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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section and Cabarrus County Department of Social Services conducted an annual, follow-up survey and complaint investigation from July 23, 2025 through July 25, 2025 and July 28, 2025 through July 30, 2025.<br><br>The complaint investigation was initiated by the Cabarrus County Department of Social Services on June 16, 2025. | D 000 | | |
| D 194 | 10A NCAC 13F .0608 (a)(b) Staffing for Facilities With A Census Of 21<br><br>10A NCAC 13F .0608 Staffing for Facilities With A Census Of 21 Or More Residents<br><br>(a) Each facility with a census of 21 or more residents shall have staff on duty to meet the needs of the residents.<br>(b) In addition to the requirement in Paragraph (a) of this Rule, each facility with a census of 21 or more residents shall comply with the following staffing requirements:<br>(1) On first shift and second shift, the total aide duty hours shall be at least:<br>(A) 16 hours of aide duty for facilities with a census of 21 to 40 residents.<br>(B) 20 hours of aide duty for facilities with a census of 41 to 50 residents.<br>(C) 24 hours of aide duty for facilities with a census of 51 to 60 residents.<br>(D) 28 hours of aide duty for facilities with a census of 61 to 70 residents.<br>(E) 32 hours of aide duty for facilities with a census of 71 to 80 residents.<br>(F) 36 hours of aide duty for facilities with a census of 81 to 90 residents.<br>(G) 40 hours of aide duty for facilities with a census of 91 to 100 residents. | D 194 | | |

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| D 194 | Continued From page 1<br>(H) 44 hours of aide duty for facilities with a census of 101 to 110 residents.<br>(I) 48 hours of aide duty for facilities with a census of 111 to 120 residents.<br>(J) 52 hours of aide duty for facilities with a census of 121 to 130 residents.<br>(K) 56 hours of aide duty for facilities with a census of 131 to 140 residents.<br>(L) 60 hours of aide duty for facilities with a census of 141 to 150 residents.<br>(M) 64 hours of aide duty for facilities with a census of 151 to 160 residents.<br>(N) 68 hours of aide duty for facilities with a census of 161 to 170 residents.<br>(O) 72 hours of aide duty for facilities with a census of 171 to 180 residents.<br>(P) 76 hours of aide duty for facilities with a census of 181 to 190 residents.<br>(Q) 80 hours of aide duty for facilities with a census of 191 to 200 residents.<br>(R) 84 hours of aide duty for facilities with a census of 201 to 210 residents.<br>(S) 88 hours of aide duty for facilities with a census of 211 to 220 residents.<br>(T) 92 hours of aide duty for facilities with a census of 221 to 230 residents.<br>(U) 96 hours of aide duty for facilities with a census of 231 to 240 residents.<br>(2) On third shift, the total aide duty hours shall be at least:<br>(A) 8 hours of aide duty for facilities with a census of 21 to 30 residents.<br>(B) 16 hours of aide duty for facilities with a census of 31 to 60 residents.<br>(C) 24 hours of aide duty for facilities with a census of 61 to 90 residents.<br>(D) 32 hours of aide duty for facilities with a census of 91 to 120 residents.<br>(E) 40 hours of aide duty for facilities with a | D 194 | | |

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| D 194 | Continued From page 2<br>census of 121 to 150 residents.<br>(F) 48 hours of aide duty for facilities with a census of 151 to 180 residents.<br>(G) 56 hours of aide duty for facilities with a census of 181 to 210 residents.<br>(H) 64 hours of aide duty for facilities with a census of 211 to 240 residents.<br>(3) If the Department determines the needs of the residents at a facility are not being met by staffing requirements of Paragraph (b) of this Rule, the Department shall require the facility to employ staff to meet the needs of the residents.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to ensure required staffing hours were met on first and second shifts based on a census of 25 to 28 residents for 5 out of 42 shifts.<br><br>The findings are:<br><br>Review of the facility's current license by the Division of Health Service Regulation effective 01/01/25 revealed the facility was a licensed with a capacity of 34 Assisted Living residents.<br><br>Review of the facility's census from 06/03/25 to 06/16/25 revealed there was a census of 25 to 28 residents which required 16 staff hours on first | D 194 | | |

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| D 194 | Continued From page 3<br>and second shifts.<br><br>Review of the staff time records from 06/03/25 to 06/16/25 revealed:<br>-On 06/03/25, the census was 25, requiring 16 hours on second shift and a total of 15 hours were provided leaving a shortage of 1 staff hour.<br>-On 06/08/25, the census was 27, requiring 16 staff hours on second shift and a total of 7 hours were provided leaving a shortage of 9 staff hours.<br>-On 06/09/25, the census was 28, requiring 16 staff hours on second shift and a total of 13.75 hours were provided leaving a shortage of 2.25 staff hours.<br>-On 06/13/25, the census was 27, requiring 16 staff hours on first shift and a total of 10 hours were provided leaving a shortage of 6 staff hours.<br>-On 06/13/25, the census was 27, requiring 16 staff hours on second shift and a total of 15 hours were provided leaving a shortage of 1 staff hour.<br><br>Interview with a MA on 07/23/25 at 2:00pm revealed:<br>-She felt there were often problems with not enough staffing for a shift.<br>-She felt that more falls occured on shifts with less staff.<br>-She felt that staff did not always know who "called out" and did not work.<br>-Staff were to notify the RCC when they were not able to come in and work and the SCC was responsible to find other staff to work.<br><br>Interview with the Administrator on 07/29/25 at 2:33pm revealed:<br>-The Resident Care Coordinator (RCC) was responsible for completing the schedule and ensuring coverage for the unit.<br>-Call outs are to be made to the RCC.<br>-The RCC was responsible for finding coverage | D 194 | | |

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| D 194 | Continued From page 4<br>and/or coming in to ensure there is proper staffing on the unit.<br>-The medication aide (MA) supervisors were able to make changes to the schedule to move staff around to ensure coverage for the shift.<br>-Any changes the MA supervisors made to the schedule were reported to the RCC.<br>-The RCC was responsible for updating the staffing schedule and providing the Administrator with a copy. | D 194 | | |
| D 235 | 10A NCAC 13F .0703 (b & c) Tuberculosis Test, Medical Exam & Immunizatio<br><br>10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations<br>(b) Each resident shall have a medical examination completed by a licensed physician or physician extender prior to admission to the facility and annually thereafter. For the purposes of this Rule, "physician extender" means a licensed physician assistant or licensed nurse practitioner. The medical examination completed prior to admission shall be used by the facility to determine if the facility can meet the needs of the resident.<br>(c) The medical examination shall be completed no more than 90 days prior to the resident's admission to the facility, except in the case of emergency admission. | D 235 | | |

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This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure 2 of 5 sampled residents (#3 and #7) had a current FL2 completed annually.

The findings are:

1. Review of Resident #3's current FL2 dated 04/29/24 revealed:
-Diagnoses included Parkinson's disease.
-There was no level of orientation documented.
-She was semi-ambulatory.
-Her level of care was assisted living.

Review of Resident #3's record revealed there was no updated FL2 provided by exit on 07/29/25.

Interview with the Administrator on 07/29/25 at 2:35pm revealed Resident #3's new FL2 was missed due to a change in management.

Refer to interview with the Resident Care Coordinator (RCC) on 07/29/25 at 2:35pm.

Refer to interview with the Administrator on 07/29/25 at 2:35pm.
2. Review of Resident #7's current FL-2 dated 02/15/24 revealed:
- Diagnoses included dementia without behavioral disturbances, irritability/agitation/depression, hyperlipidemia, hypothyroidism, osteoporosis, rheumatoid arthritis and aortic valve disorder.
- She was ambulatory and constantly disoriented.

Review or Resident #7's Resident Register revealed she was admitted to the facility on 02/15/24.

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| D 235 | Continued From page 6<br><br>Refer to interview with the Resident Care Coordinator (RCC) on 07/29/25 at 2:35pm.<br><br>Refer to interview with the Administrator on 07/29/25 at 2:35pm.<br><br>_____<br>Interview with the RCC on 07/29/25 at 10:38am revealed she did not know she was responsible for getting appointments for residents to get the annual medical examination and ensuring the FL2 was completed by their Primary Care Provider (PCP).<br><br>Interview with the Administrator on 07/29/25 at 2:35pm revealed:<br>-The residents were to have FL2s completed prior to admission, with a change/hospitalization and annually.<br>-The RCC was responsible for ensuring resident FL2s were completed by their PCP on their next visit or fax the FL2 to any outside providers for a signature.<br>-There was no process to make sure the FL2s were complete. | D 235 | | |
| D 259 | 10A NCAC 13F .0802 (a) (c) Resident Care Plan<br><br>10A NCAC 13F .0802 Resident Care Plan<br><br>(a) The facility shall develop and implement a care plan for each resident based on the resident's assessment completed in accordance with Rule .0801 of this Section. The care plan shall be resident-centered and include the resident's preferences related to the provision of care and services. A copy of each resident's current care plan shall be maintained in a location in the facility where it can be accessed by facility staff who are responsible for the implementation | D 259 | | |

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| D 259 | Continued From page 7<br>of the care plan.<br>(c) The care plan shall include the following:<br>(1) a description of services, supervision, tasks, and level of assistance to be provided to address the resident's needs identified in the resident's assessment in Rule .0801 of this Section;<br>(2) frequency of the services or tasks to be performed;<br>(3) revisions of tasks and frequency based on reassessments in accordance with Rule .0801 of this Section;<br>(4) licensed health professional tasks required according to Rule .0903 of this Subchapter;<br>(5) a dated signature of the assessor upon completion; and<br>(6) a dated signature of the resident's physician or physician extender as defined in Rule .0102 of this Subchapter within 15 days of completion of the care plan certifying the resident is under this physician's care and has a medical diagnosis with associated physical or mental limitations warranting the provision of the personal care services in the above care plan in accordance with G.S. 131D-2.15. This shall not apply to residents assessed through the Medicaid State Plan Personal Care Services Assessment for the portion of the assessment covering tasks needed for each activity of daily living of this Rule for which care planning and signing are directed by Medicaid.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on interviews, observations and record reviews, the facility failed to develop and | D 259 | | |

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implement resident-centered care plans that were accurate (#2, #5, #8 and #11) and signed by the Primary Care Provider (PCP) upon completion (#6) for 5 of 9 sampled residents.

The findings are:

1. Review of Resident #11's current FL2 dated 05/15/25 revealed:
-Diagnoses included dementia, type II diabetes, Stage 3 kidney disease and hypertension (high blood pressure).
-She was ambulatory.
-There was no documentation of orientation.
-Her level of care was Special Care Unit (SCU).

Review of Resident #11's Resident Register revealed an admission date of 04/08/25.

Review of the SCU disclosure form revealed Resident #11 was admitted to the SCU on 05/07/25.

Review of Resident #11's Care Plan dated 04/10/25 revealed:
-She wandered and was sometimes disoriented.
-She was forgetful and needed reminders.
-She was ambulatory with a walker or rollator.
-She required limited assistance with eating, ambulation/locomotion, bathing, dressing, grooming/personal hygiene and was independent with toileting and transferring.
-There was no description of supervision needed or frequency.
-The Care Plan was not signed by Resident #11's Primary Care Physician (PCP) or physician extender.

Review of Resident #11's record revealed no SCU Resident Profile and Care Plan or Care Plan

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had been completed when Resident #11 was diagnosed with dementia and was moved to the SCU.

Review of Resident #11's Accident/Incident Report dated 07/27/25 at 3:26pm revealed she was sent to the hospital due to an unwitnessed fall where she was observed lying on the ground in the courtyard.

Review of Resident# 11's Emergency Medical Services (EMS) encounter document dated 07/27/25 revealed:
-Primary impression was heat exhaustion; secondary impression was altered mental status.
-Resident #11 exhibited signs and symptoms of heat exhaustion (primary) altered mental status and tachycardia (a heartbeat greater than 100 beats per minute).
-Resident #11 had an abrasion left of the thoracic spine (the middle section of the spine) and the skin around the knees was reddened, "likely from contact with the ground."
-Within 20 minutes Resident #11 was "more responsive, able to answer some questions for EMS but confused about what was going on."
-Resident #11 was transported to a nearby Emergency Department (ED).

Interview with the Administrator on 07/29/25 at 2:35pm revealed:
-Care managers, including the RCC and SCC and sometimes the Clinical Nurse Coordinator were responsible for updating care plans.
-The Administrator and RCC or SCC would meet with families to discuss any changes, and the care plan should be updated after that meeting.
-She assisted with care plans as needed.
-She did not have a signed Care Plan for Resident #11.

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| D 259 | Continued From page 10<br>-She was aware no SCU resident care plan and profiles had been completed for Resident #11 since her move to SCU on 05/07/25.<br>-She knew the physician was required to sign the care plan.<br><br>Refer to the interview with the personal care aide (PCA) on 07/30/25 at 2:22pm.<br><br>Refer to interview with the Resident Care Coordinator (RCC) on 07/25/25 at 10:38am.<br><br>Based on observations, interviews and record reviews it was determined Resident #11 was not interviewable.<br><br>2. Review of Resident #2's current FL2 dated 08/08/24 revealed:<br>-Diagnoses included dementia, altered mental status and unspecified behavioral involuntary movements.<br>-She was ambulatory.<br>-She was constantly disoriented.<br>-Her level of care was SCU.<br><br>Review of Resident #2's Resident Register revealed she was admitted to the facility on 08/08/22.<br><br>Review of Resident #2's care plan dated 07/31/24 revealed:<br>-She was ambulatory without a device.<br>-She was always disoriented and resisted care.<br>-She had a significant loss of memory and must be directed.<br>-She required limited assistance with eating and extensive assistance with toileting, ambulation, bathing, dressing, grooming/personal hygiene and transferring. | D 259 | | |

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Review of Resident #2's SCU resident profile and care plan dated 05/10/25 revealed:
-Resident #2 was independent without devices for ambulation/mobility.
-She needed extensive assistance for transferring.

a. Review of Resident #2's Accident/Incident report dated 06/10/25 at 7:20am revealed:
-She was sent to the ED due to an unwitnessed fall where she was found on the floor of her bathroom.
-She was alert and oriented.
-She complained of right hip pain.
-The falls prevention program was documented as initiated.
-There was an entry "Care plan updated" with documentation of a response of "no."
-It was created by a MA and completed by the Administrator.

Review of Resident #2's EMS encounter note dated 06/10/25 revealed:
-Resident #2 had right hip deformity and pain.
-She had altered mental status and dementia.

Review of Resident #2's ED visit note dated 06/10/25 revealed:
-X-rays of the pelvis, right hip and femur were negative for acute fracture or dislocation and a CT of cervical-spin was negative for acute traumatic injury/fracture.
-Resident #2 returned to the facility.

Review of Resident #2's staff charting notes dated 06/10/25 revealed the SCC documented a late note on 06/26/25 for a "follow-up from fall" for Resident #2 and no changes were noted.

Review of Resident #2's record revealed:

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-Her current care plan was dated 07/31/24.
-There was no revised care plan completed 06/10/25 with a description of her supervision needs and frequency of services and tasks to be performed.

b. Review of Resident #2's Accident/Incident Report dated 06/12/25 at 10:29am revealed:
-She was sent to the ED due to an unwitnessed fall where she was found on the floor of her room.
-Falls prevention program was documented as initiated.
-There was an entry "Care plan updated" with documentation of a response of "no."

Review of Resident #2's EMS encounter notes dated 06/12/25 revealed:
-Resident #2's mental status was normal baseline for the resident.
-She had no outward injuries and showed no signs of pain during palpation.
-She was assisted up and began to stand and move with little assistance.

Review of Resident #2's ED visit note dated 06/12/25 at 11:08am revealed:
-Resident #2 was not in acute distress.
-She had no fractures or injuries noted after evaluation
-She was ambulatory to her baseline.
-She was discharged back to the facility.

Review of Resident #2's staff charting note dated 06/12/25 revealed:
-Resident #2's PCP documented an acute visit for fall follow-up for Resident #2 at 6:59am.
-Staff reported to her that Resident #2 had two falls "this week" on 06/10/25 and 06/12/25.
-Staff reported they noticed a general decline in the resident over the past week.

