged with audible sounding devices at all times when the doors were opened to prevent residents who were documented as disoriented from exiting the facility without staff's knowledge. Resident #2, who was documented as intermittently disoriented, had a diagnosis of dementia, and had behaviors of confusion and	D 067		

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D 067	Continued From page 17 trying to leave the facility requiring redirection by staff on 01/28/25 and 01/29/25, prior to the resident exiting the facility without staff's knowledge on 02/02/25, was found outside by staff lying in the driveway after a fall with injuries including a fractured arm and head injuries, requiring hospitalization and rehabilitation. The facility's failure resulted in serious physical harm and neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/29/25 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 29, 2025.	D 067		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up for routine and acute health care needs for 3 of 5 sampled residents (#1, #2, #5) related to notifying the primary care provider of a resident having behaviors and exiting the facility without staff's knowledge who was found outside and had fallen (#2), a referral to podiatry for a diabetic resident (#1), and cardiology follow-up visits for a resident with a cardiac pacemaker and a history	D 273		

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of chest pain (#5).

The findings are:

1. Review of Resident #2's current FL-2 dated 06/07/24 revealed:
-Diagnoses included type II diabetes, hypertension, hyperlipidemia, gastroesophageal reflux disease (GERD), history of transient ischemic attack (TIA), depression, irritable bowel syndrome, and cerebral infarction without residual.
-Resident #2 was ambulatory without an assistive device.
-Resident #2's orientation was intermittent.

Review of Resident #2's care plan dated 06/27/24 revealed:
-Resident #2 required supervision with eating.
-Resident #2 required limited assistance with toileting.

Review of Resident #2's incident report dated 02/02/25 revealed:
-The date and time of the incident was 02/02/25 at 10:27pm.
-The type of incident was listed a "fall of unknown origin".
-The location of the incident was other: outside on community grounds.
-The signs of injuries were documented as a cut on head and EMT (emergency medical technicians) said a possible broken arm.
-Resident #2 was transported to a local hospital.
-It was documented the primary care provider (PCP) was notified on 02/03/25 at 8:00am.
-It was documented the resident's Responsible Person was notified on 02/02/25 at 10:28pm.
-It was documented that the previous Resident Care Director (RCD) was the person who

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completed the report on 02/03/25 at 8:45pm.

Review of Resident #2's progress note dated 01/28/25 at 7:51pm revealed:
-Resident #2 was seen walking out of her room wearing only one sock.
-Resident #2 stated she was going home, and staff could not keep her at the facility.
-Resident #2 was escorted back to her room and informed staff she had millions of dollars' worth of diamonds and asked staff to retrieve the jewelry.
-Resident #2 became agitated and accused the staff of taking her jewelry.

Review of Resident #2's progress note dated 01/28/25 at 8:43pm revealed:
-Resident #2 tried to leave the facility for a second time that evening.
-Staff was able to redirect Resident #2 before she could get to the door.

Review of Resident #2's progress note dated 01/29/25 at 1:32am revealed:
-Resident #2 kept coming out of her room stating she was going home.
-Staff redirected Resident #2 back to her room each time.

Review of Resident #2's progress note dated 02/02/25 at 10:37pm revealed:
-Resident #2 had been directed twice for trying to leave the facility stating that she was going home.
-The medication aide (MA) was able to get Resident #2 back in her room and settled in bed.
-Resident #2 was not found in her room after the final rounds.
-Resident #2 was found outside on the facility grounds.
-Resident #2 had fallen and possibly had a broken arm, head lacerations and face injuries.

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D 273	Continued From page 20 Interview with Resident #2 on 05/29/25 at 6:50pm revealed she remembered falling and breaking her arm but did not remember when and where the fall occurred. Interview with a personal care aide (PCA) on 05/29/25 at 1:10pm revealed: -Resident #2 would not always remember where her room was. -Resident #2 was easily redirected. -Resident #2 had come to the nurses' station on 05/27/25 and the resident did not know where she was. Interview with a second PCA on 05/29/25 at 6:02pm revealed: -Resident #2 had come to her on the evening of 02/02/25 asking where her room was, the PCA escorted Resident #2 back to her room. -Resident #2 had come out of her room for a second time on 02/02/25 asking for snacks; the PCA provided Resident #2 with snacks and escorted her back to her room. -During the rounds, between 9:00pm and 10:00pm, the PCA checked on Resident #2 and found that she was not in her room. -The assigned MA was notified immediately. -Resident #2 was found outside in the side circle driveway nearest the 100 hall. -Resident #2 had a visible head injury and she was bleeding from her head and knee. -Resident #2 was confused and crying, saying she wanted to go home. -Resident #2 complained that her arm was hurting. -She did not remember how long Resident #2 had not been in her room when she was found outside. -Resident #2 had not been placed on increased	D 273		

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supervision.
-Resident #2 was checked on every 2 hours.

