STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 The Adult Care Licensure Section conducted an annual and complaint investigation survey on May 13-14, 2025, June 10-13, 2025 and June 16, 2025.	D 000		
D 072	10A NCAC 13F .0305 (m) Physical Environment 10A NCAC 13F .0305 Physical Environment (m) The requirements for outside premises are: (1) the outside grounds of new and existing facilities shall be maintained in a clean and safe condition. For the purpose of this Rule, "clean and safe condition" means free from debris, trash, uneven surfaces, and similar conditions as not to attract rodents and vermin and provide for safe movement throughout facility grounds. Creeks, ravines, ponds, pools, and other similar areas shall have safety protection. For the purpose of this Rule, "safety protection" means preventive measures, such as barriers, to block access to such areas; (2) if the facility has a fence around the premises, the fence shall not prevent residents from exiting or entering freely or have sharp edges, rusting posts, or other similar conditions that may cause injury; and (3) outdoor walkways and drives shall be illuminated by no less than five foot-candles of light at ground level. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record review and interviews, the facility failed to allow 10 of 10 residents to freely exit or enter the fence around	D 072		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 072	Continued From page 1	D 072		

the premises by keeping all four gates locked with padlocks.

The findings are:

Review of the facility's license revealed the license was effective from 01/01/25 through 12/31/25 for a capacity of 12 assisted living (AL) residents.

Observation of the outside of the facility on 06/10/25 at 8:30am revealed:
-There was a gated chain-link fence completely enclosing the facility.
-There was a vehicle slide gate located at the front left corner of the fence that was padlocked.
-There was a walk gate located in the middle of the front side of the gate, approximately 113 feet from the entrance to the facility, that was padlocked.
-There was a second walk gate located 3/4 of the way down the left side of the fence that was padlocked.
-There was a third walk gate located on the back right side of the fence that was approximately 33 feet from the outside of the facility that was padlocked.

Observation of the banner located on the front portion of the chain-linked fence revealed:
-No outside agencies were allowed to talk with any residents without an appointment with the Administrator.
-For admittance into the facility there was a phone number to call.

Review of the NC DHSR construction report completed on 06/03/25 revealed:
-The installed fence was not in compliance with the 2018 Building Code Section 407.9.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 072	Continued From page 2	D 072		

-Pad locks were installed on each of the gates.
-The secured gates did not allow exit discharge to the area of refuge which, according to the facility evacuation plan, is beyond the fence line into the parking lot.
-Only staff have keys to open the gate preventing the residents from exiting and entering freely.

1. Review of Resident #1's current FL2 dated 03/10/25 revealed:
-Diagnoses included continuous and severe schizophrenia.
-Her level of care was assisted living.
-There was no information related to her level of orientation.

-Review of Resident #1's Resident Register revealed:
-She was admitted to the facility on 03/7/24.
-She had a guardian.

Review of Resident #1's care plan dated 03/10/25 revealed:
-She was independent with ambulation, toileting and transfers.
-She required limited assistance with dressing and grooming.
-She required extensive assistance with bathing.
-She required total assistance with eating.

Interview with Resident #1 on 06/10/25 at 8:47am revealed:
-She was not allowed to walk outside the chain-link fence because she "might escape".
-The Administrator told her the rules were that she could not go outside the fence.
-The gates were always locked and that was the "policy" and to keep the "peace" she would not "escape".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 072	Continued From page 3	D 072		

2. Review of Resident #5's current FL2 dated 03/12/25 revealed:
-Diagnoses included bipolar disorder, diabetes, chronic heart failure and heart disease.
-His level of care was assisted living.
-There was no information related to his level of orientation.

Review of Resident #5's Resident Register revealed:
-He was admitted to the facility on 03/03/25.
-He was his own responsible person.

Review of Resident #5's care plan dated 03/12/25 revealed:
-He was independent with ambulation, toileting and transfers.
-He required limited assistance with bathing, dressing and grooming.
-He required total assistance with eating.

Interview with Resident #5 on 06/10/25 at 1:40pm and on 06/11/25 at 11:10am revealed:
-The gates have always been locked since he was admitted to the facility in March 2025.
-The gates were always locked unless an outside agency was there to see residents and the gates were locked back once the outside agency left the facility.
-The Administrator and the second shift MA Supervisor told him that he could not go outside the gate unless they let him when he took out the trash or to an appointment.
-He wanted to go outside the gate to walk but he was told that he could not.

3. Review of Resident #6's current FL2 dated 05/08/25 revealed:
-Diagnoses included mental retardation (MR), diabetes, psychotic disorder and bipolar disorder.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 072	Continued From page 4 -His level of care was assisted living. -There was no information related to his level of orientation. Review of Resident #6's Resident Register revealed: -He was admitted to the facility on 05/01/25. -He had a guardian. Review of Resident #6's care plan dated 03/12/25 revealed: -He was independent with ambulation, toileting, eating and transfers. -He required limited assistance with dressing and grooming. -He required extensive assistance with bathing. Interview with Resident #6 on 06/11/25 at 11:25am revealed he was "not allowed" to go outside of the fence. Interview with the first shift medication aide (MA) Supervisor on 06/10/25 at 8:40am revealed: -The three gates and slide gate were locked at all times since the fence was put in around the end of August 2024. -The staff and the Administrator had keys to unlock all of the gates. -In case of a fire or emergency, the staff on duty would have to unlock the gate. Telephone interview with the local Fire Marshal on 06/11/25 at 9:24am revealed: -A fire inspection was last on 09/19/24. -There was a chain-linked fence that enclosed the facility. -There were three walk gates that were locked by a padlock located on the front middle, right lower side and the back right corner of the chain-linked fence.	D 072		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 072	Continued From page 5	D 072		

-In case of a fire, the firefighters would have to gain entrance to the facility by cutting the padlock on the front walk gate which would take about an extra two minutes.
-There was a vehicle slide gate at the front left-hand corner of the fence that was locked by a padlock.

Telephone interview with a home health nurse on 06/10/25 at 3:42pm revealed:
-She had been making weekly visits with residents at the facility since February 2024, and the gates had always been locked.
-She had to call the Administrator or the MA Supervisor to notify them when she arrived at the facility.
-The MA Supervisor would come outside and unlock the gate for her to enter every time she visited the facility.

Telephone interview with the Office Manager at the facility's contracted Mental Health Nurse Practitioner's (NP) office on 06/11/25 at 12:24 revealed:
-An assistant helped the mental health NP complete telehealth virtual visits every month.
-The assistant had to call the Administrator or the MA Supervisor when she arrived at the facility due to the gates being locked.
-The MA Supervisor had to come and unlock the gate every time she visited the facility.