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| THE DRAKE | 1195 DRAKE MILL LANE SW CONCORD, NC 28025 |

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| D 259 | Continued From page 13<br><br>Review of Resident #2's record revealed:<br>-Her current care plan was dated 07/31/24.<br>-There was no revised care plan completed 06/12/25 with a description of her supervision needs and frequency of services and tasks to be performed.<br><br>c. Review of Resident #2's Accident/Incident Report dated 07/05/25 at 6:33am revealed:<br>-She was sent to the ED due to an unwitnessed fall where she was found lying on her back in a hallway.<br>-She was alert and oriented.<br>-The falls prevention program was documented as initiated.<br>-There was an entry "Care plan updated" with documentation of a response of "no."<br>-It was created by a MA and completed by the Administrator.<br><br>Review of the staff charting notes dated 07/05/25 at 4:48pm revealed the SCC documented that Resident #2 was sent to the hospital at 6:45 pm by EMS for a fall.<br><br>Review of the EMS encounter notes dated 07/05/25 revealed:<br>-Resident #2's neurological status was normal baseline for the resident.<br>-Resident #2 did not have altered mental status.<br>-Resident #2 had no deformities or bleeding.<br><br>Review of Resident #2's ED notes dated 07/05/25 revealed:<br>-She presented post unwitnessed fall with a traumatic subdural hemorrhage (bleeding between the outer covering of the brain and the brain itself) without loss of consciousness and a small right scalp hematoma (local collection of | D 259 | | |

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blood outside the blood vessels similar to a bruise).
-She was likely not able to participate in physical and occupational therapy due to her dementia but an evaluation also including speech therapy and a dietician would be ordered.
-A hospital discharge of 07/09/25 was anticipated.

Review of Resident #2's record revealed:
-Her current care plan was dated 07/31/24.
-There was no revised care plan completed 07/05/25 with a description of her supervision needs and frequency of services and tasks to be performed.

Refer to interview with the RCC on 07/29/25 at 10:38am.

Refer to interview with the Administrator on 07/29/25 at 2:35pm

Based on observations, interviews and record reviews it was determined Resident #2 was not interviewable.

3. Review of Resident #5's current FL2 dated 01/25/25 revealed:
-Diagnoses included essential hypertension, hypothyroidism and hypercholesterolemia.
-He was intermittently disoriented.
-He was semi-ambulatory.
-His recommended level of care was assisted living (AL).

Review of Resident #5's Resident Register revealed an admission date of 01/02/23.

Review of Resident #5's record on 07/24/25 revealed:
-He was admitted under Hospice services on

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| D 259 | Continued From page 15<br>03/18/25.<br>-His Hospice admitting diagnosis was senile dementia.<br><br>Review of Resident #5's Care Plan dated 01/16/25 revealed:<br>-He was ambulatory with aide or devices with a walker and wheelchair listed.<br>-He was sometimes disorientated.<br>-He was forgetful and needed reminders.<br>-He required limited assistance with eating, toileting, dressing, grooming and transfers.<br>-He required extensive assistance with bathing.<br><br>a. Review of Resident #5's Accident and Incident report dated 05/09/25 revealed:<br>-The Accident and Incident report was created by a MA on 05/09/25 at 9:49am and completed by the Administrator on 05/28/25 at 1:14pm.<br>-At 9:50am he was sent to ED due to an unwitnessed fall where he was observed laying on his back, beside his bed.<br>-There was documentation the falls prevention program was checked as initiated.<br>-There was an entry "care plan updated" with documentation of a response of "no".<br><br>Review of Resident #5's ED visit note dated 05/09/25 revealed:<br>-He was sent to the hospital due to an unwitnessed fall where he was found on the floor.<br>-He was evaluated and discharged back to the facility.<br><br>Review of Resident #5's staff charting note dated 05/09/25 revealed he was sent to the local emergency department due to a fall.<br><br>Review of Resident #5's record on 07/24/25 revealed: | D 259 | | |

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| D 259 | Continued From page 16<br>-His current care plan was dated 01/16/25.<br>-There was no revised care plan completed 05/09/25 with a description of his supervision needs and frequency of services and tasks to be performed.<br><br>b. Review of Resident #5's staff charting note dated 05/17/25 at 2:00pm revealed the Hospice Nurse was notified the resident fell.<br><br>Review of Resident #5's Hospice charting note dated 05/17/25 revealed resident had lost his balance while in the bathroom and fell on the floor.<br><br>Review of Resident #5's record revealed there was no documentation of a completed accident and incident report dated 05/17/25.<br><br>Review of Resident #5's record on 07/24/25 revealed:<br>-His current care plan was dated 01/16/25.<br>-There was no revised care plan completed 05/17/25 with a description of his supervision needs and frequency of services and tasks to be performed.<br><br>c. Review of Resident #5's Accident and Incident report dated 05/21/25 revealed:<br>-The Accident and Incident report was created by a MA on 05/21/25 at 10:14am and completed by the Administrator on 05/29/25 at 5:07pm.<br>-At 10:05pm he was sent to the hospital due to aggression towards staff.<br>-He was punching and kicking staff members.<br>-There was an entry "care plan updated" with documentation of a response of "not applicable".<br><br>Review of Resident #5's staff charting note dated 05/21/25 revealed at 10:51pm the facility notified | D 259 | | |

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resident's family member about resident eloping from the facility, punching and kicking staff.

Review of Resident #5's Hospice charting note dated 05/22/25 revealed:
-On 5/21/25 Resident #5 suddenly became very agitated, anxious and aggressive with staff.
-He started punching and kicking several staff and attempted to fight staff, trying to escape from the facility.

Review or Resident #5's ED visit note dated 05/21/25 revealed:
-He was sent to the hospital for altered mental status and throwing things at the staff.
-He was evaluated and discharged back to the facility.

Review of Resident #5's record on 07/24/25 revealed:
-His current care plan was dated 01/16/25.
-There was no revised care plan completed 05/21/25 with a description of his supervision needs and frequency of services and tasks to be performed.

d. Review of Resident #5's Accident and Incident report dated 05/26/25 revealed:
-The Accident and Incident report was created by a MA on 05/26/25 at 3:28pm and completed by the Administrator on 05/28/25 at 6:10pm.
-At 2:30pm he was observed, hitting staff members with his walker and had tried to hit another resident.
-There was an entry "was the resident sent to the ED" with documentation of a response of "no".
-Under the additional follow up section, complete behavior care plan and notify provider was indicated.
-There was documentation of follow up initiated

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with Hospice Provider.
-There was an entry "care plan updated" with documentation of a response of "no".

Review or Resident #5's ED visit note dated 05/26/25 revealed:
-At 3:51pm he was sent to the hospital due to aggressive behavior with a history of dementia.
-He became aggressive with staff when they prevented him from walking out of the facility.
-He was evaluated and discharged back to the facility.

Review of Resident #5's staff charting note dated 05/26/25 at 3:38pm revealed he was sent to the local ED due to a change in condition and behavior.

Review of Resident #5's Hospice charting note dated 05/26/25 revealed resident was agitated after arrival back to the facility from the ED where he had tried to hit another resident and hit a staff member.

Review of Resident #5's record on 07/24/25 revealed:
-His current care plan was dated 01/16/25.
-There was no revised care plan completed 05/26/25 with a description of his supervision needs and frequency of services and tasks to be performed.

e. Review of Resident #5's staff charting note dated 05/31/25 revealed at 2:47pm the Hospice Nurse came to evaluate the resident after two falls with no injuries, and the resident had two red marks on his back, with no complaint of pain.

Review of Resident #5's Hospice charting note dated 05/31/25 revealed:

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| D 259 | Continued From page 19<br>-The Hospice Nurse made a visit regarding residents unwitnessed fall per facility staff.<br>-He had two reddened areas on his back.<br><br>Review of Resident #5's record on 07/24/25 revealed:<br>-His current care plan was dated 01/16/25.<br>-There was no revised care plan completed 05/31/25 with a description of his supervision needs and frequency of services and tasks to be performed.<br><br>f. Review of Resident #5's Accident and Incident report dated 06/09/25 revealed:<br>-The Accident and Incident report was created by a MA on 06/09/25 at 3:15pm and completed by the Administrator on 06/16/25 at 11:13am.<br>-At 2:30pm, he was observed lying on the floor after an unwitnessed fall without injury.<br>-The falls prevention program was checked as initiated.<br>-There was an entry "care plan updated" with documentation of a response of "no".<br><br>Review of Resident #5's staff charting note dated 06/09/25 revealed at 3:15pm, Hospice was notified of resident's fall.<br><br>Review of Resident #5's Hospice charting note dated 06/09/25 revealed the Hospice Nurse was notified by staff upon their arrival at the facility, of resident's fall with no injuries.<br><br>Review of Resident #5's record on 07/24/25 revealed:<br>-His current care plan was dated 01/16/25.<br>-There was no revised care plan completed 06/09/25 with a description of his supervision needs and frequency of services and tasks to be performed. | D 259 | | |

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| D 259 | Continued From page 20<br><br>g. Review of Resident #5's Accident and Incident report dated 06/26/25 revealed:<br>-The Accident and Incident report was created by a MA on 06/26/25 at 9:55am and completed by the Administrator on 07/02/25 at 10:44pm.<br>-At 9:30am he was observed sitting on the floor after an unwitnessed fall without injury.<br>-The falls prevention program was checked as initiated.<br>-There was an entry "care plan updated" with documentation of a response of "no".<br><br>Review of Resident #5's staff charting note dated 06/26/25 at 2:35pm revealed Hospice Nurse was notified of residents fall and being found on the floor.<br><br>Review of Resident #5's record on 07/24/25 revealed:<br>-His current care plan was dated 01/16/25.<br>-There was no revised care plan completed 06/26/25 with a description of his supervision needs and frequency of services and tasks to be performed.<br><br>h. Review of Resident #5's Accident and Incident report dated 06/28/25 revealed:<br>-The Accident and Incident report was created by a MA on 06/28/25 at 3:57pm and completed by the Administrator on 07/02/25 at 10:50pm.<br>-At 3:20pm, he was observed lying on the ground, on his back in the courtyard after an unwitnessed fall without injury.<br>-The falls prevention program was checked as initiated.<br>-There was an entry "care plan updated" with documentation of a response of "no".<br><br>Review of Resident #5's staff charting note dated | D 259 | | |

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| D 259 | Continued From page 21<br>06/28/25 revealed at 3:20pm resident had been found on floor.<br><br>Review of Resident #5's Hospice charting note dated 06/28/25 revealed a staff member called to inform them the resident had a fall without injury, the fall occurred in the courtyard, and it was unwitnessed.<br><br>Review of Resident #5's record on 07/24/25 revealed:<br>-His current care plan was dated 01/16/25.<br>-There was no revised care plan completed 06/28/25 with a description of his supervision needs and frequency of services and tasks to be performed.<br><br>i. Review of Resident #5's Accident and Incident report dated 07/05/25 revealed:<br>-The Accident and Incident report was created by a MA on 07/05/25 at 3:28pm and completed by the Administrator on 07/07/25 at 9:07pm.<br>-At 3:00pm he was observed sitting behind his wheelchair, on the floor, in the dining room after an unwitnessed fall, without injury.<br>-The falls prevention program was checked as initiated.<br>-There was an entry "care plan updated" with documentation of a response of "no".<br><br>Review of Resident #5's staff charting note dated 07/05/25 revealed at 3:00pm the Hospice Nurse was notified the resident had a fall.<br><br>Review of Resident #5's Hospice charting note dated 07/05/25 revealed:<br>-Staff reported resident was sitting in the dining room in his wheelchair when he became restless and made several attempts to get up and "go home". | D 259 | | |

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| D 259 | Continued From page 22<br>-He fell out of his wheelchair onto his bottom.<br><br>Review of Resident #5's record on 07/24/25 revealed:<br>-His current care plan was dated 01/16/25.<br>-There was no revised care plan completed 07/05/25 with a description of his supervision needs and frequency of services and tasks to be performed.<br><br>j. Review of Resident #5's Accident and Incident report dated 07/06/25 revealed:<br>-The Accident and Incident report was created by a MA on 07/06/25 at 11:34am and completed by the Administrator on 07/07/25 at 9:10pm.<br>-At 11:30pm he was observed on his knees in front of his wheelchair after an unwitnessed fall in the dining room.<br>-The falls prevention program was checked as initiated.<br>-There was an entry "care plan updated" with documentation of a response of "no".<br><br>Review of Resident #5's staff charting note dated 07/06/25 revealed at 11:31am Hospice Nurse was notified of residents fall.<br><br>Review of Resident #5's Hospice charting note dated 07/06/25 revealed:<br>-He was attempting to get out of his wheelchair.<br>-Due to his poor safety awareness and impulse control, he was difficult to redirect.<br>-He fell onto his hands and knees next to his wheelchair.<br><br>Review of Resident #5's record on 07/24/25 revealed:<br>-His current care plan was dated 01/16/25.<br>-There was no revised care plan completed 07/06/25 with a description of his supervision | D 259 | | |

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needs and frequency of services and tasks to be performed.

k. Review of Resident #5's Accident and Incident report dated 07/10/25 revealed:
-The Accident and Incident report was created by a MA on 07/10/25 at 7:13pm and completed by the Administrator on 07/14/25 at 12:27pm.
-At 6:30pm he was observed laying on the floor mat in his room after an unwitnessed fall without injury.
-The falls prevention program was checked as initiated.
-There was an entry "care plan updated" with documentation of a response of "no".

Review of Resident #5's staff charting note dated 07/10/25 revealed at 6:30pm the Hospice Nurse was notified that resident was found on floor.

Review of Resident #5's Hospice charting note dated 07/10/25 revealed:
-He had an unwitnessed fall in his room.
-Staff reported he was found on the floor on his back beside the bed.

Review of Resident #5's record on 07/24/25 revealed:
-His current care plan was dated 01/16/25.
-There was no revised care plan completed 07/10/25 with a description of his supervision needs and frequency of services and tasks to be performed.

l. Review of Resident #5's Accident and Incident report dated 07/11/25 revealed:
-The Accident and Incident report was created by a MA on 07/11/25 at 10:07pm and closed by the Administrator on 07/14/25 at 12:45pm.
-At 6:00pm he was observed sitting on the floor in

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his room after an unwitnessed fall without injury.
-The falls prevention program was checked as initiated.
-There was an entry "care plan updated" with documentation of a response of "no".

Review of Resident #5's staff charting note dated 07/11/25 revealed at 6:05pm revealed the Hospice Nurse was notified that resident was found on floor.

Review of Resident #5's Hospice charting note dated 07/11/25 revealed staff reported they were making rounds when they found the resident sitting on the floor mat next to the bed.

Review of Resident #5's record on 07/24/25 revealed:
-His current care plan was dated 01/16/25.
-There was no revised care plan completed 07/11/25 with a description of his supervision needs and frequency of services and tasks to be performed.

m. Review of Resident #5's Accident and Incident report dated 07/13/25 revealed:
-The Accident and Incident report was created by a MA on 07/13/25 at 2:41pm and completed by the Resident Care Coordinator (RCC) on 07/13/25 at 1:30pm.
-At 1:30pm he was observed sitting on the dining floor after an unwitnessed fall and observed in model room after an unwitnessed fall.
-The falls prevention program was checked as initiated.
-There was an entry "care plan updated" with documentation of a response of "no".

Review of Resident #5's staff charting note dated 07/13/25 revealed at 2:00pm the Hospice Nurse

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| THE DRAKE | 1195 DRAKE MILL LANE SW CONCORD, NC 28025 |

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was notified the resident fell.

Review of Resident #5's Hospice charting note dated 07/13/25 revealed:
-The Hospice Nurse made a visit to assess resident post fall.
-Staff reported the resident fell on two different occasions one time out of bed and another time out of his wheelchair.
-He became agitated after the second fall where he was yelling and cussing at staff.

Review of Resident #5's record on 07/24/25 revealed:
-His current care plan was dated 01/16/25.
-There was no revised care plan completed 07/13/25 with a description of his supervision needs and frequency of services and tasks to be performed.

n. Review of Resident #5's Accident and Incident report dated 07/16/25 revealed:
-The Accident and Incident report was created by a MA on 07/16/25 at 3:48pm and completed by the facility Nurse on 07/23/25 at 11:31am.
-At 2:40pm he was observed sitting on the floor beside his wheelchair after an unwitnessed fall.
-The falls prevention program was checked as initiated.
-There was an entry "care plan updated" with documentation of a response of "no".