Interview with a MA on 05/29/25 at 10:46pm revealed:
-Resident #2 would at times walk towards the front door saying she was leaving and going to her car.
-Resident #2 did not have a car.
-She noticed Resident #2 had gone outside last week (date not provided) and sat thinking a family member was coming to take her to lunch.
-She went outside and asked Resident #2 to come back inside for lunch.
-She called Resident #2's family member and had the family member talk with Resident #2 and tell the resident that the family member could not take the resident out for lunch because the family member had to work.
-Resident #2 would wander around almost daily around 3:00pm.
-She had increased Resident #2's supervision by completing one hour checks.
-She had not documented the increased one hour checks.

Interview with a second MA on 05/29/25 at 5:18pm revealed:
-She had learned Resident #2 was not in her room on 02/02/25 by a PCA around 8:30pm.
-She immediately gathered all of the staff, and a search begin.
-She found Resident #2 outside lying on the ground in the side circle driveway nearest the 100 hall.
-Resident #2 had fallen and had a head injury and facial bruises.
-Resident #2 was crying and said her arm was hurting.
-When the EMTs arrived, they assessed Resident

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#2 for a possible broken arm due to the fall.
-She completed an incident report on 02/02/25 and placed the report in the previous RCD's folder.
-She did not remember Resident #2's diagnoses but Resident #2 was always crying and seemed depressed.
-Resident #2 wandered a lot since she had been admitted to the facility and always stated she was going home.
-She did not know why Resident #2 wanted to leave the evening of 02/02/25.
-Resident #2 had displayed wandering behaviors since she had been admitted to the facility.
-She would report the behaviors to the previous RCD and would document each time she observed Resident #2 trying to leave the facility or saying she was going to leave the facility.

Telephone interview with Resident #2's power of attorney (POA) on 05/29/25 at 2:43pm revealed:
-She received a call from the facility staff on 02/02/25 around 10:30pm that Resident #2 tried to leave the facility and had a bad fall and was found outside at the end of the first circle driveway.
-She had been informed the alarm had not been set.
-Resident #2 had suffered from a head injury, broken arm and facial bruises.
-The weather on the night of 02/02/25 was in the low to mid 40s.
-Resident #2 had a diagnosis of dementia and the facility was aware of the diagnosis.
-Staff would inform her of Resident #2's wandering behavior and said they were able to redirect her but had not provided any additional interventions.
-She had inquired with the Administrator when the door alarms were to be set at night but was never

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provided a clear answer.
-Resident #2 was discharged from the emergency room on 02/03/25 to a rehabilitation center.
-Resident #2 was at the rehabilitation center from 02/03/25 to 03/19/25.
-The RCD had informed her that staff would keep a closer watch on Resident #2.

Telephone interview with Resident #2's family member on 05/29/25 at 2:43pm revealed:
-The family member had been informed by the Administrator that Resident #2 had been outside for 30 to 45 minutes before she was found outside.
-Resident #2 had tried to leave the facility a couple days before she was found outside on the evening of 02/02/25.

Telephone interview with Resident #2's previous PCP's office on 05/30/25 at 11:35am revealed:
-Resident #2 was last seen on 10/30/24 for a routine visit.
-There was no documentation of the PCP being informed of Resident #2's elopement and wandering issues.
-There was no documentation of the PCP being informed of the 02/02/25 incident.

Telephone interview with Resident #2's current PCP on 05/30/25 at 1:30pm revealed:
-Resident #2 was a new patient and was last seen on 05/13/25.
-Resident #2 had a diagnosis of dementia.
-She was not made aware of the 02/02/25 incident where Resident #2 tried to leave the facility and had fallen outside.
-She had not been informed of Resident #2's previous elopement and wandering issues.
-She had not been made aware Resident #2 had

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received rehabilitation services.
-Resident #2 had been at her baseline and she had not made any observations of wandering behaviors.
-Had she been made aware of the 02/02/25 incident or the previous wandering behaviors she would have increased supervision checks for Resident #2.

Interview with the Resident Care Coordinator (RCC) on 05/29/25 at 12:54am revealed:
-Resident #2 was identified as a wanderer.
-The resident's PCP should be notified if the resident had a fall resulting in injuries, elopement or change in behavior or health.
-She or the RCD were responsible for informing the residents' PCP of falls with injuries and changes in the residents' condition.

Telephone interview with the RCD on 05/30/25 at 1:50pm revealed:
-He was hired as the RCD on 02/11/25.
-He did not have any information about Resident #2's 02/02/25 incident.
-He had not known of any previous elopement and wandering behavior issues with Resident #2.
-He had met with Resident #2 in the rehabilitation facility to completed a reassessment on 03/08/25.
-He met with the POA on 03/08/25 and informed her staff would keep an eye on Resident #2 by checking her room more often and ensuring Resident #2 went to the dining room for her meals.
-There were no physician progress notes in Resident #2's chart.
-The increased supervision checks were not documented in Resident #2's chart.
-Staff were to inform him or the RCC of any changes in residents' behaviors.
-He, the RCC, or the Administrator were

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responsible for contacting the residents' PCP regarding injuries.