Telephone interview with a Transitions to Community Living (TCL) Care Manager on 06/11/25 at 1:40pm revealed:
-She helped residents navigate their mental and physical health needs.
-Since the fence had been installed, the gates were always locked when she came to visit residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 072	Continued From page 6 Telephone interview with a second TCL Care Manager on 06/13/25 at 2:36pm revealed: -Since the fence had been installed, the gates were always locked when she came to visit residents. -Staff did not unlock the gate to let her inside of the fence. -She had to speak with the residents while standing outside of the fence. Telephone interview with a first TCL In-Reach Specialist on 06/10/25 at 10:22am revealed: -She was responsible for assisting individuals in accessing services, community resources, providing information and support to improve health outcomes and aid in successful community living. -She had visited the facility twice and the gates were locked on both visits. -She called the phone number listed on the banner hanging on the fence for someone to assist her. -Staff did not unlock the gate at either visit. Telephone interview with a second TCL In-Reach Specialist on 06/10/25 at 3:12pm revealed: -Since the fence had been installed, the gates were always locked when she came to visit residents. -She would have to call the Administer to get staff to assist her with seeing the residents. -Staff did not unlock the gate to let her inside of the fence. -She had to speak with the residents while standing outside of the fence. Telephone interview with a third TCL In-Reach Specialist on 06/11/25 at 2:59pm revealed: -He visited the facility on 05/22/25.	D 072		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 072	Continued From page 7	D 072		

-Upon arrival, the gates were locked.
-He called the phone number located on the banner hanging on the fence.
-Staff came outside and unlocked the padlock.

Telephone interview with the TCL Program Consultant on 06/10/25 at 2:43 revealed:
-She and a TCL In-Reach Specialist visited residents on 03/31/25.
-The gates were locked with a padlock.
-Staff did not unlock the gate to let her and the TCL In-Reach Specialist inside of the fence.
-She and the TCL In-Reach Specialist had to speak with the residents while standing outside of the fence.

Interview with the first shift MA Supervisor on 06/11/25 at 8:58am and on 06/12/25 at 8:40am revealed:
-The gates were always locked.
-The fence was installed due to a previous resident trying to leave.
-The Administrator told her to not let any TCL staff inside of the fence due to TCL staff upsetting the residents on previous visits.

Interview with the second shift MA Supervisor on 06/10/25 at 8:58am and on 06/11/25 at 9:15am revealed:
-The fence was installed in late August of 2024.
-The fence was installed due to people showing up and entering the facility without notifying the staff.
-The fence was installed so outside agencies, families and guardians would have to check in with staff prior to entering.
-The gates were locked and unlocked "sporadically".

Interview with the Administrator on 06/10/25 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 072	Continued From page 8 9:18am revealed: -The fence was installed in late August 2024 or early September 2024. -The fence was installed to keep "unwanted" visitors from entering the facility. -The fence was installed because outside agencies and visitors would not sign in or notify the staff they were in the facility. -The gate was mostly unlocked from 9:00am to 5:00pm. [Refer to tag 0338, 10A NCAC 13F .0909 Residents Rights (Type A1 Violation)]. _____ The facility failed to ensure a fence that enclosed the entire property was left unlocked to allow 10 of 10 residents to freely exit and enter the locked fence which resulted in residents being unreasonably confined to the property, and the secured gates did not allow exit to the area of refuge for the residents which, according to the facility evacuation plan, was beyond the fence line into the parking lot. This failure resulted in a substantial risk of serious physical harm which constitutes a Type A2 violation. _____ The facility provided a plan of protection on June 16, 2025, in accordance with G.S. 131D-34 for this violation. THE DATE OF CORRECTION FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED JULY 16, 2025.	D 072		
D 248	10A NCAC 13F .0704 (b) Resident Contract, Information On Facility &	D 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 248	Continued From page 9 10A NCAC 13F .0704 Resident Contract, Information On Facility, And Resident Register (b) The administrator or their management designee and the resident or the resident's representative shall complete and sign the Resident Register initial assessment within 72 hours of the resident's admission to the facility in accordance with G.S. 131D-2.15. The facility shall involve the resident in the completion of the Resident Register unless the resident is cognitively unable to participate. The Resident Register shall consist of the following: (1) resident's identification information including the resident's name, date of birth, sex, admission date, medical insurance, family and emergency contacts, advanced directives, and physician's name and address; (2) resident's current care needs including activities of daily living and services, use of assistive aids, orientation status; (3) resident's preferences including personal habits, food preferences and allergies, community involvement, and activity interests; (4) resident's consent and request for assistance including the release of information, personal funds management, personal lockable space, discharge information, and assistance with personal mail; (5) name of the individual identified by the resident who is to receive a copy of the notice of discharge per G.S. 131D-4.8; and (6) resident's consent including a signature confirming the review and receipt of information contained in the form. The Resident Register is available on the internet website, https://info.ncdhhs.gov/dhsr/acls/pdf/resregister.pdf at no charge. The facility may use a resident information form other than the Resident Register	D 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 248	Continued From page 10	D 248		

as long as it contains the same information as the Resident Register. Information on the Resident Register shall be kept updated and maintained in the resident's record.

This Rule is not met as evidenced by:
Based on record review and interviews, the facility failed to ensure a Resident Register was completed within 72 hours of admission to the facility for 1 of 3 sampled residents (Resident #3).

The findings are:

Review of Resident #3's current FL2 dated 01/13/25 revealed diagnoses included hypertension, schizoaffective disorder, depression, suicidal ideation, and subtherapeutic lithium levels.

Review of Resident #3's Resident Register revealed:
-Resident #3 was admitted to the facility on 01/20/22.
-The Resident Register was not signed or dated by Resident #3.
-The Resident Register was not signed or dated by the Administrator/designee.

Interview with the Administrator on 05/14/25 at 10:15am revealed:
-She did not know why Resident #3's Resident Register was incomplete and not signed or dated by Resident #3 or Administrator/ designee.
-The Resident Register was usually completed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 248	Continued From page 11 upon admission and if she was not there the Resident Care Coordinator would ensure it was completed. -She was ultimately responsible for ensuring the Resident Registers were completed during the admission process.	D 248		
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: Based on records review and interviews, the facility failed to ensure referral and follow-up to meet the acute health care needs for 1 of 3 sampled residents (Resident #3) related to a physician's order for monthly blood draws. The findings are: Review of Resident #3's current FL2 dated 01/13/25 revealed: -Resident #3 had diagnoses of hypertension, schizoaffective disorder, depression, suicidal ideation, and subtherapeutic lithium levels. -Resident #3 had an active order dated 03/07/25 for lithium carbonate 300mg/1 unit tablet, oral, extended release one tablet twice daily. Review of Resident #3's Resident Register revealed Resident #3 was admitted to the facility on 01/20/22. Review of Resident #3's record revealed: -Resident #3 had a physician's order dated	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 273	Continued From page 12	D 273		

03/07/25 for lithium levels every 4 weeks/ monthly.
-Resident #3 had last lithium blood draw in 2024.
-Resident #3's monthly lithium blood draw order was not discontinued and was still active.

Review of medication administration records from March 2025 to May 2025 revealed documentation that Resident #3 was administered lithium carbonate extended release (ER) 300mg one tablet by mouth twice daily.

Interview with the Branch Director at the facility's contracted Home Health agency on 05/14/25 at 4:43pm revealed:
-Resident #3's order for monthly lithium blood draws was received on 01/24/22.
-Resident #3 was admitted to home health services to monitor hypertension, schizophrenia, and diabetes.
-Resident #3 received lithium blood draws on 02/08/23, 04/04/23, 05/31/23, 06/22/23, 09/13/23, 11/13/23, 01/10/24 and 03/12/24.
-Resident #3 was discharged from home health services on 09/25/24 due to no longer requiring a skilled need.
-She could not locate any documentation related to Resident #3's lithium blood draws after 03/12/24.
-She did not have any documentation from the facility or physician about Resident #3's lithium blood draws being transferred to another home health agency after Resident #3 was discharged from their services.