Review of Resident #5's staff charting note dated 07/16/25 revealed at 2:40pm the Hospice Nurse was notified the resident fell.

Review of Resident #5's Hospice charting note dated 07/16/25 revealed staff reported resident had fallen in his bathroom while trying to use the bathroom by himself.

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| D 259 | Continued From page 26<br><br>Review of Resident #5's record on 07/24/25 revealed:<br>-His current care plan was dated 01/16/25.<br>-There was no revised care plan completed 07/16/25 with a description of his supervision needs and frequency of services and tasks to be performed.<br><br>o. Review of Resident #5's Accident and Incident report dated 07/25/25 at 11:23am revealed:<br>-The Accident and Incident report was created by the Administrator on 07/25/25 at 12:01pm and completed on 07/25/25 at 12:47pm.<br>-He had a fall with injury.<br>-He was observed sitting on the table outside in the courtyard.<br>-The falls prevention program was checked as initiated.<br>-There was an entry "care plan updated" with documentation of a response of "no".<br><br>Review of Resident #5's record on 07/24/25 revealed:<br>-His current care plan was dated 01/16/25.<br>-There was no revised care plan completed 07/16/25 with a description of his supervision needs and frequency of services and tasks to be performed.<br><br>Interview with a PCA on 07/25/25 at 12:40 pm revealed:<br>-Resident #5 had multiple falls.<br>-Resident #5 was mostly in his wheelchair now but had been able to use a walker.<br>-Resident #5 required assistance with toileting, bathing, and dressing.<br>-Resident #5 got agitated at times.<br><br>Interview with a MA on 07/29/25 at 9:58am | D 259 | | |

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revealed:
-She did not know where residents' care plans were located.
-After Resident #5 multiple falls and behaviors, 72-hour monitoring was initiated/entered into the facilities documentation system where the MAs were required to document once every shift.
-There was no access to residents' care plans in the facilities documentation system that she could find.

Refer to the interview with at PCA on 07/30/25 at 2:22pm.

Refer to the interview with the RCC on 07/29/25 at 10:38am.

Refer to interview with the Administrator on 07/29/25 at 2:35pm

Based on observations, interviews and record review it was determined Resident #5 was not interviewable.

Refer to the interview with the RCC on 07/29/25 at 10:38am.

Refer to interview with the Administrator on 07/29/25 at 2:35pm

Based on observations, interviews and record review it was determined Resident #5 was not interviewable.

4. Review of Resident 6's current FL2 dated 11/12/24 revealed:
-Diagnoses included Alzheimer's Disease, stage III chronic kidney disease coronary artery disease, and hypertension.
-She was semi-ambulatory.

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| D 259 | Continued From page 28<br>-She was intermittently disorientated.<br>-Her level of care was assisted living.<br><br>Review of Resident #6's Resident Register revealed an admission date of 09/18/23.<br><br>Review of Resident #6's admission Care Plan dated 11/12/24 revealed:<br>-She was ambulatory with the use of a walker.<br>-She was independent with toileting, bathing, dressing, grooming and transfers.<br>-The Care Plan was not signed by the PCP.<br><br>Refer to the interview with a PCA on 07/30/25 at 2:22pm.<br><br>Refer to the interview with the RCC on 07/29/25 at 10:38am.<br><br>Refer to interview with the Administrator on 07/29/25 at 2:35pm.<br><br>5. Review of Resident #8's current FL2 dated 09/12/24 revealed:<br>- Diagnoses included Alzheimer's disease, type II diabetes mellitus, generalized anxiety disorder and hypercholesterolemia (high blood cholesterol).<br>-She was semi-ambulatory and intermittently disoriented.<br><br>Review of Resident #8's Resident Register revealed an admission date of 10/09/23.<br><br>Review of Resident #8's Care Plan dated 10/09/24 revealed:<br>-She required limited assistance with eating, bathing, dressing and grooming and transfers.<br>-She required supervision with toileting and ambulation. | D 259 | | |

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| D 259 | Continued From page 29<br><br>Review of Resident #8's hospital discharge summary dated 06/05/25 revealed:<br>-She was admitted due to mood instability, crying spells and confusion.<br>-She was discharged back to the facility on 06/05/25.<br>-She was referred to Hospice.<br><br>Review of Resident #8's physician orders dated 06/06/25 revealed she was admitted under Hospice services with an admitting diagnosis of Alzheimer's disease.<br><br>Review of Resident #8's record on 07/25/25 revealed:<br>-The most recent care plan available for review was 10/09/25.<br>-There was no updated care plan available for review.<br><br>Refer to the interview with at PCA on 07/30/25 at 2:22pm.<br><br>Refer to the interview with the RCC on 07/29/25 at 10:38am.<br><br>Refer to interview with the Administrator on 07/29/25 at 2:35pm<br><br>_____<br>Interview with a second PCA on 07/30/25 at 2:22pm revealed:<br>-She did not know where residents' care plans were located.<br>-PCAs had access to the facility documentation system where there was a specified care plan tab, but there was no information listed under the tab.<br>-If she had any questions about the residents' needs, she would ask the MA. | D 259 | | |

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| D 259 | Continued From page 30<br><br>Interview with the RCC on 07/29/25 at 10:38am revealed:<br>-She and the provider were responsible for completing and updating resident care plans every six months or every year.<br>-She was "not familiar" with updating a resident's care plan after the resident had a significant change in their condition.<br>-She had not updated Resident #5's care plan after his multiple falls and behaviors.<br>-She had not completed or updated any resident care plans since becoming the RCC.<br><br>Interview with the Administrator on 07/29/25 at 2:35pm revealed:<br>-Care managers, including the RCC and SCC and sometimes the Clinical Nurse Coordinator were responsible for updating care plans.<br>-She assisted with care plans as needed.<br>-She knew the physician was required to sign the care plan.<br>-The Administrator and RCC or SCC would meet with families to discuss any changes, and the care plan should be updated after that meeting.<br>-The direct caregiving staff knew they were to notify the RCC/SCC and/or Administrator of any resident changes.<br><br>_____<br>The facility failed to ensure residents had care plans that were resident centered and included description of services to address their needs for supervision with the frequency of the tasks or services to be performed after resident #2, #5 had multiple falls with and without injuries, and #5 was admitted to Hospice care. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. This failure was detrimental to the health, safety and welfare of the residents and constitutes a | D 259 | | |

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| D 259 | Continued From page 31<br>Type B Violation.<br>_____<br>The facility provided a plan of protection in accordance with G.S. 131D-34 on July 30, 2025 for this violation.<br><br>THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 13, 2025. | D 259 | | |
| D 270 | 10A NCAC 13F .0901(b) Personal Care and Supervision<br><br>10A NCAC 13F .0901 Personal Care and Supervision<br>(b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.<br><br>This Rule is not met as evidenced by:<br>TYPE A1 VIOLATION<br><br>Based on observations, interviews and record reviews, the facility failed to provide supervision for 3 of 3 sampled residents who had multiple falls with and without injuries (#2 and #5) and a resident who had dementia who was left alone in the Special Care Unit (SCU) courtyard when the heat index outside was 107 degrees Fahrenheit (#11).<br><br>The findings are: | D 270 | | |

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| D 270 | Continued From page 32<br><br>Review of the facility's fall management policy dated September 2021 revealed:<br>-Management completes a Fall Risk Admission Evaluation on the day of admission or day of return from a hospital admission (not an ER/Emergency Room visit).<br>-When a fall/fall related accident/incident occurs, a Fall Related Accident/Incident Report will be completed by the Special Care Coordinator (SCC) or designee at which time the 72 Hour Fall Management Follow Up will be added into the electronic charting program.<br>-The resident's vital signs and observations for any changes are completed every shift by the medication aides post-fall and documented in the shift progress note.<br>-Within 24-48 hours of each fall a manager will complete the Post Fall Care Plan Evaluation for Interventions.<br>-The RCC or designee will add the "Fall Risk Banner" to the resident's Face Sheet in the electronic charting system.<br>-The RCC or designee will add the "Fall Risk Emblem" to the resident's door name plate.<br>-The RCC or designee will add intervention(s) to the orders in the electronic charting system.<br><br>1. Review of Resident #11's current FL2 dated 05/15/25 revealed:<br>-Diagnoses included dementia, type II diabetes, Stage 3 kidney disease and hypertension (high blood pressure).<br>-She was ambulatory.<br>-There was no documentation of orientation.<br>-Her level of care was Special Care Unit (SCU).<br><br>Review of Resident #11's Resident Register revealed an admission date of 04/08/25.<br><br>Review of Resident #11's record on 07/27/25 | D 270 | | |

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revealed:
-Resident #11's SCU admission date of 05/07/25 was documented on her SCU disclosure form.
-Resident #11 had a care plan dated 04/10/25 but was not signed by the assessor or by her Primary Care Physician (PCP).

Review of Resident #11's Accident/Incident Report dated 07/27/25 at 3:26pm revealed:
-Resident #11 had an unwitnessed fall.
-The location of the incident was outside on the grounds of the facility at 2:40pm.
-She was observed lying on the ground near the mulch in the courtyard.
-She did not exhibit or complain of a negative outcome related to the incident.
-She would arouse when her name was called.
-She was sent to the Emergency Department (ED) via Emergency Medical Services (EMS) at 3:40pm.
-Her PCP was notified by a secure messaging system at 2:42pm.
-Her Resident Representative was notified at 3:19pm.

Review of the EMS encounter document dated 07/27/25 revealed:
-Resident #11's history included dementia, hypertension, type 2 diabetes.
-Primary impression was heat exhaustion; secondary impression was altered mental status.
-Resident #11 exhibited signs and symptoms of heat exhaustion (primary) altered mental status and tachycardia.
-Her skin was dry and hot.
-At 3:04pm Resident #11's initial blood pressure was 130/80 while sitting, pulse was 135 beats per minute, respirations were 38 breaths per minute, and temperature was 102.7 degrees Fahrenheit (F) under her arm (normal: 97.6 degrees F to

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| D 270 | Continued From page 34<br>99.4-degree F).<br>-At 3:29pm Resident #11's blood pressure was 130/52, pulse was 141 beats per minute (normal: 60-100 beats per minute) respirations were 34 breaths per minute (normal: 12-20 breaths per minute) and temperature was 99.6 F orally (normal: 95.9 degrees F to 99.5 degrees F).<br>-She had an abrasion left of the thoracic spine (the middle section of the spine) and the skin around the knees were reddened, "likely from contact with ground."<br>-Within 20 minutes she was "more responsive, able to answer some questions for EMS but was confused about what was going on."<br>-Per the EMS narrative: "Extremely hot, humid, sunny summer afternoon ...dispatched for a memory care patient who had been unsupervised and exposed to the heat for an unknown amount of time.<br>-Per the notes the facility had found the resident out front and brought her back inside.<br>-The resident was reportedly hot and exhibiting signs of AMS (altered mental status).<br>-The resident was found sitting in a wheelchair, with her legs propped up on a chair, with her head leaning back on the back of the seat.<br>-The resident was noted to be wet from staff putting bags of ice and wet towels on her.<br>-She was semi-conscious, not alert.<br>-Her skin was hot to the touch.<br>-Her pulses were strong and regular.<br>-The resident was groaning, breathing at an elevated rate.<br>-Staff were unable to provide EMS with many details.<br>-Staff estimated the resident had been outside for 20-25 minutes.<br>-The resident's condition indicated she may have been outside for considerably longer and it was unclear if the resident was on the ground when | D 270 | | |

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they (staff) found her.
-EMS removed the resident's clothing and placed cold packs on the patient's torso, lower body and under her arms.
-The condition of the resident at the destination was improved.

Review of Resident #11's ED visit note dated 0727/25 revealed:
-Resident #11 arrived at the ED with a chief complaint of altered mental status after being found outside of the facility for an unknown time.
-Resident #11's Glasgow Coma Scale was documented as 8-10 (GCS, a scale used to measure a patient's level of consciousness and a GCS less than 8 was considered a medical emergency).
-Resident #11's rectal temperature was 101.5 degrees Fahrenheit (normal: 97.9 to 100.4 degrees F) heart rate of 109 beats per minute (normal 60-100 beats per minute) and a respiratory rate of 20 (normal: 12 to 20 breaths per minute).
-Labs were obtained, reviewed and showed signs of a urinary tract infection.
-Intravenous fluids and antibiotics were administered.
-Imaging studies were obtained, reviewed and showed signs of a 10th rib fracture.
-Resident #11 was admitted with a diagnosis of sepsis with encephalopathy without septic shock (a neurological complication caused by the body's response to an infection) and acute cystitis (a bladder infection).
-Resident #11 had multiple system failures, infections and had potential for life threatening deterioration which required frequent evaluation and titration of medications.
-Resident #11 was still hospitalized on 07/30/25.

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| D 270 | Continued From page 36<br><br>Review of the National Weather Service of the United States update dated 07/27/25 for Central North Carolina revealed:<br>-An Extreme Heat Warning, which was a notice issued by the National Weather Service of the United States within 12 hours of the heat index reaching one of two criteria levels. In most areas, a warning will be issued if there is a heat index of at least 105 degrees Fahrenheit (F) for more than 3 hours per day for two consecutive days, or if the heat index is greater than 115 degrees F for any period of time.<br>- The temperature was expected to reach 95 degrees F with heat index values of up to 107 degrees F.<br>-On July 27, 2025, the closest weather station to Harrisburg, NC recorded a high temperature of 101 degrees F and a low temperature of 77 degrees F with an average temperature of 88 degrees F.<br><br>Telephone interview with the local fire department first responder on 07/30/25 at 11:37am revealed:<br>-Resident #11 was sitting in a chair in the main lobby of the SCU, moaning.<br>-Resident #11's clothes were completely soaked with sweat.<br>-He asked staff to provide bags of ice due to Resident #11's axillary temperature reading 102.2 degrees.<br>-Staff stated Resident #11 had fallen outside after he noticed resident had skin tears on her legs.<br>-He was told that Resident #11 had been outside for 20 to 25 minutes.<br>-He was concerned about Resident #11's notable abdominal distention.<br><br>Interview with a Cabarrus County Paramedic on 07/30/25 at 09:30am and 12:35pm revealed:<br>-EMS responded to the facility call on 07/27/25 at | D 270 | | |

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approximately 2:47pm.
-Resident #11 was outside for 20-25 minutes according to staff.
-When medics arrived, Resident #11 was sitting in a wheelchair in the SCU with cold, wet towels on her and drinking a glass of water.
-She was "very altered in her mental state, just groaning. Her pulse was 154 and her temperature was 102.7 degrees axillary (under the arm). "
-Paramedics thought she was found "wandering" out in front of the building, but staff told them she had fallen outside in the SCU courtyard where she had been sitting "for 20-25 minutes."
-There were 3-4 staff around Resident #11 and one staff member at the door to let EMS into the building.
-He could not say how long it was safe to be outside in 100-degree F heat because he was not a physician.
-He believed every person responds differently to how long they can tolerate heat.
-He believed the facility may need to limit access to the SCU courtyard during times of extreme weather.

Telephone interview with Resident #11's family member on 07/29/25 at 4:44pm revealed:
-She was notified by the facility that Resident #11 was found in the courtyard on the ground.
-The EMS report stated heat exhaustion.
-Resident #11 had a fever upon arrival to the ED.
-Resident #11 had a broken rib.