Interview with the Administrator on 05/29/25 at 3:43pm revealed:
-Elopement was defined as an undocumented leave from the facility.
-The staff were to contact the residents' PCP, POA and authorities if needed.
-Residents' PCPs were contacted when a resident had a fall and needed medical treatment and for changes in behavior.
-The PCP was notified via fax.
-Resident #2's incident occurred on 02/02/25 around 10:30pm.
-Resident #2's current PCP had not recommended increased supervision.
-The staff were to report any changes in a resident's condition to him or the RCD.
-The previous RCD reported Resident's #2's 02/02/025 incident.
-He thought Resident #2's PCP was informed of the 02/02/25 incident.

2. Review of Resident #1's current FL-2 dated 03/10/25 revealed:
-Diagnoses included type 2 diabetes mellitus, hypertension, and hyperlipidemia.
-She was ambulatory with no devices.

Observation of Resident #1's feet on 05/28/25 at 9:39am revealed:
-Her left foot first toe had a thickened yellow toenail that extended approximately ½ inch over the tip of her toe.
-Her left foot 2nd and 3rd toenails were thick and yellow and extended approximately ¼ inch of the tips of the toes.
-Her left foot 4th toe had a thickened yellow toenail that curved over the tip of the toe

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approximately ½ inch and pressed into the pad of the 4th toe.
-Her left foot 5th toe had a thickened yellow toenail that curved over the tip of the toe approximately ½ inch and inward into the side of the 4th toe.
-There was an increased pink color noted at the base of the nailbed on the 4th and 5th toes.
-Her right foot first toe had a thickened yellow toenail that extended approximately ¼ inch - ½ inch over the tip of her toe and curved inward towards her 2nd toe.
-Her right foot 2nd toenail was thick and yellow and curved inward onto the pad of the 2nd toe.
-Her right foot 3rd toenail was thick and yellow and extended approximately ½ inch - ¾ inch over of the tip of the toe and curved inward towards and over onto the top of the 2nd toe.
-Her right foot 4th toe had a thickened yellow toenail that curved over the tip of the toe approximately 1 inch and pressed in between the pads of the 3rd and 4th toes.
-Her right foot 5th toe had a thickened yellow toenail that curved up and over the tip of the toe approximately ¾ inch onto the pad of the toe.
-There was an increased pink color noted at the base of the nailbed on the 5th toe.

Review of Resident #1's Resident Register revealed an admission date of 03/27/25.

Interview with Resident #1 on 05/28/25 at 9:32am revealed:
-Her toenails were long and needed trimming.
-Her toenails had not been trimmed since she was admitted to the facility.
-She was diabetic and wanted her toenails to be trimmed.

Second interview with Resident #1 on 05/29/25 at

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1:00pm revealed:
-She could walk without the use of any devices.
-She wore her black slip on walking shoes.
-She did not complain of skin breakdown and understood the importance of foot care for a diabetic.
-She had spoken with facility staff about her toenails needing to be cut but she could not recall who she spoke with or when she spoke with them.
-She had seen the primary care provider (PCP) right after she was admitted to the facility but did not remember the exact date.
-The PCP had ordered some lotion for her feet and a podiatry appointment for her due to the condition of her toenails and her being a diabetic.
-The medication aides (MAs) put the lotion on her feet every night.
-She had not seen a podiatrist since she was admitted to the facility but would definitely like to see one to get her toenails trimmed.
-She was able to provide all her own care except she could not trim her toenails due to the extreme thickness of the nails.

Interview with a personal care aide (PCA) on 05/29/25 at 8:40am revealed:
-She had never provided nail care to Resident #1.
-Resident #1 was independent as far as she knew.
-The PCAs were not allowed to do nail care to diabetic residents.

Interview with a MA on 05/29/25 at 11:05am revealed:
-She did not know if Resident #1 saw a podiatrist.
-The Resident Care Director (RCD) would know if Resident #1 saw a podiatrist or was scheduled to see them.
-She did not know anything about Resident #1's

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toenails.
-The staff were not allowed to cut diabetic residents' toenails.
-Resident #1 had some lotion for her feet but it was administered by the second shift MAs.

Interview with the RCD on 05/29/25 at 10:45am revealed:
-Resident #1 had been seen by the facility's PCP right after she arrived (could not remember the exact date).
-The PCP had written a referral order for Resident #1 see a podiatrist.
-The facility's contracted podiatrist came to the facility to see the residents quarterly.
-Their last visit was in March 2025.
-Resident #1 was placed on the list to see the podiatrist at their next visit which was the first week in June 2025.
-He did not realize the condition of her toenails at the time of the PCP's visit; he just put her on the next appointment list.