Interview with Resident #3's Psychiatrist on 05/14/25 at 12:48pm revealed:
-Resident #3 had an active order for lithium carbonate 300mg one tablet twice daily.
-She should not have written the order dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 273	Continued From page 13 03/07/25 for monthly lithium blood draws. -Resident #3's lithium levels have been stable for some time, and he did not need monthly blood draws. -Resident #3's lithium blood levels should be checked once or twice yearly. -She planned to follow-up and provide clarification with the facility. -She expected the facility to follow-up and request clarification of the order for Resident #3 to receive lithium blood draws to ensure lithium levels were within normal limits. Interview with the Administrator on 05/14/25 at 10:15am revealed: -She did not know Resident #3 did not have a lithium blood draw since March 2024. -Resident #3 had an active order for monthly lithium blood draws dated 03/07/25. -She could not locate the original order for Resident #3's monthly lithium blood draws and had repeatedly made inquiries to the provider about the status of monthly lithium blood draws. -She did not know why the blood draws had not been done. -She was responsible for ensuring Resident #3 received lithium blood draws as ordered. Attempted telephone interview with Resident #3's Primary Care Physician (PCP) on 05/14/25 was unsuccessful.	D 273		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or	D 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 280	Continued From page 14	D 280		

physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following:
(1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule;
(2) evaluating the resident's progress to care being provided;
(3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and
(4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 3 sampled residents (Resident #2 and #3) had quarterly licensed health professional services (LHPS) assessments for tasks related to collecting or testing of fingerstick blood samples, medication administration through injection.

The findings are:

1. Review of Resident #2's current FL2 dated 10/02/24 revealed:
-Diagnoses included type 1 diabetes and hypertension.
-The resident was ambulatory.
-The resident required diabetic fingerstick blood sugar (FSBS) testing four times a day.
-There was an order dated 03/10/25 for lantus (a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 280	Continued From page 15	D 280		

long acting insulin) daily at bedtime and humalog (a short acting insulin) three times a day on a sliding scale before meals.

Review of Resident #2's Care Plan dated 01/31/25 revealed he required FSBS testing four times a day.

Review of Resident #2's quarterly review for LHPS tasks revealed:
-The LHPS assessment completed by a registered nurse (RN) was dated 01/31/25.
-Tasks documented on the LHPS assessment included collecting or testing of fingerstick blood samples and medication administration through injection.
-Documentation on the LHPS form indicated monitoring of blood sugar before meals and at bedtime by fingerstick testing and diabetes management by subcutaneous insulin injections up to four times a day.

Refer to interview with the facility's contracted LHPS nurse on 05/13/25 at 9:45am.

Refer to interview with the Administrator on 05/13/25 at 11:25am.

2. Review of Resident #3's current FL2 dated 01/13/25 revealed:
-Diagnoses included hypertension, schizoaffective disorder, depression, suicidal ideation, and subtherapeutic lithium levels.
-Resident #3 had an order for weekly fingerstick blood sugar (FSBS) testing.
-Resident #3 required monthly blood pressure checks.

Review of Resident #3's Resident Register revealed Resident #3 was admitted to the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 280	Continued From page 16 on 01/20/22. Review of Resident #3's Licensed Health Professional Support assessment (LHPS) dated 01/31/25 revealed weekly FSBS testing. Review of Resident #3's record revealed there was no quarterly LHPS for April 2025 completed. Refer to interview with the facility's contracted LHPS nurse on 05/13/25 at 9:45am. Refer to interview with the Administrator on 05/14/25 at 11:40am. _____ Telephone interview with the facility's contracted LHPS Nurse on 05/13/25 at 9:45am revealed: -She was responsible for completing the facility's quarterly LHPS assessments. -She completed the quarterly LHPS assessments for January 2025. -She did not complete the quarterly LHPS assessments due in April 2025, due to the facility being on quarantine for 2 weeks (end of March 2025 through second week in April 2025). -She planned to catch up on any outstanding LHPS assessments this week. Interview with the Administrator on 05/13/25 at 11:25 am revealed: -The facility's contracted LHPS nurse was responsible for completing the quarterly LHPS assessment for residents. -Quarterly LHPS assessments for April 2025 were overdue and not completed by the contracted nurse due to the facility being quarantine for 2 weeks (end of March 2025 through second week in April 2025). -She expected LHPS assessments to be	D 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 280	Continued From page 17 completed quarterly and timely by the LHPS nurse. -She was aware the LHPS assessments were due April 2025.	D 280		
D 324	10A NCAC 13F .0906 (d) Other Resident Care And Services 10A NCAC 13F .0906 Other Resident Care And Services (d) Telephone. (1) A telephone shall be available in a location providing privacy for residents to make and receive calls. (2) A pay station telephone is not acceptable for local calls; and (3) It is not the home's obligation to pay for a resident's toll calls This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a telephone was available in a location providing privacy for 10 of 10 residents residing in the facility. The findings are: Review of the facility house rules for telephone use policy revealed: -Each resident was allowed two phone calls per day for 15 minutes each. -Each resident must ask to use the phone. -Only staff can answer the phone. -No residents are allowed to have a cell phone. Review of the facility's services and	D 324		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 324	Continued From page 18	D 324		

accommodation policy revealed:
-The date the document was signed was blank.
-Each resident was allowed to associate and communicate privately and without restriction with people and groups of his or her own choice on his or her own or their initiative at any reasonable hour.
-Each resident was allowed to have access at any reasonable hour to a telephone where he or she may speak privately.

1. Review of Resident #1's current FL2 dated 03/10/25 revealed:
-Diagnoses included continuous and severe Schizophrenia.
-Her level of care was assisted living.
-There was no information related to her level of orientation.

-Review of Resident #1's Resident Register revealed:
-She was admitted to the facility on 03/7/24.
-She had a guardian.

Interview with Resident #1 on 06/10/25 at 8:47am revealed:
-There were no cell phones allowed, and she had to ask to call her guardian if she needed too.
-There was no one else she wanted to call.

Refer to the interview with the Administrator on 06/16/25 at 12:34pm.

2. Review of Resident #6's current FL2 dated 05/08/25 revealed:
-Diagnoses included mental retardation (MR), diabetes, psychotic disorder and bipolar disorder.
-His level of care was assisted living.
-There was no information related to his level of orientation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 324	Continued From page 19 Review of Resident #6's Resident Register revealed: -He was admitted to the facility on 05/01/25. -He had a guardian. Interview with Resident #6 on 06/13/25 at 3:04pm revealed: -He had a guardian. -He did not have a cell phone because it was a rule that he couldn't have one. -He called his family member on Saturdays at 3:00pm. Interview with the second shift MA Supervisor on 06/13/25 at 3:09pm revealed: -The Administrator told her that Resident #6 was not allowed to have a cell phone because at his last facility, he called 911 a lot to order pizza. -Resident #6's familiy member, who was not his Guardian, did not want Resident #6 calling him while he was working. Refer to the interview with the Administrator on 06/16/25 at 12:34pm. 3. Review of Resident #4's current FL2 dated 10/08/24 revealed: -Diagnoses included schizoaffective disorder, bipolar, aggressive behaviors, psychosis and delirium. -There was a line marked through the orientation information section. -There was a line marked through the behavior information section. Review of Resident #4's Resident Register revealed an admission date of 07/26/23. Based on observations, record reviews and	D 324		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 324	Continued From page 20	D 324		

interviews, it was determined that Resident #4 was not interviewable.