Telephone interview with the Emergency Department Medical Director at a local hospital on 07/30/25 at 12:57pm and 2:09pm revealed:
-Resident #11 was seen in the ED for altered mental status after being outside for an unknown amount of time.
-There was an initial report from Emergency

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| D 270 | Continued From page 38<br><br>Medical Services (EMS) of a heat related illness.<br>-Resident #11 initial signs/symptoms at the facility were consistent with heat exhaustion due to her increased body temp of 102.2 degrees F., heavy sweating, weakness, and a rapid heart rate in the 130's-140's, possible fainting due to the report that Resident #11 sustained a fall, a report that she was out in 100 degree weather for an unknown amount of time and had a altered mental status.<br>-Once Resident #11 was at the ED, evaluations, tests and imaging were completed and Resident #11 was diagnosed with sepsis due to a urinary tract infection.<br>-After review of Resident #11's medical record history, ED provider notes dated 07/27/25, lab work and imagining results and evaluation by other providers at the hospital, and Resident #11 's admission diagnoses, due to Resident #11's dementia, she should have been supervised when outside in 100 degree weather because Resident #11 could have lacked the ability to comprehend the ability of being in the heat too long or the need to drink water to stay hydrated.<br><br>Interview with Resident #11's PCP dated 07/30/25 at 4:40pm revealed:<br>-She was not aware on 07/27/25 that Resident #11 had fallen outside in the SCU courtyard on 07/27/25 because she was not working that day.<br>-The facility notified the provider's triage department via secure messaging system on 07/27/25 at 2:42pm.<br>-She felt there was a detriment to a Resident if left outside in 100-degree F heat for longer than 30 mins.<br>-She believed Residents should have cold water when they are outside.<br>-Her expectation was that she did not want anyone to go outside in the high heat. | D 270 | | |

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| D 270 | Continued From page 39<br><br>Observation of the courtyard in the SCU on 07/29/25 from 4:42pm to 5:00pm revealed:<br>-The courtyard was in the center of the locked SCU.<br>-There were two unlocked glass doors on one end of the courtyard and one unlocked glass door at the other end of the courtyard.<br>-The was a sign posted on each of the three glass doors of the courtyard labeled "caution!!!! Today extremely high temperatures outside".<br>-There was a concrete walkway surrounding an area of fake grass.<br>-The fake grass area contained three round tables with chairs.<br>-The concrete walkway had 5 chairs for residents to sit in.<br>-The outer parameter contained mulch, shrubs and flowers.<br><br>Observation of the courtyard in the SCU on 07/30/25 from 9:30am to 10:00am revealed:<br>-There were two unlocked glass doors on one end of the courtyard and one unlocked glass door at the other end of the courtyard.<br>-The was a sign posted on each of the three glass doors of the courtyard labeled "caution!!!! Today extremely high temperatures outside".<br><br>Interview with personal care aide (PCA) on 07/30/25 at 12:30pm revealed:<br>- She worked in the SCU on first shift on 07/27/25.<br>- Resident #11 often enjoyed going into the courtyard but did not usually go outside when it was too hot.<br>- On 07/27/25, she recalled seeing Resident #11 at the end of lunch around 12:30pm.<br>- She left around 2:00pm to run an errand and did not remember seeing Resident #11 again before | D 270 | | |

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she left.
- When she returned, Resident #11 was sitting in a chair inside the facility, receiving medical attention.

Telephone interview with a medication aide (MA) on 07/29/25 at 3:20pm revealed:
-She and another staff member found Resident #11 outside in the SCU secure courtyard about 2:30pm.
-She stated Resident #11 liked to go outside in the secure courtyard frequently.
-One of the PCAs saw Resident #11 on the ground in the mulch in the SCU courtyard, she called the MA and they got her into a wheelchair and brought her back inside the SCU.
-Resident #11 was breathing a little fast and was warm, so they got a cool towel to put on her forehead and neck.
-Resident #11 was given water to drink.
-She called the SCC and called EMS for evaluation.
-Resident #11 "wasn't her normal self" but she was talking ok.
-She had seen Resident #11 in the courtyard about 30 minutes before when the resident went to sit outside in the courtyard. She was aware it was "hot outside" but didn't know the temperature.
-She stated Resident #11 "looked fine to me, she was sitting in a regular chair outside ...she often sits outside and comes in and out.
-The doors to the SCU secure courtyard do not lock to prevent residents from entering the courtyard on their own.

Interview with the RCC on 07/29/25 at 1:10pm revealed:
-She was aware Resident #11 was found on the ground outside the SCU secure courtyard at

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approximately 2:30pm 07/27/25 because the MA working that day notified her that day.
-She was aware Resident #11 was transported to the hospital and was admitted.
-She was told by the staff that Resident #11 was outside in the SCU courtyard "only about 25 minutes" and that they put cool, wet clothes on her and gave her water to drink while calling EMS.
-She did not know how long a Resident should stay outside on a hot day, but that Resident #11 "liked to come and go in the courtyard all day long. But she didn't usually stay long."
-Staff are expected to make rounds on all facility residents "at least every two hours."

Refer to the interview with the Administrator on 07/29/25 at 02:35pm.

2. Review of Resident #2's current FL2 dated 08/08/24 revealed:
-Diagnoses included dementia, altered mental status and unspecified behavioral involuntary movements.
-She was ambulatory.
-She was constantly disoriented.
-Her level of care was SCU.

Review of Resident #2's Resident Register dated 08/08/22 revealed an admission date of 08/08/22.

Review of Resident #2's Care Plan dated 07/31/24 revealed:
-She was ambulatory without a device.
-She was always disoriented and resisted care.
-She had a significant loss of memory and must be directed.
-She required limited assistance with eating and extensive assistance with toileting, ambulation, bathing, dressing, grooming/personal hygiene

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and transferring.
-There was no description of supervision needed or frequency

Review of Resident #2's SCU Resident Profile and Care Plan dated 05/10/25 revealed:
-She was independent without devices for ambulation/mobility.
-She needed extensive assistance for transferring.

Review of Resident #2's Licensed Health Professional Support (LHPS) evaluation dated 04/29/25 revealed she was receiving occupational therapy (OT) for self-sufficiency with activities of daily living (ADLs) and she was progressing.

a. Review of Resident #2's Accident and Incident Report dated 06/10/25 at 7:20am revealed:
-She was found on the floor of her bathroom.
-The incident was not witnessed by a staff member.
-She was alert and oriented.
-She complained of right hip pain.
-She was sent to the Emergency Department (ED) via EMS at 7:39am.
-Her PCP was notified 6/10/25 at 9:00am via a secure messaging system to medical providers.
-Her daughter was notified 06/1025 at 9:10am.
-She was not hospitalized.
-The facility initiated a Falls Prevention Program from 06/25/25 to 06/28/25 to monitor status for 72 hours for bruising, change in mental status/condition, pain or other injuries related to fall.
-Special instructions included to complete a shift note every shift for 72 hours.

Review of the EMS encounter document dated 06/10/25 revealed:

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| D 270 | Continued From page 43<br>-She had right hip deformity and pain.<br>-She had altered mental status and dementia.<br><br>Review of Resident #2's ED Provider Note dated 06/10/25 revealed X-rays of the pelvis, right hip and femur were negative for acute fracture or dislocation and a CT of cervical spine was negative for acute traumatic injury/fracture.<br><br>Review of Resident #2's Readmission/Return, Follow Up from a Fall progress note dated 06/10/25 at 1:31pm revealed resident did not have any changes post-fall.<br><br>Review of the Electronic Medication Administration Record (eMAR) dated 06/11/25 to 06/13/25 revealed:<br>-There was documentation Resident #2's vital signs were monitored every shift for 72 hours after the fall on 06/10/25.<br>-There was no documentation Resident #2 was monitored for more frequent checks for bruising, change in mental status/condition, pain or other injuries related to fall after the fall 06/10/25.<br><br>b. Review of Resident #2's Accident and Incident Report dated 06/12/25 at 10:29am revealed:<br>-She was found on the floor of her room.<br>-The incident was not witnessed by a staff member.<br>-The resident did not exhibit or complain of pain and/or injury.<br>-She would arouse when her name was called.<br>-Her Primary Care Provider (PCP) was at the facility at the time of incident and was notified at 10:19am.<br>-Her daughter was notified at 10:30am.<br>-She was sent to the ED at 10:40am.<br>-She was not hospitalized.<br>-The facility's Fall Prevention Program was | D 270 | | |

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initiated.

Review of the EMS encounter document dated 06/12/25 revealed:
-Her mental status was normal baseline for patient.
-She had no outward injuries and showed no signs of pain during palpation.
-She was assisted up and began to stand and move with little assistance.

Review of Resident #2's PCP visit note dated 06/12/25 at 6:59am revealed:
-Resident #2 was seen due to reports of multiple falls.
-Staff reported to her they noticed a general decline in the patient over the past week.
-Resident #2 self-ambulates but leaned "further back a little bit when walking."

Review of the eMAR dated 06/12/25 to 06/15/25 revealed:
-There was documentation Resident #2's vital signs were monitored every shift for 72 hours after the fall on 06/12/25.
-There was no documentation Resident #2 was monitored for more frequent checks for bruising, change in mental status/condition, pain or other injuries related to fall after the fall 06/12/25.

c. Review of Resident #2's Accident and Incident Report dated 07/05/25 at 6:33am revealed:
-She was found lying on her back in a hallway.
-The incident was not witnessed by a staff member.
-She did not exhibit or complain of pain and/or injury related to this fall.
-She was alert and oriented.
-Her PCP was notified on 07/07/25 at 4:47pm via a secure messaging system.

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| D 270 | Continued From page 45<br>-Her daughter was notified on 07/05/25 at 6:46am.<br>-She was transported to the ED at 6:45am.<br><br>Review of the EMS encounter document dated 07/05/25 revealed:<br>-Her neurological status was normal baseline for the patient.<br>-She did not have altered mental status.<br>-No deformities or bleeding were noted on the patient.<br><br>Review of Resident #2's hospital notes dated 07/05/25 revealed:<br>-She presented post unwitnessed fall with a traumatic subdural hemorrhage without loss of consciousness and a small right scalp hematoma.<br>-She was likely not able to participate in physical and occupational therapy due to her dementia but an evaluation also including speech therapy and a dietician would be ordered.<br>-A hospital discharge of 07/09/25 was anticipated.<br><br>Review of Resident #2's Admission/Return from Hospital progress note dated 07/11/25 at 03:23pm revealed she returned from the hospital.<br><br>Review of Resident #2's progress note dated 07/11/25 at 4:01pm revealed she had no pain and no additional injuries since the fall.<br><br>Review of Resident #2's progress note dated 07/12/25 at 9:07am revealed she had no changes following her return to facility.<br><br>Review of Resident #2's progress note dated 07/13/25 at 10:04am revealed she had no changes following her return to facility. | D 270 | | |

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| D 270 | Continued From page 46<br><br>Review of Resident #2's eMAR for 07/11/25 to 07/15/25 revealed:<br>-There was documentation Resident #2's vital signs were monitored every shift for 72 hours after hospital discharge on 7/11/25.<br>-There was no documentation Resident #2 was monitored for more frequent checks after hospital discharge on 07/11/25.<br><br>Interview with a patient care aide (PCA) on 07/25/25 at 10:55am revealed:<br>-She knew Resident #2 fell on 06/10/25 but she didn't recall on which shift.<br>-She did not witness the fall.<br>-Resident #2 "falls a lot, we can't stop her from getting up and walking."<br><br>Telephone interview with a second PCA on 07/28/25 at 3:30pm revealed:<br>-She opened Resident #2's door on 06/12/25 and saw she was not in her bed.<br>-As she walked by Resident #2's room "several minutes later", she saw her on the floor by the bed.<br>-She did not see any injuries to Resident #2, who got up and was walking "right after she was on the floor."<br>-She called EMS to evaluate Resident #2 because no one had seen her fall.<br><br>Telephone interview with a medication aide (MA) on 07/23/25 at 2:30pm revealed:<br>-She found Resident #2 on the floor in her bathroom when she made her first shift resident rounds "around 7:00am" on 06/10/25.<br>-Resident #2 had a "large bump on her right hip"<br>-She did not believe anyone saw Resident #2 fall.<br>-She called EMS who transported Resident #2 to the ED. | D 270 | | |

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| D 270 | Continued From page 47<br><br>Interview with a second MA on 07/25/25 at 10:15am revealed:<br>-Resident #2 "usually falls on third shift" when she first wakes up.<br>-She didn't see her fall on 06/10/25 but later saw the "bruise" on her right hip.<br>-She believed it was very difficult to stop Resident #2 from falling.<br>-SCU staff assisted the resident with toileting.<br>-Residents were checked every hour but it was documented on the eMAR once a shift.<br>-She did not know why documentation wasn't completed for every shift.<br><br>Telephone interview with Resident #2's PCP 07/29/25 at 9:45am:<br>-She was aware Resident #2 had a fall 06/10/25, 06/12/25 and 07/05/25.<br>-She sees the facility residents on a "weekly basis."<br>-Resident #2 was sent to the ED on 06/10/25 and on 06/12/25, "had a workup there and nothing major was found, no fractures and she was sent back to the facility after her falls on those dates.<br>-She was aware Resident #2 had been admitted to the hospital after the 07/05/25 fall but did not have any changes to care.<br>-She did not believe any of Resident #2's medications would contribute to falls.<br>-She did not believe Resident #2's falls could be prevented.<br><br>Refer to the interview with the RCC on 07/29/25 at 10:38am.<br><br>Refer to the interview with the Administrator on 07/29 at 2:35pm.<br><br>Telephone interview with Resident #2's Responsible Party was not successful. | D 270 | | |

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| D 270 | Continued From page 48<br><br>Based on observations, interviews and record reviews Resident #2 was not interviewable.<br>3. Review of Resident #5's current FL2 dated 01/25/25 revealed:<br>-Diagnoses included essential hypertension, hypothyroidism and hypercholesterolemia.<br>-He was intermittently disoriented.<br>-He was semi-ambulatory.<br>-His recommended level of care was domiciliary.<br><br>Review of Resident #5's Resident Register revealed an admission date of 01/02/23.<br><br>Review of Resident #5's record on 07/24/25 revealed:<br>-He was admitted under Hospice services on 03/18/25.<br>-Senile dementia was his Hospice admitting diagnosis.<br><br>Review of Resident #5's Care Plan dated 01/16/25 revealed:<br>-He was ambulatory with aide or devices with a walker and wheelchair listed.<br>-He was sometimes disorientated.<br>-He was forgetful and needed reminders.<br>-He required limited assistance with eating, toileting, dressing, grooming and transfers.<br>-He required extensive assistance with bathing.<br><br>a. Review of Resident #5's Accident and Incident report dated 05/09/25 9:25am revealed:<br>-He was sent to the hospital due to an unwitnessed fall where he was observed laying on his back, beside his bed.<br>-The falls prevention program was checked as initiated.<br>-There was an entry "care plan updated" with documentation of a response of "no". | D 270 | | |

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| D 270 | Continued From page 49<br><br>Review of Resident #5's ED visit note dated 05/09/25 revealed:<br>-He was sent to the hospital due to an unwitnessed fall where he was found on the floor.<br>-He was evaluated and discharged back to the facility.<br><br>Review of Resident #5's record on 07/24/25 revealed:<br>-There was no documentation that a post fall care plan evaluation for interventions had been completed after residents 05/09/25 fall.<br>-There was no documentation to increase supervision.<br><br>Review of Resident #5's May 2025 eMAR revealed:<br>-There was documentation Resident #5's vital signs were monitored every shift for 72 hours after the fall on 05/09/25.<br>-There was documentation Resident #5 was monitored every shift for 72 hours for bruising, change in mental status/condition, pain or other injuries related to fall on 05/09/25.<br>-There was no documentation resident was checked on more frequently than every 8 hours (shift).<br><br>b. Review of Resident #5's staff charting note dated 05/17/25 revealed the Hospice Nurse was notified of residents fall.<br><br>Review of Resident #5's record on 07/24/25 revealed:<br>-There was no documentation of a completed accident and incident report dated 05/17/25.<br>-There was no documentation that a post fall care plan evaluation for interventions had been completed after residents 05/17/25 fall. | D 270 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| THE DRAKE | 1195 DRAKE MILL LANE SW CONCORD, NC 28025 |

| (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 |
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| D 270 | Continued From page 50<br>-There was no documentation to increase supervision.<br><br>Review of Resident #5's May 2025 eMAR revealed:<br>-There was documentation Resident #5's vital signs were monitored every shift for 72 hours after the fall on 05/17/25.<br>-There was documentation Resident #5 was monitored every shift for 72 hours for bruising, change in mental status/condition, pain or other injuries related to fall on 05/17/25.<br>-There was no documentation resident was checked on more frequently than every 8 hours (shift).<br><br>c. Review of Resident #5's staff charting note dated 05/31/25 at 2:47pm revealed:<br>-Hospice Nurse came to evaluate resident after two falls.<br>-There was documentation of falls with no injury, two red marks on his back but no pain.<br><br>Review of Resident #5's record on 07/24/25 revealed:<br>-There was no documentation that an updated fall risk interventions care plan had been completed after the resident fell on 05/31/25.<br>-There was no documentation to increase supervision.<br>-There was no documentation resident was checked on more frequently than every 8 hours (shift).<br><br>Review of Resident #5's June 2025 eMAR revealed there was documentation Resident #5's vital signs were monitored every shift for 72 hours after the fall on 05/31/24 starting on 06/01/25. | D 270 | | |

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| D 270 | Continued From page 51<br><br>d. Review of Resident #5's Accident and Incident report dated 06/09/25 at 3:15pm revealed:<br>-He was observed lying on the floor after an unwitnessed fall without injury.<br>-The falls prevention program was checked as initiated.<br>-There was an entry "care plan updated" with documentation of a response of "no".<br><br>Review of Resident #5's record on 07/24/25 revealed:<br>-There was no documentation that an updated fall risk interventions care plan had been completed after residents 06/09/25 fall.<br>-There was no documentation to increase supervision.<br><br>Review of Resident #5's June 2025 eMAR revealed:<br>-There was documentation Resident #5's vital signs were monitored every shift for 72 hours after the fall on 06/09/25.<br>-There was no documentation resident was checked on more frequently than every 8 hours (shift).<br><br>e. Review of Resident #5's Accident and Incident report dated 06/26/25 at 9:30am revealed:<br>-He was observed sitting on the floor after an unwitnessed fall without injury.<br>-There was documentation of follow up initiated with Hospice Provider.<br>-There was an entry "care plan updated" with documentation of a response of "no".<br><br>Review of Resident #5's record on 07/24/25 revealed:<br>-There was no documentation that an updated fall risk interventions care plan had been completed after residents 06/26/25 fall. | D 270 | | |

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| D 270 | Continued From page 52 | D 270 | | |

-There was no documentation to increase supervision.