Telephone interview with Resident #1's PCP on 05/30/25 at 1:19pm revealed:
-She had seen Resident #1 on 05/08/25 but was not aware of any problems with her toenails.
-Her colleague had seen Resident #1 on 04/09/25 and ordered a podiatry appointment.
-She would be concerned about any skin breakdown, wounds, or infections that may be caused by her toenail condition since Resident #1 was a diabetic.

Telephone interview with the Administrator on 05/30/25 at 2:13pm revealed:
-He was not aware of the condition of Resident #1's toenails other than what he had been told by the RCD (but did not explain what he had been told).

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-He was not aware if Resident #1 was able to do her own personal care or not.
-He would expect the staff to notify the RCD if residents needed to be seen by the PCP or podiatrist.

3. Review of Resident #5's current FL-2 dated 10/02/24 revealed:
-Diagnoses included vascular dementia with anxiety, cerebrovascular atherosclerosis, coronary artery disease, sick sinus syndrome, aortic stenosis status post valve replacement, essential hypertension, type 2 diabetes mellitus, hyperlipidemia, and gastroesophageal reflux disease.
-The resident was documented as constantly disoriented.

Review of Resident #5's Resident Register revealed the resident's date of admission to the facility was 10/14/24.

Review of Resident #5's current assessment and care plan dated 10/15/24 revealed:
-The resident's diagnoses (in addition to the diagnoses on the FL-2 dated 10/02/24) included chronic ischemic heart disease.
-The resident was documented as sometimes disoriented, forgetful, and needed reminders.

Review of Resident #5's facility progress note dated 10/28/24 at 7:03am revealed:
-The resident said he was having severe chest pain, and it felt like heavy pressure.
-Staff called 911 immediately and the resident was transported to the hospital.

Review of Resident #5's hospital emergency room (ER) after visit summary (AVS) dated 10/28/24 revealed:

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-The resident was seen at the ER for chest pain.
-The resident was diagnosed with nonspecific chest pain.

Review of Resident #5's facility progress note dated 11/07/24 at 11:40pm revealed:
-At 11:05pm, the resident was complaining of chest pain and stated he was having a heart attack.
-Emergency Medical Services (EMS) was called and the resident's vital signs were taken.
-The resident's blood pressure was 138/76, pulse was 60, and oxygen level was 92%.
-The resident was transported to the hospital.

Review of Resident #5's hospital ER AVS form dated 11/08/24 revealed:
-The resident was seen at the ER for chest pain.
-The resident was diagnosed with nonspecific chest pain.
-Instructions included follow-up with the PCP and a cardiology provider.
-The PCP documented "reviewed" and initialed the top right corner of the AVS form and dated it 11/13/24.

Review of Resident #5's facility progress note dated 01/10/25 at 6:02pm revealed:
-At dinner, another resident told staff that Resident #5 was not doing good.
-Staff went to see Resident #5 and the resident appeared very pale and appeared unresponsive.
-The resident was taken outside of the dining room and into the hallway until EMS arrived.
-The resident held his chest and said to call for help.
-The resident was administered a Nitroglycerin tablet (used to treat chest pains).
-The resident was transported to the hospital.

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Review of Resident #5's facility progress note dated 01/13/25 at 4:53pm revealed the resident returned to the facility from the hospital via EMS.

Review of Resident #5's hospital discharge summary dated 01/13/25 revealed:
-The resident was admitted to the hospital on 01/10/25 and discharged on 01/13/25.
-The resident's admission diagnoses included syncope (fainting or temporary loss of consciousness) and acute kidney injury.
-The resident was initially noted to be hypotensive (low blood pressure) and complained of chest pain.
-A pacemaker interrogation (checked the device to ensure it was working properly) was completed and showed the resident was being paced 99% of the time (indicated the heart was primary relying on the device for rhythm regulation).
-The resident had a history of sick sinus syndrome (heart rhythm disorder) status post pacemaker (implanted device that delivers electrical impulses to the heart to regulate the heart rate), aortic valve stenosis (narrowing of the large blood vessel in the heart) status post valve replacement on chronic Warfarin (a blood thinner) therapy, hypertension, diabetes, and vascular dementia.
-At the time of discharge, the resident's heart had normal rate and regular rhythm.
-There were instructions to follow-up with the cardiologist within one week.
-The resident was to follow-up with the cardiology provider to review medication and make any necessary changes.
-There were instructions to follow-up with the PCP within one week.

Review of Resident #5's physician visits and facility progress notes revealed no documentation

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of Resident #5 being seen by a cardiology provider.