Refer to the interview with the Administrator on 06/16/25 at 12:34pm.

4. Review of Resident #5's current FL2 dated 03/12/25 revealed diagnoses included chronic heart failure (CHF), diabetes and bipolar disorder.

Review of Resident #5's Resident Register revealed:
-He was admitted to the facility on 03/03/25.
-He was his own responsible person.

Review of the Resident #5's facility house rules for telephone use policy signed by Resident #5 on 03/01/25 revealed:
-Each resident was allowed two phone calls per day for 15 minutes each.
-Each resident must ask to use the phone.
-Only staff can answer the phone.
-No residents are allowed to have a cell phone.

Review of Resident #5's services and accommodation policy signed by Resident #5 on 03/01/25 revealed:
-Each resident was allowed to associate and communicate privately and without restriction with people and groups of his or her own choice on his or her own or their initiative at any reasonable hour.
-Each resident was allowed to have access at any reasonable hour to a telephone where he or she may speak privately.

Interview with Resident #5 on 06/11/25 at 11:10am revealed he was told by the Administrator when he was admitted that cell phones were not allowed and his family had only

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 324	Continued From page 21 visited one time since his admission March 2025. Refer to the interview with the Administrator on 06/16/25 at 12:34pm. _____ Interview with the Administrator on 06/16/25 at 12:34pm revealed: -She did not know the rules and regulations related to resident phone use. -She had created the contract around five years ago due to residents wanting to make phone calls constantly. -She did not allow residents to have cell phones due to issues with a previous resident sending inappropriate pictures. [Refer to tag 0338, 10A NCAC 13F .0909 Residents Rights (Type A1 Violation)].	D 324		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, record reviews and interviews, the facility failed to ensure 10 of 10 residents were treated with dignity, respect, allowed private visits with their mental health provider, freedom to leave the facility, the opportunity to participate in activities of their choosing and receive care and services offered	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 338	Continued From page 22	D 338		

by outside agencies.

The findings are:

Review of the Bill of Rights posted at the facility revealed:
-The residents were to receive care, treatment, and services that are adequate and appropriate, and in compliance with relevant Federal and State laws and rules and regulations.
-The residents were to be free of mental and physical abuse, neglect and exploitation.
-The residents were to associate and communicate privately and without restriction with people and groups of his or her own choice on his or her own initiative at reasonable hour.
-The residents were to have access at any reasonable hour to a telephone where he or she may speak privately.
-The residents were to have the freedom to participate by choice in accessible community activities and in social, political, medical and religious resources and to have freedom to refuse such participation.
-The residents were to receive a copy of the Bill of Rights.

Review of the facility's undated House Rules revealed:
-The house rules pertained to all residents who were admitted to the facility.
-On admission the resident or family member were to sign the house rules document to show they understood and would abide by all rules.
-The house rules were made so that each resident knew what was or was not expected of the residents and their families.
-Visitation hours were allowed at 9:00am to 5:00pm and if a visitor lived a distance away a call was to be made first to help plan ahead so

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 338	Continued From page 23	D 338		

the time was not wasted.
-Residents were to have one or two phone calls daily, for thirty minutes.
-There were no cell phones allowed.
-Only staff could answer the facility phone.
-The facility had the right to ask the resident to move if the house rules were not followed.

Review of the facility's license revealed the license was effective 01/01/25 through 12/31/25 for a capacity of 12 assisted living (AL) residents.

Observation of the outside of the facility on 06/10/25 at 8:30am revealed:
-There was a gated chain-link fence completely enclosing the facility.
-There was a vehicle slide gate located at the front left corner of the fence that was padlocked.
-There was a walk gate located in the middle of the front side of the gate, approximately 113 feet from the entrance to the facility, that was padlocked.
-There was a second walk gate located 3/4 of the way down the left side of the fence that was padlocked.
-There was a third walk gate located on the back right side of the fence that was approximately 33 feet from the outside of the facility that was padlocked.

Observation of the banner located on the front portion of the chain-linked fence revealed:
-No outside agencies were allowed to talk with any residents without an appointment with the Administrator.
-For admittance into the facility there was a phone number to call.

Observation of the dining room on 06/13/25 at 9:30am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 338	Continued From page 24 -The was a table six feet into the doorway on the left-hand side of the wall where the mental health provider conducted her virtual visits. -Three feet beyond that table was a door into the medication room. Review of the NC DHSR construction report completed on 06/03/25 revealed: -The installed fence was not in compliance with the 2018 Building Code Section 407.9. -The secured gates did not allow exit discharge to the area of refuge which, according to the facility evacuation plan, was beyond the fence line into the parking lot. -Pad locks were installed on each of the gates. -Only staff have keys to open the gate preventing the residents from exiting and entering freely. Review of the facility's undated Service and Accommodation Policy revealed: -The activity program was designed to promote the residents' active involvement with each other, their families, and the community. -The program was to provide social, physical, intellectual, and recreational activities in a planned, coordinated, and structural manner. -The program was designed to promote active involvement by all residents but was not to require any individual to participate in any activity against his/her will. -The residents were allowed to associate and communicate privately and without restriction with people and groups of his or her own choice on his or her own or their initiative at any reasonable hour. -The residents were allowed to have access at any reasonable hour to a telephone where he or she may speak privately. -Visiting in the home and community at reasonable hours is encouraged and arranged	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 338	Continued From page 25	D 338		

through the mutual prior understanding of the residents and Administrator.

1. Review of Resident #1's current FL2 dated 03/10/25 revealed:
-Diagnoses included continuous and severe Schizophrenia.
-Her level of care was assisted living.
-There was no information related to her level of orientation.

Review of Resident #1's Resident Register revealed:
-She was admitted to the facility on 03/7/24.
-She had a guardian.

Review of Resident #1's care plan dated 03/10/25 revealed:
-She was independent with ambulation, toileting and transfers.
-She required limited assistance with dressing and grooming.
-She required extensive assistance with bathing.
-She required total assistance with eating.

Review of Resident #1's record revealed:
-There was a copy of the Bill of Rights signed by the Guardian.
-There was a copy of the House Rules signed by the Guardian.
-There was a copy of the sign in/out policy signed by the Guardian.
-There was a copy of the Activity Program policy signed by the Guardian.