Review of Resident #5's June 2025 eMAR revealed:
-There was documentation Resident #5's vital signs were monitored every shift for 72 hours after the fall on 06/26/25.
-There was no documentation resident was checked on more frequently than every 8 hours (shift).

f. Review of Resident #5's Accident and Incident report dated 06/28/25 at 3:20pm revealed:
-He was observed lying on the ground, on his back in the courtyard after an unwitnessed fall without injury.
-Falls prevention program was checked as initiated.
-There was an entry "care plan updated" with documentation of a response of "no".

Review of Resident #5's record on 07/24/25 revealed:
-There was no documentation that an updated fall risk interventions care plan had been completed after residents 06/28/25 fall.
-There was no documentation to increase supervision.

Review of Resident #5's June 2025 eMAR revealed:
-There was documentation Resident #5's vital signs were monitored every shift for 72 hours after the fall on 06/28/25.
-There was no documentation resident was checked on more frequently than every 8 hours (shift).

g. Review of Resident #5's accident and incident

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| D 270 | Continued From page 53 | D 270 | | |

report dated 07/05/25 at 3:00pm revealed:
-He was observed sitting behind his wheelchair in the dining room after an unwitnessed fall, without injury.
-There was documentation the falls prevention program was checked as initiated.
-There was an entry "care plan updated" with documentation of a response of "no".

Review of Resident #5's record on 07/24/25 revealed:
-There was no documentation that an updated fall risk interventions care plan had been completed after residents 07/05/25 fall.
-There was no documentation to increase supervision.

Review of Resident #5's July 2025 eMAR revealed:
-There was documentation Resident #5's vital signs were monitored every shift for 72 hours after the fall on 07/05/25.
-There was no documentation resident was checked on more frequently than every 8 hours (shift).

h. Review of Resident #5's Accident and Incident report dated 07/06/25 at 11:30am revealed:
-He was observed on his knees in front of his wheelchair after an unwitnessed fall in the dining room.
-There was documentation the falls prevention program was checked as initiated.
-There was an entry "care plan updated" with documentation of a response of "no".

Review of Resident #5's record on 07/24/25 revealed:
-There was no documentation that an updated fall risk interventions care plan had been completed

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| D 270 | Continued From page 54 | D 270 | | |

after residents 07/06/25 fall.
-There was no documentation to increase supervision.

Review of Resident #5's July 2025 eMAR revealed:
-There was documentation Resident #5's vital signs were monitored every shift for 72 hours after the fall on 07/06/25.
-There was no documentation resident was checked on more frequently than every 8 hours (shift).

i. Review of Resident #5's Accident and Incident report dated 07/10/25 at 6:30pm revealed:
-He was observed laying on the floor mat in his room after an unwitnessed fall without injury.
-There was documentation the falls prevention program was checked as initiated.
-There was an entry "care plan updated" with documentation of a response of "no".

Review of Resident #5's record on 07/24/25 revealed:
-There was no documentation that an updated fall risk interventions care plan had been completed after residents 07/10/25 fall.
-There was no documentation to increase supervision.

Review of Resident #5's July 2025 eMAR revealed:
-There was documentation Resident #5's vital signs were monitored every shift for 72 hours after the fall on 07/10/25.
-There was no documentation resident was checked on more frequently than every 8 hours (shift).

j. Review of Resident #5's Accident and Incident

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| D 270 | Continued From page 55 | D 270 | | |

report dated 07/11/25 at 8:00pm revealed:
-He was observed sitting on the floor in his room after an unwitnessed fall without injury.
-The falls prevention program was checked as initiated.
-There was an entry "care plan updated" with documentation of a response of "no".

Review of Resident #5's record on 07/24/25 revealed:
-There was no documentation that an updated fall risk interventions care plan had been completed after residents 07/10/25 fall.
-There was no documentation to increase supervision.

Review of Resident #5's July 2025 eMAR revealed:
-There was documentation Resident #5's vital signs were monitored every shift for 72 hours after the fall on 07/11/25.
-There was no documentation resident was checked on more frequently than every 8 hours (shift).

k. Review of Resident #5's Accident and Incident report dated 07/13/25 at 1:30pm revealed:
-He was observed sitting on the dining floor after an unwitnessed fall and observed in model room after an unwitnessed fall.
-Falls prevention program was checked as initiated.
-The falls prevention program was checked as initiated.
-There was an entry "care plan updated" with documentation of a response of "no".

Review of Resident #5's record on 07/24/25 revealed:
-There was no documentation that an updated fall

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| D 270 | Continued From page 56 | D 270 | | |

risk interventions care plan had been completed after residents 07/13/25 fall.
-There was no documentation to increase supervision.

Review of Resident #5's July 2025 eMAR revealed:
-There was documentation Resident #5's vital signs were monitored every shift for 72 hours after the fall on 07/13/25.
-There was no documentation resident was checked on more frequently than every 8 hours (shift).

1. Review of Resident #5's Accident and Incident report dated 07/16/25 at 2:40pm revealed:
-He was observed sitting on the floor beside his wheelchair after an unwitnessed fall.
-The falls prevention program was checked as initiated.
-There was an entry "care plan updated" with documentation of a response of "not applicable".

Review of Resident #5's record on 07/24/25 revealed:
-There was no documentation that an updated fall risk interventions care plan had been completed after residents 07/16/25 fall.
-There was no documentation to increase supervision.

Review of Resident #5's July 2025 eMAR revealed:
-There was documentation Resident #5's vital signs were monitored every shift for 72 hours after the fall on 07/16/25.
-There was no documentation resident was checked on more frequently than every 8 hours (shift).

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| D 270 | Continued From page 57 | D 270 | | |

m. Review of Resident #5's Accident and Incident report dated 07/25/25 at 11:23am revealed:
-He had a fall with injury.
-He had been observed sitting on the table outside in the courtyard.
-The falls prevention program was checked as initiated.
-There was an entry "care plan updated" with documentation of a response of "no".

Observation of Resident #5 on 07/25/25 at 11:20am revealed:
-Resident #5 was observed by the Adult Home Specialist (AHS) slumped over sitting in his wheelchair, alone in the courtyard.
-Resident #5 was trying to open the courtyard door to come into the facility when the AHS witnessed him fall.
-Resident #5 tried to get up off the ground and fell again.
-Resident #5 was able to stand and then sat on a nearby table.
-AHS asked Resident #5 to stay there and left to find staff for assistance.
-After AHS did not find staff in the hallway, she notified the Administrator.
-As the AHS and the Administrator were walking towards where Resident #5 was, a PCA walked inside of the facility through a back door.
-The RCC then appeared, and the AHS asked her for assistance.

Interview with Resident #5's previous Hospice Nurse on 07/28/25 at 11:22am revealed:
-He was aware that Resident #5 had multiple falls.
-The facility always notified him or Hospice when Resident #5 had fallen or had behaviors.

Interview with Resident #5's Hospice Nurse on

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| D 270 | Continued From page 58<br>07/25/25 at 10:29am and at 12:49pm revealed:<br>-She just started seeing Resident #5 and had one previous visit with him.<br>-She was on her way to the facility when she was notified of his 07/25/25 fall.<br><br>Observation of Resident #5 on 07/25/25 at 12:49pm revealed that during his Hospice Nurse's post fall evaluation, superficial bilateral knee abrasions were present.<br><br>Interview with a PCA on 07/25/25 at 12:40 pm revealed:<br>-Resident #5 had multiple falls.<br>-Resident #5 got agitated at times.<br>-She was not aware of any increased supervision checks for residents.<br>-She tried to check on Resident #5 every hour, but she did not document checks.<br>-She did not know Resident #5 was by himself when he had fallen in the courtyard on 07/25/25.<br>-Resident #5 should not have been outside alone in the courtyard because he had fallen multiple times.<br><br>Interview with a MA on 07/29/25 at 9:58am revealed:<br>-Resident #5 had multiple falls.<br>-Resident #5 was placed 72-hour monitoring where the MAs document once every shift after resident fell.<br>-Resident #5 needed a sitter because, "he falls all the time."<br><br>Interview with the RCC and the Administrator on 07/25/25 at 1:15am revealed:<br>-Staff were to check on Resident #5 every two hours but did not document every two-hour checks.<br>-Staff only document increased supervisor in a | D 270 | | |

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| D 270 | Continued From page 59<br>resident's record when ordered.<br>-RCC stated she had completed an after-fall assessment on 07/25/25 where she only noticed facial discoloration.<br>-When asked, the RCC stated she did not look at Resident #5's lower extremities and was not aware of superficial bilateral knee abrasions.<br><br>Attempted telephone interview with Resident #5's PCP on 07/25/25 at 12:38pm and on 07/28/25 at 11:32am was unsuccessful.<br><br>Based on observations, interviews and record reviews it was determined that Resident #5 was not interviewable.<br><br>_____<br>The facility failed to ensure supervision for Resident #11, who was allowed to go outside in the SCU courtyard alone when there was an extreme heat advisory in place with a heat index of 107 degrees, where she fell sustaining a rib fracture and hospitalized for signs and symptoms of heat exhaustion. Resident #2 who had multiple unwitnessed falls with injury who was sent to the local hospital for evaluation, and Resident #5 who had multiple unwitnessed falls, including a fall while he was alone in the facility courtyard. The facility's failure resulted in serious neglect and physical harm which constitutes a Type A1 Violation.<br><br>_____<br>The facility provided a plan of protection in accordance with G.S. 131D-34 on July 30, 2025, for this violation.<br><br>THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 29, 2025. | D 270 | | |

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| D 273 | Continued From page 60 | D 273 | | |
| D 273 | 10A NCAC 13F .0902(b) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.<br><br>This Rule is not met as evidenced by:<br>Based on interviews and record reviews, the facility failed to ensure referral and follow-up to meet the routine healthcare needs for 1 of 5 sampled residents related to notifying their Mental Health Provider (MHP) about medications used to treat mood and depression that were not available for administration (#9).<br><br>The findings are:<br><br>Review of Resident #9's current FL2 dated 12/31/25 revealed diagnoses included vascular dementia, coronary artery disease, hypertension and benign prostatic hyperplasia (an enlarged prostrate).<br><br>Review of Resident #9's MHP initial consultation notes dated 06/11/25 revealed:<br>-Resident #9 was seen for severe vascular dementia with behavioral disturbances including agitation and aggression.<br>-Resident #9 had a history of major depressive disorder which could be contributing to his current mood disturbances.<br>-Resident #9 was currently on duloxetine 20mg twice a day.<br>-Due to Resident #9's cognitive impairment, Resident #9 was unable to express depressive symptoms effectively.<br>-The plan was to initiate sertraline 25mg every day to better manage his depressive symptoms | D 273 | | |

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and mood.
-She was going to attempt a gradual dose reduction of duloxetine from 20mg twice a day to 20mg at bedtime.
-She would follow-up in 14 days to re-evaluate Resident #9's mood and behaviors.

Review of Resident #9's MHP visit notes dated 06/25/25 revealed:
-Resident #9 was currently on duloxetine 20mg at bedtime.
-Resident #9's previous dosage of duloxetine was 20mg twice a day, but it was reduced due to Resident #9 being on sertraline 25mg every day for depression and to reduce the risk of serotonin syndrome (a potentially life-threatening symptoms that occur when antidepressants were taken with other medications that also raise serotonin levels).
-The plan was to continue the gradual reduction of the duloxetine and the duloxetine 25mg at bedtime was discontinued.
-The sertraline 25mg every day was refilled, and staff were aware.
-She scheduled a follow-up appointment for 14 days.

Review of Resident #9's MHP visit notes dated 07/09/25 revealed:
-Due to pharmacy irregularities, the duloxetine 25mg at bedtime was discontinued from the facility's contracted pharmacy and sertraline 25mg every day was re-ordered from Resident #9's pharmacy.

Review of Resident #9's MHP visit notes dated 07/23/25 revealed:
-Resident #9's anxiety was a part of a broader spectrum of mood disturbances, including major depressive disorder and vascular dementia with

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behavioral disturbances.
-It was unclear if Resident #9's recent episodes of screaming were related to anxiety, anger or agitation.
-The plan was to increase the sertraline to 50mg every day to better manage Resident #9's anxiety symptoms,
-She had to discontinue the duloxetine 20mg two times a day and the duloxetine 25mg at bedtime again due to pharmacy irregularities.

a. Review of Resident #9's MHP's signed physician orders revealed:
-On 06/11/25, there was an order for sertraline 25mg every day.
-On 07/23/25, there was an order to discontinue sertraline 25mg every day.
-On 07/23/25, there was an order for sertraline 50mg every day.

Review of Resident #9's June 2025 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for sertraline 25mg every day, and an original start date of 06/11/25 documented as waiting on pharmacy/on hold/unavailable at 8:00am 06/13/25 to 06/29/25.
-The sertraline 25mg was documented as administered on 06/30/25 at 8:00am.

Interview with a MA on 07/25/25 at 2:30pm revealed:
-According to Resident #9's June 2025 eMAR, she did not administer Resident #9 sertraline 25mg at 9:00am on 06/13/25, 06/21/25 and 06/22/25 because there was no medication to administer/on hold and waiting on the pharmacy.
-She did not notify Resident #9's MHP.

Review of Resident #9's July 2025 eMAR

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE DRAKE | 1195 DRAKE MILL LANE SW CONCORD, NC 28025 |

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revealed:
-There was an entry for sertraline 25mg every day, and an original start date of 06/11/25 documented as waiting on pharmacy/unavailable on 07/01/25, 07/04/25 and 07/19/25 at 8:00am.
-The sertraline 25mg was documented as administered on 06/24/25 at 8:00am.
-The sertraline was not discontinued on 07/23/25.
-There was no entry for sertraline 50mg every day with a start date of 07/23/25.

Interview with a MA on 07/25/25 at 2:30pm revealed:
-According to Resident #9's July 2025 eMAR she did not administer Resident #9's sertraline 25mg every day on 07/04/25 and 07/19/25 at 9:00am because there was no medication available and was waiting on pharmacy.
-Today (07/25/25), Resident #9's POA came in and brough a new bottle of sertraline with instruction on the bottle to administer 50mg every day which did not match the eMAR so she called the MHP and was told that was the new order as of 06/25/25.
-She notified the RCC about the change who was responsible for notifying the pharmacy and/or change the order in the eMAR.
-She did not notify Resident #9's MHP.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/25/25 at 10:22am revealed:
-There was an order for sertraline 25mg every day documented as profile only and was not dispensed to the facility.
-There was no signed physician's order to discontinue sertraline 25mg every day listed on Resident #9's profile.
-There was no signed physician's order for sertraline 50mg every day listed on Resident #9's

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profile.
-Resident #9 used a private pharmacy.