Interview with the Resident Care Director (RCD) on 05/29/25 at 4:30pm revealed:
-He was not working at the facility in January 2025 when Resident #5 was hospitalized and had instructions to see a cardiologist.
-The previous RCD would have been responsible for setting up the appointment or reaching out to the resident's family member.
-He spoke with the resident's family member today, 05/29/25, who was the resident's health care power of attorney (POA).
-The family member did not make a cardiology appointment for the resident.
-There was no documentation regarding the resident's cardiology appointment.
-The family member told the RCD that the resident's pacemaker was monitored via a transmitter device in the resident's room.
-He did not know when the resident's pacemaker was last checked or how often it should be checked.

Telephone interview with a scheduler at Resident #5's cardiology provider's office on 05/30/25 at 10:08am revealed:
-Resident #5 had not been seen by the provider in 2025.
-The resident had an appointment for a physical in-office device check for his pacemaker on 04/25/25 but was a "no show, no call".
-That meant the resident did not come to the appointment and no one called to cancel the appointment.
-There was no documentation of any appointments being scheduled for any hospital follow-ups in 2025.
-The resident had a pacemaker check

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appointment scheduled for 07/25/25.

Telephone interview with the RCD on 05/30/25 at 11:49am revealed:
-He was not aware Resident #5 had an appointment scheduled with the cardiology provider on 04/25/25.
-He was not aware Resident #5 had an upcoming appointment scheduled with the cardiology provider on 07/25/25.
-Neither the 04/25/25 or the 07/25/25 cardiology appointments for Resident #5 were listed on the facility's resident appointment schedule book.

Telephone interview with the Administrator on 05/30/25 at 2:14pm revealed:
-The RCD and Resident Care Coordinator (RCC) worked in conjunction and were responsible for referrals.
-Resident #5's family member knew about the cardiology appointments and chose not to take the resident.
-There was no documentation indicating why the resident did not follow-up with a cardiology provider.
-There was no documentation regarding the resident's missed cardiology appointment.
-The Administrator, RCD, and RCC reviewed all resident care data quarterly.
-There were weekly meetings with the RCC about resident issues.
-No other system to monitor health care referrals and follow-up was indicated.

Telephone interview with Resident #5's PCP on 05/30/25 at 1:17pm revealed:
-She was transitioning into the role of the facility's contracted PCP in April 2025.
-She was not aware Resident #5 had missed any cardiology appointments or pacemaker checks.

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D 273	Continued From page 34 Attempted telephone interview with Resident #5's family member on 05/29/25 at 5:45pm was unsuccessful. Attempted telephone interview with Resident #5's cardiology provider on 05/30/25 at 10:12am was unsuccessful. Based on observations, interviews, and record reviews, it was determined that Resident #5 was not interviewable. _____ The facility failed to ensure health care referral and follow-up for 3 of 5 sampled residents. The facility failed to notify Resident #2's previous primary care provider (PCP) of behaviors of confusion and trying to leave the facility and requiring redirection by staff on 01/28/25 and 01/29/25, prior to the resident exiting the facility without staff's knowledge on 02/02/25 and being found later by staff outside lying in the driveway with injuries including a fractured arm and head injuries. The facility also failed to make the resident's current PCP aware of the resident's past behavior of trying to leave the facility and requiring redirection and the incident with injuries on 02/02/25. The facility failed to coordinate timely podiatry care for Resident #1, who was diabetic, and had long, thickened, yellow toenails, including some toenails that were so long they curved over the top of the toes and pressed into the pads of the toes, putting the resident at risk for skin breakdown, wounds, and infections. The facility failed to coordinate follow-up visits with a cardiology provider after a hospitalization for syncope (fainting) and for pacemaker checks for Resident #5 who had multiple diagnoses related to the condition of his heart and had past visits to the emergency room for chest pain. The failure	D 273		

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D 273	Continued From page 35 of the facility to provide health care coordination and follow-up 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 05/30/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 14, 2025.	D 273		
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: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 residents (#5) sampled for record review including multiple missed doses of a blood thinner medication used to treat and prevent blood clots. The findings are: Review of the facility's undated Medication Policies and Procedures revealed: -If not automatically refilled by the pharmacy,	D 358		

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refills must be ordered.
-Reorder medication 5 days in advance of need to assure adequate supply on hand.

Review of Resident #5's current FL-2 dated 10/02/24 revealed:
-Diagnoses included vascular dementia with anxiety, cerebrovascular atherosclerosis, coronary artery disease, sick sinus syndrome, aortic stenosis status post valve replacement, essential hypertension, type 2 diabetes mellitus, hyperlipidemia, and gastroesophageal reflux disease.
-The resident was documented as constantly disoriented.
-There was an order for Warfarin 5mg 1 ½ tablets once a day. (Warfarin is a blood thinner used to treat and prevent blood clots.)

Review of Resident #5's clarification of hospital discharge orders dated 01/15/25 revealed the Warfarin dose was changed to 5mg 1 tablet daily.

Review Resident #5's lab report dated 03/24/25 revealed:
-The resident's INR lab was collected on 03/24/25. [International Normalized Ratio (INR) is a lab value used to monitor Warfarin therapy. The target INR range is generally recommended to be 2.0 - 3.0 for most clinical situations.]
-The resident's INR was 2.35 (within therapeutic range).