Interview with Resident #1 on 06/10/25 at 8:47am revealed:
-She was not allowed to walk outside the chain-link fence because she "might escape".
-The Administrator told her the rules were that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 338	Continued From page 26	D 338		

she could not go outside the fence.
-The gates were always locked and that was the "policy" and to keep the "peace" she would not "escape.
-She kept repeating she "must follow" the rules and she was a rule follower.
-She knew she would get into trouble if she broke the rules, but she did not know what the trouble would be.
-The Administrator told her it was dangerous and she could get hurt if she went through the gate.
-She went to her primary care office when she needed to but did not go anywhere else like outings, trips to the store, park or special outings.
-Her Guardian visited her but there were no friends or family that visited her.
-There were no cell phones allowed, and she had to ask to call her guardian if she needed too.
-There was no one else she wanted to call.

Telephone interview with Resident #1's Guardian on 06/11/25 at 11:26am revealed:
-He visited Resident #1 on a monthly basis.
-On 01/22/25, a Transition to Community Living (TCL) In-Reach Specialist called him and gave him the information about the services that could be offered to Resident #1.
-After a brief discussion they agreed that Resident #1 was not suitable for independent living but could benefit from other services offered so he gave the TCL In-Reach Specialist permission to visit with Resident #1 and called the Administrator and let her know as well.
-When he talked to the Administrator, she told him about the TCL In-Reach Specialist.
-The Administrator told him that she had some residents were upset after the TCL In-Reach Specialist visited because along with not checking in with staff, TCL In-Reach Specialists spoke with other residents who were not on their

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 338	Continued From page 27	D 338		

service and lead them to believe they qualified to live on their own and that was why the Administrator put up the chain-link fence and locked the gates.
-The Administrator required all outside agencies to call her number first to set up an appointment.
-He always made an appointment to come and see Resident #1 because of his work schedule.
-On 02/07/25, he had a video conference with the TCL In-Reach Specialist and the TCL Program Manager to discuss the TCL In-Reach Specialist concerns with the Administrator refusing entrance into the facility and to meet with Resident #1 in private to build a rapport, but he did not want to make it uncomfortable for Resident #1 and the staff so he did not assist the TCL In-Reach Specialist by meeting her at the facility.
-He did not know there were not any activities over the past two months or outing into the community.
-After speaking with the TCL In-Reach Specialist, he felt Resident #1 could benefit from the other services they could provide.

Telephone interview with a first TCL In-Reach Specialist on 06/11/25 at 1:47pm revealed:
-She was responsible for assisting individuals in accessing services, community resources, providing information and support to improve health outcomes and aid in successful community living.
-On 01/17/25, she was first assigned to Resident #1.
-On 01/22/25, she called the facility and after identifying herself, she tried to schedule an appointment to see Resident #1 and was told she needed to call and speak to the Administrator.
-On 01/22/25, she called Resident #1's Guardian, identified who she was and the services she could assist with and that she could not reach the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 338	Continued From page 28 Administrator to set up a date and time to meet with Resident #1. -On 01/22/25, Resident #1's Guardian gave her permission to meet with Resident #1 and access the possibilities of services she could provide. -On 01/27/25, was the first time going to the facility to meet with Resident #1. -On 01/27/25, she arrived at the facility, there was a chain-link fence around the facility and a gate that was pad-locked. -The banner on the fence had a number to call for entrance to the gate. -She called the number that was posted and no one answered, left a voice mail, called back immediately and there was no answer again and after 15 minutes a staff member came out to the gate and asked her who she was and what she wanted. -The staff member called the Administrator, and she explained who she was and why she needed to speak to Resident #1, and she was told by the Administrator that Resident #1 did not need the services she was assessing for, and Resident #1 was "hard to understand". -The Administrator spoke to the staff member on the phone, locked the gate back, returned to the facility. -After the Administrator went inside the facility, the Administrator brought Resident #1 out on the front porch. -Resident #1 was wearing a mask and that was how she was supposed to talk with Resident #1. -She could hardly hear and understand Resident #1 because the porch was far away and Resident #1 was wearing a mask. -She asked to come in and was told no by the staff. -Resident #1 said something else and went back into the facility. -She needed to have private one-on-one	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 338	Continued From page 29	D 338		

interaction to establish rapport with Resident #1.
-On 02/07/25, she met with the TCL Program Consultant and Resident #1's Guardian virtually to discuss the concerns about not getting to have a one-on-one private interaction with Resident #1 and to schedule a visit with all three of them and Resident #1 at the facility.
-On 04/17/25, she and the TCL Program Consultant met at the facility.
-She called the number on the banner, waited 15 minutes and called again with no answer.
-After 15 minutes, Resident #1 was brought out on the porch and was told by staff the same as before that Resident #1 did not want to talk and was taken back into the facility.
-Resident #1's Guardian was aware of the services other than independent living and was interested to see if Resident #1 would like the services such as, day programs that would allow interaction with people outside of facility, peer support, volunteer work and in some cases employment.
-She was not given the opportunity to explain the other services to the Administrator because the Administrator was very aggressive in her behavior and cut her off when she tried to explain the reasons for her visits with Resident #1.

Refer to telephone interview with the facilities contracted Mental Health Nurse Practitioner (NP) on 06/11/25 at 10:31am, on 06/13/25 at 9:45am and on 06/16/25 at 3:03pm.

Refer to telephone interview with a Fire Marshal on 06/11/25 at 9:24am.

Refer to interview with the first shift MA Supervisor on 06/11/25 at 8:58am and on 06/13/25 at 9:12am.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 338	Continued From page 30	D 338		

Refer to interview with the second shift MA Supervisor on 06/10/25 at 8:58am and on 06/11/25 at 9:15am.

Refer to the interview with the Administrator on 06/10/25 at 9:18am, on 06/12/25 at 10:00am and 06/16/25 at 12:34pm revealed:

2. Review of Resident #6's current FL2 dated 05/08/25 revealed:
-Diagnoses included mental retardation (MR), diabetes, psychotic disorder and bipolar disorder.
-His level of care was assisted living.
-There was no information related to his level of orientation.

Review of Resident #6's Resident Register revealed:
-He was admitted to the facility on 05/01/25.
-He had a guardian.

Review of Resident #6's care plan dated 03/12/25 revealed:
-He was independent with ambulation, toileting, eating and transfers.
-He required limited assistance with dressing and grooming.
-He required extensive assistance with bathing.

Review of Resident #6's record revealed:
-There was a copy of the Bill of Rights signed by the Guardian.
-There was a copy of the House Rules signed by the Guardian.
-There was a copy of the sign in/out policy signed by the Guardian.
-There was a copy of the Activity Program policy signed by the Guardian.

Review of Resident #6's TCL In-Reach

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 338	Continued From page 31	D 338		

Specialist's visit note dated 05/23/25 revealed:
-Resident #6's referral was for personal care and services, intellectual/developmental disability, and mental health.
-On 05/22/25, he attempted a visit with Resident #6 and was denied by the facility staff and Administrator.
-The Administrator stated Resident #6 was assigned to TCL by mistake and he was not allowed to see Resident #6.
-He "snuck" to see Resident #6 in the hallway.

Interview with Resident #6 on 06/11/25 at 11:25am revealed he was "not allowed" to go outside of the fence.

Telephone interview with Resident #6's Guardian on 06/11/25 at 4:06pm revealed:
-Resident #6 was new to the facility.
-Resident #6 was not capable of independent living and she was not aware of any other services they offered.
-It was a rule that the Administrator had her sign a form to acknowledge cell phone were not allowed in the facility.
-The facility would call her if Resident #6 needed to speak to her.