Telephone interview with a pharmacist from Resident #9's pharmacy on 07/25/25 at 11:19am revealed:
-There was no signed physician's order for sertraline 25mg every day dated 06/11/25.
-On 07/23/25, there was a signed physician's order dated 07/23/25 for sertraline 50 mg every day that was filled.
-On 07/23/25, the sertraline 50mg tablets, 30 tablets (a 30-day supply), were dispensed and picked up at the pharmacy.

Interview with the medication pass MA on 07/24/25 at 7:10am revealed:
-She was unable to administer the duloxetine 20mg because there was none of the medication in the medication cart to administer.
-She attempted to re-order the medication through the eMAR but the re-order button did not accept the re-order.
-She looked through the medication cart and could not find any of the duloxetine for Resident #9.
-She looked on the eMAR at Resident #9's duloxetine's history and saw that it had been on hold/unavailable/awaiting pharmacy or discontinued for most of July 2025.
-She would let the RCC know after her medication pass.
-The RCC was responsible for calling the pharmacy about the missing medication.
-She did not call Resident #9's PCP to inform her that the medication was not available to be administered.

Review of an email from Resident #9's power of attorney (POA) to the Administrator on 07/10/25

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| D 273 | Continued From page 65<br><br>(unable to see time) revealed:<br>-The body of the email documented Resident #9's POA's first concern as Resident #9 had a primary pharmacy and signed papers for the facility's contracted pharmacy as the back-up pharmacy in the event the facility could not reach her, and a medication was needed and for any urgent medication need.<br>-There were concerns from Resident #9's POA about the MHP sending prescriptions to "no man's land" and finding out from a MA at the facility that Resident #9's prescription had run out.<br>-Resident #9's POA met with the previous SCC at the facility and was told the previous SCC was able to get 7-day supply for some of the medications Resident #9 was out of from the facility contracted pharmacy and have the prescriptions sent to Resident #9's pharmacy to be filled.<br>-Resident #9's other concern was why the prescriptions were not filled by the facility's contracted pharmacy since she signed for them to be the "back-up" pharmacy.<br>-Resident #9 documented problems with things "falling through the cracks", she was not alerted until there were only 1-3 medications left to administer instead of a week before, why the medication aides (MAs) were not communicating with the pharmacy or her, or not notifying her there were new providers.<br>-Resident #9's POA documented that she spoke to the current Resident Care Coordinator (RCC) at the beginning of last week (07/10/25) and was told by the current RCC, they would take care of the prescriptions and get them filled and she still had not heard from the previous RCC.<br><br>b. Review of Resident #9's MHP's signed physician orders revealed:<br>-On 06/11/25, there was an order to discontinue | D 273 | | |

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duloxetine 20mg two times a day.
-There was an order for duloxetine 20mg every day at bedtime.
-On 06/25/25, there was an order to discontinue duloxetine 20mg at bedtime.
-On 07/09/25, there was an order to discontinue duloxetine 20mg at bedtime again.
-On 07/23/25, there was an order to discontinue duloxetine 20mg at bedtime again.

Review of Resident #9's June 2025 eMAR revealed:
-There was an entry for duloxetine 20mg two times a day, with an original start date of 03/19/25.
-The duloxetine 20mg two times a day was documented as administered 06/01/25 to 06/11/25 at 8:00am and 8:00pm.
-The duloxetine 20ng two times a day was documented as administered 06/12/25 to 06/29/25 at 8:00am and 8:00pm instead of daily at 8:00pm.

Review of Resident #9's July 2025 eMAR revealed:
-There was an entry for duloxetine 20mg two times a day, with an original start date of 03/19/25.
-The duloxetine 20mg twice a day was documented as administered for 16 out of 46 opportunities instead of discontinuation of the duloxetine as ordered on 06/25/25.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/25/25 at 10:22am revealed:
-There was an MHP signed order for duloxetine 20mg at bedtime dated 06/25/25.
-On 06/25/25, the duloxetine 20mg, 7 tablets (a 7-day supply) were dispensed to the facility.

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| D 273 | Continued From page 67<br><br>-On 06/25/25, only a 7-day supply of duloxetine was dispensed to the facility and put on profile because Resident #9 had another pharmacy listed as their primary pharmacy.<br>-The order for duloxetine 20mg every night dated 06/25/25 was faxed to Resident #9's primary pharmacy.<br>-They did not receive an order to discontinue the duloxetine 20 mg at nighttime dated 06/25/25.<br><br>Telephone interview with a Pharmacist from Resident #9's pharmacy on 07/25/25 at 11:19am revealed:<br>-There was an order dated 03/18/25 for duloxetine 20mg two times a day.<br>-There was no order dated 06/11/25 to discontinue the duloxetine 20mg two times a day and start duloxetine 20mg at bedtime.<br>-There was no order dated 06/25/25 to discontinue the duloxetine 20mg at bedtime.<br><br>Interview with the medication pass MA on 07/24/25 at 7:10am revealed:<br>-She was unable to administer the duloxetine 20mg because there was none of the medication in the medication cart.<br>-She attempted to re-order the medication through the eMAR but the re-order button did not accept the re-order.<br>-She looked through the medication cart and could not find any of the duloxetine for Resident #9.<br>-She looked on the eMAR at Resident #9's duloxetine history and saw that the medication had been on hold/unavailable/waiting pharmacy or discontinued for most of July 2025.<br>-She would let the RCC know after her medication pass.<br>-The RCC was responsible for calling the pharmacy about the missing medication. | D 273 | | |

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| D 273 | Continued From page 68<br>-She did not call Resident #9's PCP to inform her that the medication was not available to be administered.<br><br>c. Review of Resident #9's previous primary care provider's (PCP) signed physician's orders dated 04/24/25 revealed an order for tamsulosin 0.4mg every day.<br><br>Review of Resident #9's current PCP's signed physician's orders dated 07/10/25 revealed an order for tamsulosin 0.4mg every day.<br><br>Review of Resident #9's July 2025 eMAR revealed there was an entry for tamsulosin 0.4mg every day at 8:00pm, with a start date of 03/12/25 documented as on hold or unavailable for 16 out of 24 opportunities.<br><br>Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/25/25 at 10:22am revealed:<br>-On 03/11/25, tamsulosin 0.4mg every day was documented as profile only.<br>-On 06/25/25 a signed physician's order for tamsulosin 0.4mg every day was received, and a 7-day supply was dispensed to the facility and put as profile only after that.<br>-On 06/25/25 the signed physicians order was faxed to Resident #9's primary pharmacy.<br><br>Telephone interview with a Pharmacist from Resident #9's pharmacy on 07/25/25 at 9:37am revealed:<br>-On 02/26/25, a signed physician's order for tamsulosin 0.4mg every day and 90 tablets (a 90-day supply) was dispensed.<br>-There was no signed physician's order for tamsulosin 0.4mg every day dated 04/24/25 or 07/10/25 documented. | D 273 | | |

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| D 273 | Continued From page 69<br><br>Interview with Resident #9's POA on 07/25/25 at 11:30am revealed:<br>-Resident #9 used an outside pharmacy but she had signed up with the facility's contracted pharmacy as back-up upon move in December 2024.<br>-There were no problems with Resident #9's medication until June 2025 after previous Administrator left.<br>-Since the previous Administrator left, she now had to call and check with the staff to make sure medications were ordered, and make sure the refills were completed.<br>-She made multiple phone calls to the current Administrator related to mediation not on hand, ordered or the prescription was sent to the back-up pharmacy instead of Resident #9's pharmacy.<br>-Around the first week of June 2025 she filled out paperwork to make the facility's contracted pharmacy as Resident #9's back-up pharmacy because if the medication did not come from Resident #9's primary pharmacy then it would come from the facility's contracted pharmacy.<br>-The first-second of June 2025, Resident #9 began having increased yelling and screaming episodes.<br>-On 06/11/25, Resident #9 saw the MHP and medications were changed.<br>-The MHP's plan was to start sertraline 25mg every day, and taper by decreasing the duloxetine from 20mg twice a day to nighttime until no duloxetine at all.<br>-On 06/26/25, she had a meeting with the previous Special Care Coordinator (SCC) and the current Administrator to discuss continuing problems with getting Resident #9's medication from the facility's contracted pharmacy.<br>-On 06/26/25, she filled out paperwork to make | D 273 | | |

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the facility's contracted pharmacy Resident #9's primary pharmacy because the prescriptions were going to the facility's contracted pharmacy and the orders were getting lost in the shuffle.
-Other issue that led to the medication issues was because in June 2025, Resident #9 was switched over to a new provider at the facility.
-On 07/03/25, she met with Resident #9's new PCP and was told that the new PCP did not know Resident #9 was on her list to be seen.
-On 07/03/25, she did not know Resident #9 did not have a PCP for 3-4 weeks.
-On 07/23/25, due to Resident #9's yelling and screaming episodes, the MHP then discontinued the duloxetine and increased the sertraline to 50mg every day.
-Today (07/25/25), she went to Resident #9's previous primary pharmacy and got the sertraline 50mg everyday filled because the facility's contracted pharmacy had Resident #9 listed as profile only and did not fill the prescription.

Interview with a MA on 07/25/25 at 2:30pm revealed:
-She administered Resident #9's sertraline and duloxetine according to the eMAR and the medications on hand.
-Resident #9's medications came from an outside pharmacy and could not be re-ordered in the eMAR with a press of the button, the RCC was responsible for re-ordering medication from an outside pharmacy because of the paperwork and phone calls.
-When Resident #9's medication was out when she worked, she notified the previous and current RCC.
-Today (07/25/25), after the morning medication pass, Resident #9's POA came in with a new bottle of Resident #9's sertraline and new instructions to administer now 50mg every day.

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-Resident #9's POA also had questions about Resident #9's duloxetine.
-Since the sertraline did not match what was on the eMAR and the duloxetine was not available to administer, she texted Resident #9's MHP.
-Resident #9's MHP texted her back and stated that Resident #9's sertraline was increased to 50mg every day and the duloxetine was changed from 20mg two times a day to at night only on 06/11/25 and discontinued on 06/25/25.
-She was not able to change the sertraline and duloxetine orders on the eMAR so she notified the RCC.
-On 07/04/25, she completed a medication cart audit on Resident #9 and matched the medications on hand to the eMAR order, and everything matched and the RCC was made aware that the sertraline and duloxetine were not available for administration and the current RCC said she would take care of it.
-She did not know the sertraline and duloxetine orders had changed.
-She did not notify Resident #9's MHP before today about the medications not available to administer.

Interview with the RCC on 07/28/25 at 1:29pm revealed:
-There was a lot of confusion with Resident #9's medications, orders, prescribing provider, which pharmacy was the primary, which pharmacy was the back up and if the POA was picking up the medications and she did not sit down and figure it all out after she took over as the RCC for the entire building around the first of July 2025.
-She did not speak to Resident #9's MHP about the medication issues just Resident #9's POA.

Interview with the Administrator on 07/25/25 at 12:25pm and on 07/28/25 at 10:00am revealed:

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| D 273 | Continued From page 72<br><br>-She received an email from Resident #9's POA around the beginning of July 2025 in reference to Resident #9's prescriptions and pharmacy issues.<br>-She told Resident #9's POA to contact Resident #9's MHP about the prescriptions.<br>-She found out from the pharmacy that Resident #9's MHP was sending prescriptions to the facility's contracted pharmacy which was Resident #9's back-up pharmacy and was only getting a week's worth of medications and then sent to Resident #9's primary pharmacy to be filled.<br>-About 2-3 weeks ago Resident #9's POA signed for the facility's contracted pharmacy to be the primary instead of the backup.<br>-She did not follow-up with Resident #9's POA, MHP, or the pharmacy to make sure everything was correct. | D 273 | | |
| D 358 | 10A NCAC 13F .1004 (a) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>The facility failed to administer medications as ordered during the medication pass on 07/24/25 from 7:00am to 8:08am for 3 of 8 sampled residents related to medications for depression, mood and prostate (#9), a medication for high blood pressure (#10) and a medication used to | D 358 | | |

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| D 358 | Continued From page 73<br>treat hyperthyroidism (#5).<br><br>The findings are:<br><br>The medication error rate was 15% as evidenced by 4 errors out of 26 opportunities during the medication pass on 07/24/25 from 7:00am to 8:08am.<br><br>1. Observation of the medication pass on 07/24/25 at 7:10am revealed:<br>-The medication aide (MA) was administering Resident #9's morning medications.<br>-Resident #9's sertraline 25mg every day was not available to administer to Resident #9.<br>-Resident #9's duloxetine 20mg two times a day was not available to administer to Resident #9.<br>-Resident #9's tamsulosin 0.4mg every day was not available to administer to Resident #9.<br><br>Review of Resident #9's current FL2 dated 12/31/25 revealed diagnoses included vascular dementia, coronary artery disease, hypertension and benign prostatic hyperplasia (an enlarged prostrate).<br><br>Interview with Resident #9 Power of Attorney (POA) on 07/25/25 at 11:30am revealed:<br>-Resident #9 used an outside pharmacy but she had signed up with the facility's contracted pharmacy as back up upon move in December 2024.<br>-There were no problems with Resident #9's medication until June 2025 after previous Administrator left.<br>-Since the previous Administrator left, she now had to call and check with the staff to make sure medications were ordered, and make sure the refill were completed.<br>-She made multiple phone calls to the current | D 358 | | |

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Administrator relater to mediation not on hand, ordered or the prescription was sent to the back-up pharmacy instead of Resident #9's pharmacy.
-Around the first week of June 2025 she filled out paperwork to make the facility's contracted pharmacy as Resident #9's back-up pharmacy because if the medication did not come from Resident #9's primary pharmacy then it world come from the facility's contracted pharmacy.
-The first-second of June 2025, Resident #9 began having increased yelling and screaming episodes.
-On 06/11/25, Resident #9 saw the MHP and medications were changed.
-The MHP's plan was to start sertraline 25mg every day, and taper by decreasing the duloxetine from 20mg twice a day to at nighttime until no duloxetine at all.
-On 06/26/25, she had a meeting with the previous Special Care Coordinator (SCC) and the current Administrator to discuss continuing problems with getting Resident #9's medication from the facility's contracted pharmacy.
-On 06/26/25, she filled out paperwork to make the facility's contracted pharmacy Resident #9's primary pharmacy because the prescriptions were going to the facility's contracted pharmacy and the orders were getting lost in the shuffle.
-Other issue that lead to the medication issues was because in June 2025, Resident #9 was switched over to a new provider at the facility.
-On 07/03/25, she met with Resident #9's new PCP and was told that the new PCP did not know Resident #9 was on her list to be seen.
-On 07/03/25, she did not know Resident #9 did not have a PCP for 3-4 weeks.
-On 07/23/25, due to Resident #9's yelling and screaming episodes, the MHP then discontinued the duloxetine and increased the sertraline to

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50mg every day.
-Today (07/25/25), she went to Resident #9's previous primary pharmacy and got the sertraline 50mg everyday filled because the facility's contracted pharmacy had Resident #9 listed as profile only and did not fill the prescription.

Review of Resident #9's Mental Health Provider (MHP) initial consultation notes dated 06/11/25 revealed:
-Resident #9 was seen for severe vascular dementia with behavioral disturbances including agitation and aggression.
-Resident #9 had a history of major depressive disorder which could be contributing to his current mood disturbances.
-Resident #9 was currently on duloxetine 20mg twice a day.
-Due to Resident #9's cognitive impairment, Resident #9 was unable to express depressive symptoms effectively.
-The plan was to initiate sertraline 25mg every day to better manage his depressive symptoms and mood.
-She was going to attempt a gradual dose reduction of duloxetine from 20mg twice a day to 20mg at bedtime.
-She would follow-up in 14 days to re-evaluate Resident #9's mood and behaviors.

Review of Resident #9's MHP visit notes dated 06/25/25 revealed:
-Resident #9 was currently on duloxetine 20mg at bedtime.
-Resident #9's previous dosage of duloxetine was 20mg twice a day, but it was reduced due to Resident #9 being on sertraline 25mg every day for depression and to reduce the risk of serotonin syndrome (a potentially life-threatening symptoms that occur when antidepressants were taken with

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other medications that also raise serotonin levels).
-The plan was to continue the gradual reduction of the duloxetine and the duloxetine 25mg at bedtime was discontinued.
-The sertraline 25mg every day was refilled and staff were aware.
-She scheduled a follow-up appointment for 14 days.