Review of Resident #5's physician's order dated 04/10/25 revealed:
-There were no new medication changes.
-There was an order to recheck INR next week.

Review Resident #5's lab report dated 04/17/25 revealed:

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D 358	Continued From page 37 -The resident's INR lab was collected on 04/17/25. -The resident's INR was 1.2 (below therapeutic range). Review of Resident #5's physician's order dated 04/17/25 revealed: -There was an order for Warfarin 5mg 1 tablet daily. -There was an order for Warfarin 1mg 1 tablet on Mondays, Wednesdays, and Fridays (in addition to 5mg to equal 6mg). Review of Resident #5's April 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Warfarin 5mg 1 tablet once a day scheduled at 8:30pm. -Warfarin 5mg was documented as administered daily from 04/01/25 - 04/12/25 and 04/16/25. -Warfarin 5mg was documented as not being administered daily from 04/13/25 - 04/15/25 due to medication not on cart. -This entry for Warfarin 5mg 1 tablet daily was documented as being discontinued on 04/17/25. -There was a second entry for Warfarin 5mg 1 tablet once a day scheduled at 8:30pm with a start date of 04/17/25. -Warfarin 5mg 1 tablet daily was documented as administered from 04/17/25 - 04/21/25 and 04/24/25 - 04/30/25. -Warfarin 5mg 1 tablet daily was documented as not being administered on 04/22/25 and 04/23/25 due to medication not on cart. -There was an entry for Warfarin 1mg 1 tablet daily on Monday, Wednesday, and Friday, take with the 5mg tablet to equal 6mg total. -Warfarin 1mg was scheduled to be administered at 8:30pm on Mondays, Wednesdays, and Fridays.	D 358		

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-Warfarin 1mg was documented as not being administered on Friday, 04/18/25; Monday, 04/21/25, and Wednesday, 04/23/25 due medication not on cart, medication on order.
-Warfarin 1mg was documented as administered on Friday, 04/25/25, Monday, 04/28/25, and Wednesday, 04/30/25.
-The resident did not receive 5 doses of Warfarin 5mg and 3 doses of Warfarin 1mg as ordered in April 2025.

Review Resident #5's lab report dated 05/05/25 revealed:
-The resident's INR lab was collected on 05/05/25.
-The resident's INR was 1.7 (below therapeutic range).

Review of Resident #5's verbal order dated 05/07/25 revealed:
-There was an order for Warfarin 5mg 1 tablet daily.
-There was an order for Warfarin to 1mg tablet on Mondays, Wednesdays, Fridays, Saturdays, and Sundays (in addition to the 5mg tablet daily).

Review Resident #5's lab report dated 05/21/25 revealed:
-The resident's INR lab was collected on 05/21/25.
-The resident's INR was 2.8 (within therapeutic range).

Review of Resident #5's physician's orders dated 05/22/25 revealed:
-The resident's recent INR was 2.8 (within therapeutic range).
-There was an order to continue the current Warfarin regimen and repeat INR in 2 weeks.

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Review of Resident #5's May 2025 eMAR dated 05/01/25 - 05/29/25 revealed:
-There was an entry for Warfarin 5mg 1 tablet once a day scheduled at 8:30pm.
-Warfarin 5mg was documented as administered daily from 05/01/25 - 05/20/25.
-This entry for Warfarin 5mg 1 tablet daily was documented as being discontinued on 05/21/25.
-There was a second entry for Warfarin 5mg 1 tablet once a day scheduled at 8:30pm with a start date of 05/21/25.
-Warfarin 5mg 1 tablet daily was documented as administered from 05/21/25 - 05/28/25.
-There was an entry for Warfarin 1mg 1 tablet daily on Monday, Wednesday, and Friday, take with the 5mg tablet to equal 6mg total.
-Warfarin 1mg was scheduled to be administered at 8:30pm on Mondays, Wednesdays, and Fridays.
-Warfarin 1mg was documented as administered on Friday, 05/02/25 and Monday, 05/05/25.
-This entry for Warfarin 1mg was documented as being discontinued on 05/07/25.
-There was a second entry for Warfarin 1mg 1 tablet daily on Monday, Wednesday, Friday, Saturday, and Sunday, take with the 5mg tablet to equal 6mg total.
-Warfarin 1mg was scheduled to be administered at 8:30pm on Mondays, Wednesdays, Fridays, Saturdays, and Sundays.
-Warfarin 1mg was not documented as being administered on 05/10/25 due to medication not on cart.
-The resident received Warfarin 5mg on 05/10/25 instead of Warfarin 6mg as ordered.