Interview with Resident #6 on 06/13/25 at 3:04pm revealed:
-He has a Guardian.
-He did not have a cell phone because it was a rule that he could not have one.

Interview with the first shift MA Supervisor on 06/12/25 at 8:30am revealed:
-On 05/22/25, she was working when Resident #6's TCL In-Reach Specialist arrived at the facility
-She was told by the Administrator to not let Resident #6's TCL In-Reach Specialist into the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 338	Continued From page 32	D 338		

building.
-She believed it was to protect the residents and did not want to lose them to independent living.

Interview with the second shift MA Supervisor on 06/13/25 at 3:09pm revealed the Administrator told her that Resident #6 was not allowed to have a cell phone because at his last home, he called 911 a lot to order pizza.

Refer to telephone interview with the facilities contracted Mental Health NP on 06/11/25 at 10:31am, on 06/13/25 at 9:45am and on 06/16/25 at 3:03pm.

Refer to telephone interview with a Fire Marshal on 06/11/25 at 9:24am.

Refer to interview with the first shift MA Supervisor on 06/11/25 at 8:58am and on 06/13/25 at 9:12am.

Refer to interview with the second shift MA Supervisor on 06/10/25 at 8:58am and on 06/11/25 at 9:15am.

Refer to the interview with the Administrator on 06/10/25 at 9:18am, on 06/12/25 at 10:00am and 06/16/25 at 12:34pm revealed:

3. Review of Resident #4's current FL2 dated 10/08/24 revealed:
-Diagnoses included schizoaffective disorder, bipolar, aggressive behaviors, psychosis and delirium.
-There was a line marked through the orientation information section.
-There was a line marked through the behavior information section.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 338	Continued From page 33 Review of Resident #4's Resident Register revealed an admission date of 07/26/23. Review of Resident #4's care plan dated 10/03/24 revealed: -She was independent with toileting, ambulation, and transfers. -She required limited assistance with dressing and grooming. -She required extensive assistance with dressing. -She required total assistance with eating. Based on observations, record review and interviews, it was determined that Resident #4 was not interviewable. Telephone interview with Resident #4's guardian on 06/12/25 at 11:41am revealed: -Since the fence was installed, the gates were sometimes locked but not always. -She was present during a meeting on 01/07/25 with Resident #4, Resident #4's care manager, the care manager's supervisor, and the Administrator. -She witnessed the Administrator sit on Resident #4's lap and hug the resident during the meeting on 01/07/25. Telephone interview with the TCL care manager for Resident #4 on 06/11/25 at 1:40pm and on 06/13/25 at 10:36am revealed: -She helped residents navigate their mental and physical health needs. -Since the fence had been installed, the gates were always locked with a padlock. -She had to call the number on the banner, hanging on the fence in order get staff to assist her. -She and her supervisor visited Resident #4 on	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 338	Continued From page 34	D 338		

01/07/25 in the facility dining room.
-She said the Administrator was present during most of the meeting.
-Resident #4's guardian later joined.
-She witnessed the Administrator sit on Resident #4's lap and the resident became very upset.

Telephone interview with Resident #4's TCL care manager's supervisor on 06/13/25 at 9:37am revealed:
-He visited the facility on 01/07/25 and the gates were locked.
-He was present during a meeting on 01/07/25 with Resident #4, Resident #4's guardian, the care manager, and the Administrator.
-He witnessed the Administrator sit on Resident #4's lap and place her arm around the resident's upper back.
-The Administrator did state that she did remember Resident #4 not liking being touched but had forgotten.

Review of the previous TCL In-Reach Specialist's progress notes for Resident #4 dated 03/31/25 revealed:
-She and the TCL Program Consultant visited the facility on 03/31/25.
-Upon arrival she called the phone number listed on the banner hanging on the fence without an answer.
-She called the facility without an answer.
-The gates were locked.
-After waiting around 15 minutes, the second shift MA Supervisor came outside.
-She asked the MA Supervisor why she was not allowed inside of the fence or facility and MA Supervisor told her only certain people were allowed to visit residents.
-She told the MA Supervisor she needed to see the members' face.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 338	Continued From page 35 -Resident #4 came out on the front porch and asked why she and the TCL Program Consultant could not come in and visit and the staff member said they can not. Telephone interview with the previous TCL In-Reach Specialist for Resident #4 on 06/10/25 at 3:12pm revealed: -She was responsible for assisting individuals in accessing services, community resources, providing information and support to improve health outcomes and aid in successful community living. -Since the fence had been installed, the gates were always locked when she came to visit residents. -She had to call the number on the banner, hanging on the fence in order get staff to assist her. -The Administrator would not allow her to visit residents or let her inside of the fence. -She was told by the second shift MA Supervisor she could not come inside of the fence when she and the TCL Program Consultant visited on 03/31/25. -She had to speak with Resident #4 while standing at the fence while the resident was standing on the front porch. -Resident #4 asked the MA Supervisor why she and the TCL Program Consultant could not come in and visit and the MA Supervisor stated they can't. -The MA Supervisor told her the TCL staff upset Resident #4 when they had visited, and the facility staff had to calm Resident #4 down after they left. Review of the TCL Program Consultant progress notes for Resident #4 dated 03/31/25 revealed: -She and the Program Consultant for TCL visited the facility on 03/31/25.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 338	Continued From page 36 -She and the In-Reach Specialist visited Resident #4 on 03/31/25. -Upon arrival at the facility, the gates were locked, and there was a phone number listed for visitors to call on a banner hanging on the fence. -After the visit with another resident she and the In-Reach Specialist left but the In-Reach Specialist remembered she needed to visit Resident #4. -Upon returning to the facility, the In-Reach Specialist called the number listed on the banner. -During their 40-minute wait, the In-Reach Specialist attempted to call the facility but there was no answer. -When a facility staff member came outside of the front door, the In-Reach Specialist asked if she could say hi to Resident #4. -The In-Reach Specialist asked facility staff about coming into the facility, but the staff member stated only certain people can come into the facility and they were not allowed to because they upset people. -Resident #4 was brought to the front porch waved and asked why she and the In-Reach Specialist could not come in and visit and the staff member said they can not. -The In-Reach Specialist later called her stating the In-Reach Specialist had read the care manager's note stating the Administrator had sat on Resident #4's lap which triggered the resident who became upset and later sent to the hospital. Telephone interview with the TCL Program Consultant on 06/10/25 at 2:43pm revealed: -She was the TCL program Consultant and worked with all four TCL agencies. -She and the TCL In-Reach Specialist came to the facility on 03/31/25 to visit Resident #4. -There was a fence around the premises and the gates were locked with a padlock.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 338	Continued From page 37	D 338		

-There was a banner on the fence instructing all outside agencies to call to schedule an appointment.
-After the visit with another resident she and the In-Reach Specialist left but the In-Reach Specialist remembered she needed to visit Resident #4.
-Upon returning to the facility, the In-Reach Specialist called the number listed on the banner.
-During their 40-minute wait, the In-Reach Specialist attempted to call the facility but there was no answer.
-The second shift MA Supervisor came outside.
-She asked the second shift MA Supervisor if they could come inside of the fence and the MA Supervisor stated they could not come in.
-She second shift MA Supervisor did bring Resident #4 outside of the facility, on the front porch.
-Resident #4 asked the second shift MA Supervisor why she and the In-Reach Specialist could not come in.
-The second shift MA Supervisor stated she was not allowed to let them come in.
-The In-Reach Specialist reported there was documentation in a TCL care manager's note that the Administrator had sat in Resident #4's lap, which made the resident very upset.