Review of Resident #9's MHP visit notes dated 07/09/25 revealed:
-Due to pharmacy irregularities, the duloxetine 25mg at bedtime was discontinued from the facility's contracted pharmacy and sertraline 25mg every day was re-ordered from Resident #9's pharmacy.
-She informed Resident #9's Power of Attorney (POA).

Review of Resident #9's MHP visit notes dated 07/23/25 revealed:
-Resident #9's anxiety was apart of a broader spectrum of mood disturbances, including major depressive disorder and vascular dementia with behavioral disturbances.
-It was unclear if Resident #9's recent episodes of screaming were related to anxiety, anger or agitation.
-The plan was to increase the sertraline to 50mg every day to better manage Resident #9's anxiety symptoms,
-She had to discontinue the duloxetine 20mg two times a day and the duloxetine 25mg at bedtime again due to pharmacy irregularities.

Review of an email from Resident #9's POA to the Administrator on 07/08/25 at 5:11pm revealed:
-The body of the email documented Resident #9's

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| D 358 | Continued From page 77<br><br>POA spoke with the current RCC on 07/07/25 around 12:30pm on the phone and the RCC was to get back with her.<br>-Resident #9's POA inquired about Resident #9's medication orders from 07/02/25 to 07/04/25 because Resident #9 was still running out of medication.<br>-Resident #9's POA still had not heard from Resident #9's pharmacy to pick up medications.<br><br>a. Review of Resident #9's MHP's signed physician orders revealed:<br>-On 06/11/25, there was an order for sertraline 25mg every day.<br>-On 07/23/25, there was an order to discontinue sertraline 25mg every day.<br>-On 07/23/25, there was an order for sertraline 50mg every day.<br><br>Review of Resident #9's June 2025 electronic Medication Administration Record (eMAR) revealed:<br>-There was an entry for sertraline 25mg every day, and an original start date of 06/11/25 documented as waiting on pharmacy/on hold/unavailable at 8:00am 06/13/25 to 06/29/25.<br>-The sertraline 25mg was documented as administered on 06/30/25 at 8:00am.<br><br>Interview with another MA on 07/25/25 at 2:30pm revealed:<br>-According to Resident #9's June 2025 eMAR, she did not administer Resident #9 sertraline 25mg at 9:00am on 06/13/25, 06/21/25 and 06/22/25 because there was no medication to administer/on hold and waiting on the pharmacy.<br><br>Review of Resident #9's July 2025 eMAR revealed:<br>-There was an entry for sertraline 25mg every | D 358 | | |

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| D 358 | Continued From page 78<br>day, and an original start date of 06/11/25 documented as waiting on pharmacy/unavailable on 07/01/25, 07/04/25 and 07/19/25 at 8:00am.<br>-The sertraline 25mg was documented as administered on 07/24/25 at 8:00am.<br>-The sertraline was not discontinued on 07/23/25.<br>-There was no entry for sertraline 50mg every day with a start date of 07/23/25.<br><br>Interview with another MA on 07/25/25 at 2:30pm revealed:<br>-According to Resident #9's July 2025 eMAR she did not administer Resident #9's sertraline 25mg every day on 07/04/25 and 07/19/25 at 9:00am because there was no medication available and was waiting on pharmacy.<br>-Today (07/25/25), Resident #9's POA came in and brough a new bottle of sertraline with instruction on the bottle to administer 50mg every day which did not match the eMAR so she called the MHP and was told that was the new order as of 06/25/25.<br>-She notified the RCC about the change who was responsible to notify the pharmacy and/or change the order in the eMAR.<br><br>Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/25/25 at 10:22am revealed:<br>-There was an order for sertraline 25mg every day documented as profile only and was not dispensed to the facility.<br>-There was no signed physician's order to discontinue sertraline 25mg every day listed on Resident #9's profile.<br>-There was no signed physician's order for sertraline 50mg every day listed on Resident #9's profile.<br>-Resident #9 used a private pharmacy. | D 358 | | |

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| D 358 | Continued From page 79<br><br>Telephone interview with a pharmacist from Resident #9's pharmacy on 07/25/25 at 11:19am revealed:<br>-There was no signed physician's order for sertraline 25mg every day dated 06/11/25.<br>-On 07/23/25, there was a signed physician's order dated 07/23/25 for sertraline 50 mg every day that was filled.<br>-On 07/23/25, the sertraline 50mg tablets, 30 tablets (a 30-day supply), were dispensed and picked up at the pharmacy.<br><br>b. Review of Resident #9's MHP's signed physician orders revealed:<br>-On 06/11/25, there was an order to discontinue duloxetine 20mg two times a day.<br>-There was an order for duloxetine 20mg every day at bedtime.<br>-On 06/25/25, there was an order to discontinue duloxetine 20mg at bedtime.<br>-On 07/09/25, there was an order to discontinue duloxetine 20mg at bedtime again.<br>-On 07/23/25, there was an order to discontinue duloxetine 20mg at bedtime again.<br><br>Review of Resident #9's June 2025 eMAR revealed:<br>-There was an entry for duloxetine 20mg two times a day, with an original start date of 03/19/25.<br>-The duloxetine 20mg two times a day was documented as administered 06/01/25 to 06/11/25 at 8:00am and 8:00pm.<br>-The duloxetine 20ng two times a day was documented as administered 06/12/25 to 06/29/25 at 8:00am and 8:00pm instead of daily at 8:00pm.<br><br>Interview with another MA on 07/25/25 at 2:30pm revealed: | D 358 | | |

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| D 358 | Continued From page 80<br>-According to Resident #9's June 2025 eMAR she did not know Resident #9's duloxetine was changed from 20mg two times a day to only at bedtime.<br>-She administered Resident #9's duloxetine 20mg on 06/13/25, 06/20/25 and 06/21/25 at 8:00am instead of not at 8:00am.<br><br>Review of Resident #9's July 2025 eMAR revealed:<br>-There was an entry for duloxetine 20mg two times a day, with an original start date of 03/19/25.<br>-The duloxetine 20mg twice a day was documented a administered for 16 out of 46 opportunities instead of discontinuation of the duloxetine as ordered on 06/25/25.<br><br>Interview with the medication pass medication aide (MA) on 07/24/25 at 7:10am revealed:<br>-She was unable to administer the duloxetine 20mg because there was none of the medication in the medication cart to administer.<br>-She attempted to re-order the medication through the eMAR but the re-order button did not accept the re-order.<br>-She looked through the medication cart and could not find any of the duloxetine for Resident #9.<br>-She looked on the eMAR at Resident #9's duloxetine's history and saw that it had been on hold/unavailable/awaiting pharmacy or discontinued for most of July 2025.<br>-She would let the Resident Care Coordinator (RCC) know after her medication pass.<br>-The RCC was responsible for calling the pharmacy about the missing medication.<br>-She did not complete medication cart audits yet because she had only been at the facility for two weeks. | D 358 | | |

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| D 358 | Continued From page 81<br><br>Interview with another MA on 07/25/25 at 2:30pm revealed on 07/05/25 she administered duloxetine 20mg because she found a prescription bottle of duloxetine 20mg with Resident #9's name on it labeled to administer two times a day and administered the medication because she did not know the medication had been discontinued.<br><br>Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/25/25 at 10:22am revealed:<br>-There was an MHP signed order for duloxetine 20mg at bedtime dated 06/25/25.<br>-On 06/25/25, the duloxetine 20mg, 7 tablets (a 7-day supply) was dispensed to the facility.<br>-On 06/25/25, only a 7-day supply of duloxetine was dispensed to the facility and put on profile because Resident #9 had another pharmacy listed as their primary pharmacy.<br>-The order for duloxetine 20mg every night dated 06/25/25 was faxed to Resident #9's primary pharmacy.<br>-They did not receive an order to discontinue the duloxetine 20 mg at nighttime dated 06/25/25.<br><br>Telephone interview with a Pharmacist from Resident #9's pharmacy on 07/25/25 at 11:19am revealed:<br>-There was an order dated 03/18/25 for duloxetine 20mg two times a day and 180 tablets (a 90 day supply) was dispensed to the facility.<br>-There was no order dated 06/11/25 to discontinue the duloxetine 20mg two times a day and start duloxetine 20mg at bedtime.<br>-There was no order dated 06/25/25 to discontinue the duloxetine 20mg at bedtime.<br><br>c. Review of Resident #9's previous primary care | D 358 | | |

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provider's (PCP) signed physician's orders dated 04/24/25 revealed an order for tamsulosin 0.4mg every day.

Review of Resident #9's current PCP's signed physician's orders dated 07/10/25 revealed an order for tamsulosin 0.4mg every day.

Review of Resident #9's July 2025 eMAR revealed there was an entry for tamsulosin 0.4mg every day at 8:00pm, with a start date of 03/12/25 documented as on hold or unavailable for 16 out of 24 opportunities.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/25/25 at 10:22am revealed:
-On 03/11/25, tamsulosin 0.4mg every day was documented as profile only.
-On 06/25/25 a signed physician's order for tamsulosin 0.4mg every day was received, and a 7-day supply was dispensed to the facility and put as profile only after that.
-On 06/25/25 the signed physicians order was faxed to Resident #9's primary pharmacy.

Telephone interview with a Pharmacist from Resident #9's pharmacy on 07/25/25 at 9:37am revealed:
-On 02/26/25, a signed physician's order for tamsulosin 0.4mg every day and 90 tablets (a 90-day supply) was dispensed.
-There was no signed physician's order for tamsulosin 0.4mg every day dated 04/24/25 or 07/10/25 documented.

Interview with another MA on 07/25/25 at 2:30pm revealed:
-She administered Resident #9's sertraline and duloxetine according to the eMAR and the

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medications on hand.
-Resident #9's medications came from an outside pharmacy and could not be re-ordered in the eMAR with a press of the button, the RCC was responsible for re-ordering medication from an outside pharmacy because of the paperwork and phone calls.
-When Resident #9's medication were out when she worked she notified the previous and current RCC.
-Today (07/25/25), after the morning medication pass, Resident #9's POA came in with a new bottle of Resident #9's sertraline and new instructions to administer now 50mg every day.
-Resident #9's POA also had questions about Resident #9's duloxetine.
-Since the sertraline did not match what was on the eMAR and the duloxetine was not available to administer, she texted Resident #9's MHP.
-Resident #9's MHP texted her back and stated that Resident #9's sertraline was increased to 50mg every day and the duloxetine was changed from 20mg two times a day to at night only on 06/11/25 and discontinued on 06/25/25.
-She was not able to change the sertraline and duloxetine orders on the eMAR so she notified the RCC.
-On 07/04/25, she completed a medication cart audit on Resident #9 and matched the medications on hand to the eMAR order and everything matched and the RCC was made aware that the sertraline and duloxetine were not available for administration and the current RCC said she would take care of it.
-She did not know the sertraline and duloxetine orders had changed.

Interview with the RCC on 07/28/25 at 1:29pm revealed:
-The previous RCC dealt with Resident #9's

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medication issues and she came in on the end of those issues when she began as the RCC for the whole building around the first of July 2025.
-There was a lot of confusion with Resident #9's medications, orders, prescribing provider, which pharmacy was the primary, which pharmacy was the back up and if the POA was picking up the medications and she did not sit down and figure it all out after she took over as the RCC for the entire building around the first of July 2025.
-She had not completed a medication cart audit in the past 1-2 months because she was still learning her job duties as the RCC.

Interview with the Administrator on 07/25/25 at 12:25pm and on 07/28/25 at 10:00am revealed:
-She received an email from Resident #9's POA around the beginning of July 2025 in reference to Resident #9's prescriptions and pharmacy issues.
-She told Resident #9's POA to contact Resident #9's MHP about the prescriptions.
-She found out that Resident #9's MHP was sending the prescriptions to the facility's contracted pharmacy which was Resident #9's back-up pharmacy and was only getting a weeks worth of medications and then sent to Resident #9's primary pharmacy to be filled.
-About 2-3 weeks ago Resident #9's POA signed for the facility's contracted pharmacy to be the primary instead of the back up.
-She did not follow-up with Resident #9's POA or the pharmacy to make sure everything was correct.

Refer to interview with the RCC on 07/25/25 at 12:23pm.

Refer to interview with the Administrator on 07/25/25 at 12:25pm.

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| D 358 | Continued From page 85<br><br>2. Observation of the medication pass on 07/24/25 at 8:08am revealed:<br>-The medication aide (MA) was administering Resident #10's morning medications.<br>-Resident #10's lisinopril 2.5mg every day was not available to administer to Resident #10.<br><br>Review of Resident #10's current FL2 dated 04/10/23 revealed;<br>-Diagnoses included hypertension.<br>-An order for lisinopril 2.5mg every day.<br><br>Review of Resident #10's signed physician's order dated 06/12/25 revealed an order for lisinopril 2.5mg every day.<br><br>Review of Resident #10's electronic Medication Administration Record (eMAR) July 2025 eMAR revealed there was an entry for lisinopril 2.5mg every day with a start date of 07/18/25 documented as unavailable on 07/21/25 to 07/24/25.<br><br>Telephone interview with a Pharmacist at the facility's contracted pharmacy on 07/25/25 at 10:37am revealed:<br>-A signed physician's order dated 07/18/25 for lisinopril 2.5mg every day and 10 tablets (a 10 day supply) was dispensed to get Resident #10 back on cycle fill.<br>-On 07/24/25, lisinopril 2.5mg 7 tablets (a 7 day supply) was dispensed.<br><br>Interview with the medication pass MA on 07/24/25 at 8:10am revealed:<br>-There was no lisinopril 2.5mg on the medication cart for Resident #10 available to administer.<br>-The lisinopril could not be re-ordered when she attempted to re-order it through the eMAR system. | D 358 | | |

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-She looked in the medication cart and in the extra medication storage area and still could not locate the lisinopril for Resident #10.
-She notified the RCC today (07/24/25).
-The RCC was responsible to contact the pharmacy about the missing medication.
-Resident #10 was out four days ago and she could not re-order then either and forgot to tell the RCC.

Telephone interview with Resident #10's PCP on 07/25/25 at 2:10pm revealed:
-Resident #10 was last seen on 07/17/25.
-She did not know Resident #10 was not demister lisinopril for her high blood pressure.
-Her concern was that Resident #10's blood pressure could be higher than normal after missing four doses over the past four days.

Interview with the Resident Care Coordinator (RCC) on 07/25/25 at 3:18pm revealed Resident #10's lisinopril 2.5mg was found in with another resident's medications on 07/24/25 and had not received a total of 3 doses.

Review of Resident #10's medication available for administration on 07/25/25 at 3:15pm revealed there was a bubble pack labeled lisinopril 2.5mg every day, with a dispense date of 07/24/25, with 10 tablets left to administer.

Refer to interview with the RCC on 07/25/25 at 12:23pm.

Refer to interview with the Administrator on 07/25/25 at 12:25pm.

3. Review of Resident #5's current FL2 dated 01/25/25 revealed:
-Diagnoses included essential hypertension,

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hypothyroidism and hypercholesterolemia.
-He was intermittently disoriented.
-He was semi-ambulatory.
-His recommended level of care was domiciliary.

Review of Resident #5's Resident Register revealed an admission date of 01/02/23

Review of Resident #5's Physician orders dated 04/16/25 revealed an order for levothyroxine (used to treat hyperthyroidism) 100 mcg by mouth once daily.

Review of Resident #5's May 2025 eMAR revealed:
-There was an entry for levothyroxine 100 mcg by mouth one daily.
-Levothyroxine 100 mcg was documented as not administered due to waiting on pharmacy on 05/02/25, 05/05/25 and on 05/09/25.
-Levothyroxine 100 mcg was documented as not administered due to medication documented as unavailable on 05/10/25 and on 05/16/25.
-Levothyroxine 100 mcg was documented as administered on 05/03/25, 05/04/25, 05/06/25 through 05/08/25, 05/11/25 through 05/15/25 and on 05/17/25.

Review of Resident #5's staff charting note dated 05/17/25 revealed Resident #5 had not received levothyroxine from 05/02/25 through 05/17/25.

Telephone interview with the facilities contracted Pharmacist on 07/25/25 at 11:30am revealed:
-The pharmacy had sent a message to facility on 04/22/25 requesting a new prescription for Resident #5's levothyroxine 100 mcg with no response received.
-The pharmacy did receive a resupply request from the facility on 05/16/25.