Review of Resident #5's medications on hand on 05/29/25 at 11:02am revealed:
-There was a supply of Warfarin 5mg tablets dispensed on 05/21/25 with instructions to take 1

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tablet once a day.
-There were 7 of 14 Warfarin 5mg tablets remaining.
-There was a supply of Warfarin 1mg tablets dispensed on 05/21/25 with instructions to take 1 tablet daily on Monday, Wednesday, Friday, Saturday, and Sunday (take with the 5mg tablet to equal 6mg total).
-There were 5 of 10 tablets remaining.
-Both supplies of Warfarin had a round green sticker in the upper left corner of the bubble card.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/29/25 at 5:19pm revealed:
-The pharmacy provided monthly cycle fills for most scheduled medications with some exceptions.
-Warfarin was not included in monthly cycle fills because of potential for frequent dose changes due to INR levels.
-Non-cycle fill medications, including Warfarin, had a round green sticker on the bubble card to let facility staff know it was not a cycle fill medication and had to be reordered.
-The facility staff would have to reorder fills for Warfarin since it was a non-cycle medication.
-The pharmacy dispensed and delivered 5 Warfarin 5mg tablets on 04/07/25.
-Warfarin was not reordered again by facility staff until 04/15/25 at 8:28pm when staff clicked the reorder button on the eMAR system.
-There was no refill request by the facility prior to 04/15/25 at 8:28pm.
-The pharmacy dispensed and delivered 7 Warfarin 5mg tablets on 04/16/25.
-The resident's INR was checked on 04/17/25 and 3 Warfarin 1mg tablets were dispensed and delivered to the facility on 04/17/25 due to an order change.

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-Warfarin 1mg would have been available for administration at the facility on 04/18/25, 04/21/25, and 04/23/25.
-There were 10 Warfarin 1mg tablets dispensed and delivered to the facility on 05/07/25 so it would have been available for administration on 05/10/25.

Review of Resident #5's pharmacy dispensing records dated 12/01/24 - 05/29/25 revealed:
-There were 14 Warfarin 5mg tablets (14-day supply) dispensed on 03/24/25.
-There were 5 Warfarin 5mg tablets (5-day supply) dispensed on 04/07/25.
-There were 7 Warfarin 5mg tablets (7-day supply) dispensed on 04/16/25.
-There were 3 Warfarin 1mg tablets (3 doses = 1 week supply) dispensed on 04/17/25.
-There were 10 Warfarin 1mg tablets (10 doses = 2 weeks supply) dispensed on 05/07/25.
-There were 14 Warfarin 5mg tablets (14-day supply) dispensed on 05/07/25.
-There were 10 Warfarin 1mg tablets (10 doses = 2 weeks supply) dispensed on 05/21/25.
-There were 14 Warfarin 5mg tablets (14-day supply) dispensed on 05/21/25.

Interview with a medication aide (MA) on 05/29/25 at 6:00pm revealed:
-She did not recall why Resident #5 ran out of Warfarin in April 2025 and May 2025.
-The MAs usually reordered medications.
-The Resident Care Coordinator (RCC) or Resident Care Director (RCD) could also reorder medications if they saw that the MAs had not ordered it.
-Second shift MAs did not usually contact providers if a resident ran out of a medication because it was usually after business hours on second shift.

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D 358	Continued From page 42 Interview with the RCC on 05/29/25 at 5:53pm revealed: -She worked as a MA at times but not very often to fill in when needed. -She remembered Resident #5's Warfarin not being in the medication cart in April 2025, so she documented the medication was not on the cart. -The MAs were responsible for ordering medications when the supply got to the blue colored strip on the bubble card. -She was not aware of a back-up pharmacy used by the facility. -She or the MAs would notify the RCD if a medication was not received by the pharmacy and the RCD would notify the provider. -She did not remember if she notified the RCD about the resident's Warfarin not being on the medication cart. Interview with the RCD on 05/29/25 at 6:12pm revealed: -The facility's contracted pharmacy delivered medications to the facility every day. -If medications were ordered in the morning, they could usually get them delivered the same day. -He reviewed random eMARs weekly but not all eMARs weekly. -He was not aware Resident #5 had missed any doses of Warfarin in April 2025 or May 2025. -The MAs were responsible for reordering medications when the supply got to the blue strip on the bubble card or a 5-day supply. -He did not recall if anyone had reported Resident #5's Warfarin was not on the medication cart. -There were a lot of times when a MA reported medications were unavailable, but the MAs have overlooked medications that were in the medication cart.	D 358		

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D 358	Continued From page 43 Interview with the Administrator on 05/29/25 at 6:55pm revealed: -He was unaware Resident #5 had missed doses of Warfarin in April 2025 and May 2025. -The facility got new medication carts around that time in April 2025 -He wondered if that may have contributed to the MAs not being able to locate the Warfarin in the new medication carts. Telephone interview with Resident #5's primary care provider (PCP) on 05/30/25 at 1:17pm revealed: -She was transitioning into the role of the facility's contracted PCP in April 2025. -She was not aware Resident #5 had missed any doses of Warfarin. -Missed doses of Warfarin could cause low INR levels, which could cause blood clots that could lead to heart attack or stroke. Based on observations, interviews, and record reviews, it was determined that Resident #5 was not interviewable.	D 358		
D 378	10A NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations, interviews, and record	D 378		

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reviews, the facility failed to ensure 2 of 4 medication carts in the hallways (100 hall, 400 hall) were locked when not under the direct physical supervision of staff in charge of medication administration.