Interview with the first shift MA Supervisor on 06/11/25 at 8:58am and on 06/12/25 at 8:40am revealed:
-She was told by the Administrator to not let any TCL staff inside of the fence due to TCL staff upsetting the residents on previous visits.
-She was present during a meeting on 01/07/25 with Resident #4, Resident #4's guardian, the care manager, the care manager's supervisor and the Administrator.
-She witnessed the Administrator stand beside

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 338	Continued From page 38	D 338		

Resident #4, crouch down and place one arm around her upper back.

Interview with the second shift MA Supervisor on 06/10/25 at 8:58am revealed she did not let two TCL staff members inside of the fence when they came to visit Resident #4.

Interview with the Administrator on 06/10/25 at 9:18am and on 06/12/25 at 10:00am revealed:
-She told the staff to not allow any visitors inside of the fence unless they visitors gave them information as to why they were at the facility.
-She was present during a meeting on 01/07/25 with Resident #4, Resident #4's guardian, the care manager, the care manager's supervisor and the first shift MA Supervisor.
-She placed her arm around Resident #4's upper back but did not sit on her lap.
-She remembered after placing her arm around Resident #4's back that she did not like being touched.

Refer to the telephone interview with the facilities contracted Mental Health NP on 06/11/25 at 10:31am, on 06/13/25 at 9:45am and on 06/16/25 at 3:03pm.

Refer to telephone interview with a Fire Marshal on 06/11/25 at 9:24am.

Refer to interview with the first shift MA Supervisor on 06/11/25 at 8:58am and on 06/13/25 at 9:12am.

Refer to interview with the second shift MA Supervisor on 06/10/25 at 8:58am and on 06/11/25 at 9:15am.

Refer to interview with the Administrator on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 338	Continued From page 39 06/10/25 at 9:18am, on 06/12/25 at 10:00am and 06/16/25 at 12:34pm revealed: 4. Review of Resident #5's current FL2 dated 03/12/25 revealed diagnoses included chronic heart failure (CHF), diabetes and bipolar disorder. Review of Resident #5's Resident Register revealed: -He was admitted to the facility on 03/03/25. -He was his own responsible person. Review of Resident #5's care plan dated 03/12/25 revealed: -He was independent with ambulation, toileting and transfers. -He required limited assistance with bathing, dressing and grooming. -He required total assistance with eating. Review of Resident #5's record revealed: -He signed the facility Bill of Rights on 03/01/25. -He signed the facility House Rules on 03/01/25. -He signed the sign in/out policy on 03/01/25. -He signed the Activity Program on 03/01/25. Interview with Resident #5 on 06/10/25 at 1:40pm and on 06/11/25 at 11:10am revealed: -The gates have always been locked since he was admitted to the facility in March 2025. -The gates were always locked unless an outside agency was there to see residents and the gates were locked back once the outside agencies left the facility. -The Administrator and the second shift MA Supervisor told him that he could not go outside the gate unless they let him when he took out the trash or go to a doctor's appointment. -His family had only visited one time since his admission March 2025.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 338	Continued From page 40	D 338		

-His TCL-In-Reach Specialist had to schedule a visit and the visiting hours were from 9:00am to 5:00pm.
-He would go outside the gate to walk but he was told that he could not.
-There were no activities at the facility since he was admitted in March 2025.
-There have been no outside activities or visitor from the community since his admission in March 2025.

Review of the previous TCL In-Reach Specialist progress notes for Resident #5 dated 03/31/25 revealed:
-She and the TCL Program Consultant visited the facility on 03/31/25.
-Upon arrival she called the phone number listed on the banner hanging on the fence without an answer.
-The Administrated answered and told her Resident #5 was in the shower.
-The second shift MA Supervisor came outside with Resident #5. She and the TCL Program Consultant were not allowed inside of the locked fence.
-The MA Supervisor was standing nearby while the In-Reach Specialist and the TCL Program Consultant were visiting with Resident #5.
-The MA Supervisor stated the resident had a Primary Care Provider (PCP) appointment.

Telephone interview with the previous TCL In-Reach Specialist for Resident #5 on 06/10/25 at 3:12pm revealed:
-Since the fence had been installed, the gates were always locked when she came to visit residents.
-She had to call the number on the banner hanging on the fence in order get staff to assist her.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 338	Continued From page 41	D 338		

-The Administrator would not allow her to visit residents or let her inside of the fence.
-She was told by the second shift MA Supervisor she could not come inside of the fence when she and the TCL Program Consultant visited on 03/31/25.
-She and the TCL Program Consultant remained outside the fence.
-The MA Supervisor brought Resident #5 to the gate after waiting for 15 minutes.
-The MA Supervisor was standing nearby while the In-Reach Specialist and the TCL Program Consultant were visiting with Resident #5.
-After a few minutes of visiting with Resident #5, the MA Supervisor stated the resident had a PCP appointment.
-She and the TCL Program Consultant left the facility and after a few minutes the previous In-Reach Specialist forgot that she needed to speak to another resident and returned to the facility.
-After being at the facility and waiting outside the fence for about 40 minutes, Resident #5 had not left for his PCP appointment.

Review of the TCL Program Consultant progress notes for Resident #5 dated 03/31/25 revealed:
-She and the Program Consultant for TCL visited the facility on 03/31/25.
-She and the In-Reach Specialist visited Resident #5 on 03/31/25.
-Upon arrival at the facility, the gates were locked, and there was a phone number listed to for all visitors to call, on a banner, hanging on the fence.
- In-Reach Specialist called the number and spoke with staff who stated Resident #5 was in the shower.
-After waiting 20 minutes, Resident #5 met with her and the In-Reach Specialist at the fence with a staff member standing nearby.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 338	Continued From page 42	D 338		

-The facility staff member would not allow her and the In-Reach Specialist entrance inside of the fence.
- The facility staff member stood nearby during their conversation with Resident #5.
- After a few minutes of meeting with Resident #5, the staff member stated it was time for the resident to leave for a PCP appointment.

Telephone interview with the TCL Program Consultant on 06/10/25 at 2:43pm revealed:
-She and the TCL In-Reach Specialist came to the facility on 03/31/25 to visit Resident #5.
-There was a fence around the premises and the gates were locked with a padlock.
-There was a banner on the fence instructing all outside agencies to call to schedule an appointment.
-The In-Reach Specialist called the number on the banner and was told Resident #5 was in the shower.
-After waiting about 20 minutes, the second shift MA Supervisor brought Resident #5 to the gate.
-The MA Supervisor stated she was not allowed to let them inside of the fence.
-The MA Supervisor stood nearby while they were visiting with Resident #5.
-The MA Supervisor told Resident #5 he had a PCP appointment.
-The MA Supervisor lead Resident #5 back to the facility.