The findings are:

Review of the facility's Pharmaceutical Policies and Procedures dated 01/01/20 revealed all prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration.

1. Observation of the 400 hall on 05/28/25 between 2:27pm - 2:37pm revealed:
-At 2:27pm, there were two medications carts parked in the hallway between resident rooms 401 and 403.
-There was no staff, including no medication aides (MAs,) observed in the 400 hallway or in sight of the medication carts.
-The medication cart on the right, near room 403 was unlocked, except the controlled substance drawer was locked.
-All other medications on the cart were unlocked and accessible to residents.
-At 2:30pm, there was a housekeeper in the hallway of the 400 hall, cleaning the floor.
-At 2:32pm, the resident residing in room 401 opened the door, came out of the room into the 400 hallway and looked at the medication carts parked in the hallway beside her room.
-The resident then walked further into the hallway and looked toward the 300 hall, then walked back toward her room door, touched a chair in the hall to the left of her room door, then went back in her

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room and closed the door at 2:33pm.
-At 2:36pm, the MA assigned to the 300 hall and 400 hall medication carts came out of the staff lounge near the dining room on another hallway.
-The MA stopped to get incontinent supplies for a resident in a storage room across from the staff lounge.
-At 2:37pm, surveyor asked the MA to come to the medication carts parked in the hallway of the 400 hall.

Interview with the MA assigned to the 300 hall and 400 hall medication carts on 05/28/25 at 2:37pm revealed:
-She was last at the medication carts in the hallway of the 400 hall at 2:30pm.
-The medication carts should have been locked
-She knew that she had locked both medication carts before she left the carts unattended.
-Both medication carts should have been locked.
-She was not sure who unlocked the medication cart.
-She thought the Resident Care Coordinator (RCC) and the Resident Care Director (RCD) had keys to the medication carts.

Interview with the RCD on 05/28/25 at 2:55pm revealed:
-The facility got new medication carts about 5 to 6 weeks ago.
-There was a medication cart for each of the halls (100 hall, 200 hall, 300 hall, 400 hall).
-There was a different set of keys for each medication cart.
-The MAs only had keys to the carts they were assigned to during their shift.
-The RCC did not have keys to the new medication carts.
-He had keys to the medication carts.
-He had not unlocked the medication cart in the

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D 378	Continued From page 46 hallway of the 400 hall today, 05/28/25. Refer to interview with the RCD on 05/28/25 at 2:55pm Refer to interview with the Administrator on 05/28/25 at 3:06pm. Refer to a second interview with the Administrator on 05/29/25 at 1:00pm. 2. Observation of the 100 hall on 05/29/25 from 8:20am - 8:22am revealed: -At 8:20am, a medication aide (MA) was standing at the 100 hall medication cart parked about halfway down the 100 hall. -The MA walked away from the 100 hall medication cart without locking the medication cart. -The MA walked off the 100 hall and passed the nurses' station to the 200 hall to the medication cart parked about halfway down the 200 hall. -At 8:22am, surveyor asked the MA to come to the 100 hall medication cart parked in the hallway of the 100 hall. Interview with the MA assigned to the 100 hall medication cart on 05/29/25 at 8:22am revealed: -She thought she had locked the 100 hall medication cart when she walked away to administer medications on the 200 hall. -She did not realize she forgot to lock the 100 hall medication cart. -She should have locked the 100 hall medication cart before she walked away to go to the 200 hall. Refer to interview with the Resident Care Director (RCD) on 05/28/25 at 2:55pm Refer to interview with the Administrator on	D 378		

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D 378	Continued From page 47 05/28/25 at 3:06pm. Refer to a second interview with the Administrator on 05/29/25 at 1:00pm. _____ Interview with the RCD on 05/28/25 at 2:55pm revealed: -The medication carts should be locked at all times if a MA was not at the medication cart. -If a MA walked away from a medication cart and the medication cart was not in sight, the medication cart should be locked. -The MAs were responsible for ensuring the medication carts were locked when not in use. Interview with the Administrator on 05/28/25 at 3:06pm revealed: -The medication carts should be locked except during medication passes when it was under the direct supervision of the MAs. -The MAs were responsible for making sure the medication carts were locked. Interview with the Administrator on 05/29/25 at 1:00pm revealed they reviewed with the MAs today, 05/29/25, that the medication carts should be locked when the MAs were not using the medication carts.	D 378		