Interview with a resident on 03/13/25 at 3:40pm revealed:
-There were no scheduled activities.
-He watched TV and read magazines for an activity.
-The facility used to have horseshoes and cornhole boards available.
-He does not know what happened to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 338	Continued From page 43	D 338		

horseshoes or cornhole boards, but he would like to have them back.
-The facility used to have Wednesday night bible study that he enjoyed but no one had done bible study in a very long time.

Refer to the telephone interview with the facility's contracted Mental Health NP on 06/11/25 at 10:31am, on 06/13/25 at 9:45am and on 06/16/25 at 3:03pm.

Refer to telephone interview with a Fire Marshal on 06/11/25 at 9:24am.

Refer to interview with the first shift MA Supervisor on 06/11/25 at 8:58am and on 06/13/25 at 9:12am.

Refer to interview with the second shift MA Supervisor on 06/10/25 at 8:58am and on 06/11/25 at 9:15am.

Refer to interview with the Administrator on 06/10/25 at 9:18am, on 06/12/25 at 10:00am and 06/16/25 at 12:34pm revealed:

_____

Telephone interview with the facility's contracted Mental Health NP on 06/11/25 at 10:31am and on 06/13/25 at 9:45am revealed:
-Because she did not come to the facility, she conducted virtual visits at the facility with the resident with the help of her assistant.
-Her assistant would go to the facility monthly, set up the tablet and ask the Administrator and staff about the residents and any new issues or concerns.
-She was provided a private place in the dining room to speak with the residents virtually.
-The Administrator and the second shift MA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 338	Continued From page 44 Supervisor were present during the visits and did provide insight, truths and untruths the residents stated which could have been given to the assistant prior to the resident's visit time. -With the residents who had delusions and mental health issues the staff provided insight about their behaviors while she was not physically in the facility. -At any time, if a resident asked for privacy, she would clear the room of her assistant and staff and continued with the visit. -She did not know the residents did not have community involvement at the facility and did not go on outings since December 2025. -She did not know the resident did not have activities in two months. -Having outside community involvement and activities would help with their mental health. Telephone interview with a Fire Marshal on 06/11/25 at 9:24am revealed: -A fire inspection was last completed on 09/19/24. -There was a chain-linked fence that enclosed the facility. -There were three walk gates that were locked by a padlock located on the front middle, right lower side and the back right corner of the chain-linked fence. -In case of a fire, the firefighters would have to gain entrance to the facility by cutting the padlock on the front walk gate which would take about an extra two minutes. -There was a vehicle slide gate at the front left-hand corner of the fence that was locked by a padlock. Interview with the first shift MA Supervisor on 06/11/25 at 8:58am and on 06/12/25 at 8:40am revealed: -The gates were always locked.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 338	Continued From page 45	D 338		

-The fence was installed due to a previous resident trying to leave.
-She was told by the Administrator to not let any TCL staff inside of the fence due to TCL staff upsetting the residents on previous visits.
-She also believed it was to protect the residents and the Administrator did not want to lose them to independent living.
- The second shift MA Supervisor used to take residents out to eat, to the library, to the park and out on shopping trips but they had not taken the residents anywhere for a couple of months due to her having to fill in for another staff member who was out on leave.
-No one comes into the facility to complete activities, no bible study or other community involvement.

Interview with the second shift MA Supervisor on 06/10/25 at 8:58am and on 06/11/25 at 9:15am revealed:
-The fence was installed in late August of 2024.
-The fence was installed due to people showing up and entering the facility without notifying the staff.
-The fence was installed so outside agencies, families and guardians would have to check in with staff prior to entering.
-The staff and the Administrator had keys to unlock all the gates.
-The gates were locked and unlocked sporadically.

Interview with the Administrator on 06/10/25 at 9:18am, on 06/12/25 at 10:00am and 06/16/25 at 12:34pm revealed:
-The fence was installed in late August 2024 or early September 2024.
-The fence was installed to keep unwanted visitors ("drugheads") out.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 338	Continued From page 46	D 338		

-The fence was installed because outside agencies and visitors would not sign in or notify the staff they were in the facility.
-The gate was mostly unlocked from 9:00am to 5:00pm.
-She told the staff to not allow any visitors inside of the fence unless they visitors gave them information as to why they were at the facility.
-When the residents were admitted she submitted the required paperwork that notified TCL the resident was at her facility.
-When TCL was notified, a TCL In-Reach Specialist was to visit the residents to begin the process to see if the resident qualified for independent living.
-The guardians gave their permission for the TCL In-Reach Specialist to visit their resident with the exception of Resident #6 because he was new.
-She refused the TCL In-Reach Specialist access because it was a way to prevent the residents from acting out and leaving the staff to take care of their behavior.
-About 5 years ago, the TCL In-Reach Specialists came into the facility, would not check in and would just go and speak to the residents.
-The TCL In-Reach Specialists were not there to just talk to the residents they came to see but to all residents and promised things they could not do, and the other residents became upset and acted out.
-About the end of August 2024, she had the chain-link fence put up and locked all gates with a pad-lock to keep unwanted visitors out of the facility and placed her cell phone number on the banner for all outside agencies to call to gain access to the facility to stop TCL In-Reach Specialists from just entering the facility and not signing in and just talking to everyone.
-They were her residents, and she knew better and to protect her residents, all outside agencies

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 338	Continued From page 47	D 338		

were to make an appointment to see the residents.
-She did not remember the rules and regulations related to having reasonable visiting hours available for at least 10 hours each day.
-She thought her visitation hours were, "a good time period."
-She did not know the rules and regulations related to resident phone use.
-She had created the contract around five years ago due to residents wanting to make phone calls constantly.
-She did not allow residents to have cell phones due to issues with a previous resident sending inappropriate pictures.
-The facility did not have any outings in May 2025 or June 2025 due to a staff member being out on leave and another staff member filling in for her.
-There haven't been any church services and no one from the community had been coming to complete activities with residents since December 2024 because of COVID in January 2025 which put everything off track and a staff member having to be out of work over the past two months.

[Refer to tag 0072, 10A NCAC 13F .0305(m)(2) Physical Environment (Type A2 Violation)].

[Refer to tag 0324, 10A NCAC 13F .0906(d) Other Resident Care And Services].

The facility failed to provide access to 10 of 10 residents by keeping the chain-linked fence padlocked at all times, residents were being confined to the property without reason, and restricting visitors and outside agencies from performing care and services requiring all visitors to call a number to gain access to the facility at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023041	A. BUILDING: _____ B. WING _____	C 06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS REST HOME	630 SUGAR HILL ROAD LAWNDALE, NC 28090

(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 338	Continued From page 48 the Administrator's discretion. The residents were not allowed to freely enter and exit the facility, restricted to only 8 hours of visitation a day, the right to the facility phone was restricted to only two, 15-minute phone calls a day, the freedom to participate and the opportunity for community bible study, and the right to communicate privately during MH provider and TCL In-Reach Specialist's visits resulting the facility staff controlling the resident's rights. This failure resulted in serious neglect and abuse which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/16/25 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JULY 16, 2024.	D 338		