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| D 358 | Continued From page 88<br>-The pharmacy did dispense 15 tablets of levothyroxine 100 mcg on 05/17/25.<br>-Resident #5 could experience fatigue, weight loss and dry skin if levothyroxine was not being administered as ordered.<br><br>Telephone interview with Resident #5's family member on 07/28/25 at 10:19am revealed the family member was not made aware that Resident #5 had not received his levothyroxine 100 mcg from 05/02/25 through 05/17/25.<br><br>Interview with a third shift MA on 07/29/25 at 9:58am revealed:<br>-She did not know Resident #5 had been out of his levothyroxine 100 mcg until the RCC had made her aware.<br>-She had mistakenly documented she had administered Resident #5's levothyroxine 100 mcg at 6:00am, eight times when the medication was unavailable.<br>-She did not know why Resident #5 did not have his levothyroxine 100 mcg available for administration.<br>-The first and second shift MAs were responsible for calling the residents PCP and the pharmacy when medications were not available or when medications needed to be reordered.<br>-MAs should be comparing all medications for administration to the resident's eMAR before administrating the medications to residents.<br>-She did not compare Resident #5's medications to his eMAR prior to administrating his medications.<br><br>Interview with the RCC on 07/29/25 at 10:38am revealed:<br>-She could not say why Resident #5 was without his levothyroxine 100 mcg.<br>-MAs are supposed to compare the medication to | D 358 | | |

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the eMAR three times before administering medications to residents.
-Medication cart audits are completed Monday through Friday.
-There was no documentation of medication cart audits.
-MAs only notify the RCC if they find expired medication or missing medications.
-She was the one who contacted the pharmacy after it was discovered that Resident #5 had been without his levothyroxine 100 mcg after reviewing his May 2025 eMAR.

Interview with the Administrator on 07/30/25 at 5:03pm revealed:
-She did not know Resident #5 had been without his levothyroxine 100mcg.
-MAs were responsible for notifying the pharmacy if there was a medication missing.

Refer to interview with the RCC on 07/25/25 at 12:23pm and on 07/28/25 at 1:29pm.

Refer to interview with the Administrator on 07/25/25 at 12:25pm.

Attempted telephone interviews with Resident #5's PCP on 07/25/25 at 12:38pm and on 07/28/25 at 11:32am were unsuccessful.

Based on observations, interviews and record reviews, it was determined that Resident #5 was not interviewable.

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Interview with the RCC on 07/25/25 at 12:23pm and on 07/28/25 at 1:29pm revealed:
-The MAs were responsible for re-ordering a medication through the eMAR system, document in the eMAR and notify her.
-The MAs were responsible for checking for a

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backup/extra supply of the medication in the building after ordering medication and notifying her.
-The MAs were responsible for calling the pharmacy after the medication was missing for 3 days and notifying her.
-She was responsible for follow-up with the pharmacy on the 3rd day if the medication was still out.
-The MAs were responsible for completing weekly medication cart audits on each resident to check to make sure the medications on hand matched the eMAR order and the signed physician's order and notify her if they did not.
-When a provider completed a visit note, the provider entered the visit note into the resident's electronic record at the facility and then emailed it to the facility.
-The provider's notes contained a plan which was also orders.
-The providers were responsible for sending all orders electronically to the pharmacy.

Interview with the Administrator on 07/25/25 at 12:25pm and on 07/28/25 at 10:00am revealed:
-The MAs were responsible for administering the medications as ordered.
-The MAs were responsible for weekly medication cart audits to verify a resident's medications on hand matched the eMAR and the signed physician's orders to make sure the residents received their medications as ordered.
-The MAs were responsible for re-ordering a resident's medications when they were out and notifying the RCC the medications were re-ordered.
-The RCC was responsible for calling the pharmacy and finding out why the medications were not available to be administered.
-The RCC was responsible for verifying weekly

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| D 358 | Continued From page 91<br>medication cart audits were completed and if there were any issues or concerns were identified and addressed them.<br>-She did not know the medication cart audits had not been completed in the past 2 months. | D 358 | | |
| D 367 | 10A NCAC 13F .1004 (j) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(j) The resident's medication administration record (MAR) shall be accurate and include the following:<br>(1) resident's name;<br>(2) name of the medication or treatment order;<br>(3) strength and dosage or quantity of medication administered;<br>(4) instructions for administering the medication or treatment;<br>(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;<br>(6) date and time of administration;<br>(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,<br>(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to ensure medication administration records were accurate for 3 of 8 sampled residents related to medications used to | D 367 | | |

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treat mood and depression (#9), a medication used to treat hyperthyroidism (#5), and application and removal of ted hose (#7).

The findings are:

1. Review of Resident #9's current FL2 dated 12/31/25 revealed diagnoses included vascular dementia, coronary artery disease, hypertension and benign prostatic hyperplasia (an enlarged prostrate).

Review of Resident #9's Mental Health Provider's (MHP) initial consultation notes dated 06/11/25 revealed:
-The plan was to initiate sertraline 25mg every day to better manage his depressive symptoms and mood.
-She was going to attempt a gradual dose reduction of duloxetine from 20mg twice a day to 20mg at bedtime.
-She would follow-up in 14 days to re-evaluate Resident #9's mood and behaviors.

Review of Resident #9's MHP visit notes dated 06/25/25 revealed:
-Resident #9 was currently on duloxetine 20mg at bedtime.
-Resident #9's previous dosage of duloxetine was 20mg twice a day, but it was reduced due to Resident #9 being on sertraline 25mg every day for depression and to reduce the risk of serotonin syndrome (a potentially life-threatening symptoms that occur when antidepressants were taken with other medications that also raise serotonin levels).
-The plan was to continue the gradual reduction of the duloxetine and the duloxetine 25mg at bedtime was discontinued.
-The sertraline 25mg every day was refilled and

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staff were aware.
-She scheduled a follow-up appointment for 14 days.

Review of Resident #9's MHP's visit notes dated 07/09/25 revealed:
-Due to pharmacy irregularities, the duloxetine 25mg at bedtime was discontinued from the facility's contracted pharmacy and sertraline 25mg every day was re-ordered from Resident #9's pharmacy.

Review of Resident #9's MHP visit notes dated 07/23/25 revealed:
-The plan was to increase the sertraline to 50mg every day to better manage Resident #9's anxiety symptoms,
-She had to discontinue the duloxetine 20mg two times a day and the duloxetine 25mg at bedtime again due to pharmacy irregularities.

Review of Resident #9's MHP's signed physician orders revealed:
-On 06/11/25, there was an order to discontinue duloxetine 20mg two times a day.
-There was an order for duloxetine 20mg every day at bedtime.
-On 06/25/25, there was an order to discontinue duloxetine 20mg at bedtime.
-On 07/09/25, there was an order to discontinue duloxetine 20mg at bedtime again.
-On 07/23/25, there was an order to discontinue duloxetine 20mg at bedtime again.

Review of Resident #9's June 2025 electronic Medication Administration (eMAR) revealed:
-There was an entry for duloxetine 20mg two times a day, with an original start date of 03/19/25.
-The duloxetine 20mg two times a day was

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documented as administered 06/01/25 to 06/11/25 at 8:00am and 8:00pm.
-The duloxetine 20ng two times a day was documented as administered 06/12/25 to 06/29/25 at 8:00am and 8:00pm instead of daily at 8:00pm.

Review of Resident #9's July 2025 eMAR revealed:
-There was an entry for duloxetine 20mg two times a day, with an original start date of 03/19/25.
-The duloxetine 20mg twice a day was documented as administered for 16 out of 46 opportunities instead of discontinuation of the duloxetine as ordered on 06/25/25 when there was no medication to administer in the building.

Telephone interview with a Pharmacist at the facilities contracted pharmacy on 07/25/25 at 10:22am revealed:
-There was an MHP signed order for duloxetine 20mg at bedtime dated 06/25/25.
-On 06/25/25, the duloxetine 20mg, 7 tablets (a 7-day supply) was dispensed to the facility.
-On 06/25/25, only a 7-day supply of duloxetine was dispensed to the facility and put on profile because Resident #9 had another pharmacy listed as their primary pharmacy.
-The order for duloxetine 20mg every night dated 06/25/25 was faxed to Resident #9's primary pharmacy.
-They did not dispense duloxetine 20mg after 06/25/25.

Telephone interview with a Pharmacist from Resident #9's pharmacy on 07/25/25 at 11:19am revealed:
-There was an order dated 03/18/25 for duloxetine 20mg two times a day and 180 tablets

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| D 367 | Continued From page 95<br>(a 90 day supply) was dispensed to the facility.<br>-There was no order dated 06/11/25 to discontinue the duloxetine 20mg two times a day and start duloxetine 20mg at bedtime.<br>-There was no order dated 06/25/25 to discontinue the duloxetine 20mg at bedtime.<br>-They did not dispense duloxetine after 03/18/25.<br><br>Interview with the RCC on 07/28/25 at 1:29pm revealed:<br>-The MAs were responsible to document a medication as administered only after watching a resident take to medication.<br>-You can't document administration of a medication if the medication was not in the building.<br>-She did not know the MAs were documenting a medication as administered when the medication was not in the building.<br><br>Interview with the Administrator on 07/25/25 at 12:25pm and on 07/28/25 at 10:00am revealed:<br>-The MA were responsible for documentation of a medication only after it was swallowed by a resident.<br>-She did not know the MAs were documenting a medication as administered when the medication was available to be administered.<br><br>2. Review of Resident #5's current FL2 dated 01/25/25 revealed:<br>-Diagnoses included essential hypertension, hypothyroidism and hypercholesterolemia.<br>-He was intermittently disoriented.<br>-He was semi-ambulatory.<br>-His recommended level of care was domiciliary.<br><br>Review of Resident #5's Resident Register revealed an admission date of 01/02/23 | D 367 | | |

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| D 367 | Continued From page 96<br><br>Review of Resident #5's Physician orders dated 04/16/25 revealed an order for levothyroxine (used to treat hyperthyroidism) 100 mcg by mouth once daily.<br><br>Review of Resident #5's May 2025 eMAR revealed:<br>-There was an entry for levothyroxine 100 mcg by mouth one daily.<br>-Levothyroxine 100 mcg was documented as not administered due to waiting on pharmacy on 05/02/25, 05/05/25 and on 05/09/25.<br>-Levothyroxine 100 mcg was documented as not administered due to medication unavailable on 05/10/25 and on 05/16/25.<br>-Levothyroxine 100 mcg was documented as administered on 05/03/25, 05/04/25, 05/06/25 through 05/08/25, 05/11/25 through 05/15/25 and on 05/17/25.<br><br>Review of Resident #5's staff charting note dated 05/17/25 revealed Resident #5 had not received levothyroxine from 05/02/25 through 05/17/25.<br><br>Telephone interview with the facilities contracted Pharmacist on 07/25/25 at 11:30am revealed:<br>-The pharmacy had sent a message to facility on 04/22/25 requesting a new prescription for Resident #5's levothyroxine 100 mcg with no response received.<br>-The pharmacy did receive a resupply request from the facility on 05/16/25.<br>-The pharmacy did dispense 15 tablets of levothyroxine 100 mcg on 05/17/25.<br>-Resident #5 could experience fatigue, weight loss and dry skin if levothyroxine was not being administered as ordered.<br><br>Interview with a third shift MA on 07/29/25 at 9:58am revealed: | D 367 | | |

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| D 367 | Continued From page 97<br>-She did not know Resident #5 had been out of his levothyroxine 100 mcg until the RCC had made her aware.<br>-She had mistakenly documented administering Resident #5's levothyroxine 100 mcg, and "just hit the button by mistake" a total of eight times when the medication was unavailable.<br>-MAs should make sure medications were available for administration before documenting the medication was administered.<br>-She did not compare Resident #5's medications to his eMAR prior to administrating his medications.<br><br>Interview with the RCC on 07/29/25 at 10:38am revealed:<br>-She could not say why Resident #5 was without his levothyroxine 100 mcg.<br>-MAs are supposed to compare the medication to the eMAR three times before administering medications to residents.<br>-MAs should always document a reason why medications were not available for administration.<br>-She was the one who contacted the pharmacy after it was discovered that Resident #5 had been without his levothyroxine 100 mcg after reviewing his May 2025 eMAR.<br><br>Interview with the Administrator on 07/30/25 at 5:03pm revealed:<br>-She did not know Resident #5 had been without his levothyroxine 100mcg.<br>-She expected MAs to correctly document on eMAR.<br><br>3. Review of Resident #7's current FL-2 dated 02/15/24 revealed:<br>- Diagnoses included dementia without behavioral | D 367 | | |

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disturbances; irritability/agitation/depression; hyperlipidemia; hypothyroidism; osteoporosis; rheumatoid arthritis; aortic valve disorder; hyperglyceridemia.
- She was ambulatory and constantly disoriented.

Review or Resident #7's Resident Register revealed she was admitted to the facility on 02/15/24.

Review of Resident #7's signed physician orders dated 02/26/25 revealed an order for Thrombo-Embolic Deterrent (TED) hose, apply in AM and remove in PM; scheduled for 5:00am and 7:00pm.

Review of Resident #7's current Licensed Health Professional Support (LHPS) review dated 07/08/25 revealed:
-Applying and removing TED hose was documented as a task
-At the time of the assessment on 07/08/25, Resident #7 was not wearing her TED hose.
- No changes or follow-up were recommended.
- The nurse who conducted the assessment on 07/08/25 documented that staff had been trained on applying and removing TED hose.

Review of Resident #7's current care plan dated 01/02/25 revealed:
- Resident #7 required limited assistance with bathing, dressing, grooming, transferring and eating, and was independent with toileting and ambulation.
- Applying and removing Resident #7's TED hose was listed as a task.
Observations of resident #7 revealed:
- On 07/23/25 at 12:10pm, she did not have on TED hose.
- On 07/24/25 at 2:20pm she did not have on

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TED hose.
- On 07/25/25 at 8:30am she did not have on TED hose.
- On 07/28/25 at 8:35am she did not have on TED hose.

Review of resident #7 July 2025 electronic Medication Administration Record (eMAR) revealed:
- There was an entry for TED house with an original start date of 11/19/24, documenting TEDs should be applied in the AM and removed in the PM, scheduled for application at 5:00am and removal at 7:00pm.
-TED hose were documented as applied on 07/23/25, 07/24/25, 07/25/25 and 07/28/25 in the AM.
-The TED hose were documented as removed on 07/23/25, 07/24/25 and 07/25/25 in the PM.

Interview with a MA on 07/24/25 revealed:
- She usually worked first shift.
- Third shift staff were responsible for applying Resident #7's TED hose and also for documenting application on the eMAR.
- She occasionally checked to see if Resident #7 was wearing her TED hose and would apply them if she noticed she was not wearing them.
- When she applied TED hose for Resident #7 during first shift, she would not document it because it was not a scheduled task during first shift.
- Second shift was responsible for removing Resident #7's TED hose and document on the eMAR.

Interview with a second MA staff on 07/29/25 at 10:25am revealed:
- She usually worked third shift.
- Resident #7 was "mostly independent" and was

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| D 367 | Continued From page 100<br>usually up and dressed with her shoes on before 5:00am.<br>- If Resident #7 was already dressed for the day with her shoes on, she would not put Resident #7's TED hose on.<br>- Resident #7's TED hose were kept in her room and were accessible to staff.<br>-Resident #7 never refused to wear her TED hose.<br>- She usually documented Resident #7's TED hose on the eMAR toward the end of the shift because of the time they were scheduled to be applied.<br>- She documented she applied Resident #7's TED hose daily because "there was no way to document on the eMAR that she was already up and dressed" and therefore, staff could not apply the TED hose.<br><br>Interview with Administrator on 07/29/25 at 2:33pm revealed:<br>- When staff were unable to apply a resident's TED hose, they were supposed to report it to the RCC and the Special Care Coordinator (SCC).<br>- The care manager was responsible for notifying the resident's provider and following up to schedule a visit to assess if the resident needed to continue using TED hose.<br>- She was not aware that Resident #7's TED hose were being documented as administered when they were not being applied for the resident. | D 367 | | |
| D 411 | 10A NCAC 13F .1010 (d) Pharmaceutical Services<br><br>10A NCAC 13F .1010 Pharmaceutical Services (d) The facility shall assure the provision of medication for residents on temporary leave from the facility or involved in day activities out of the | D 411 | | |

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facility. The facility shall have written policies and procedures for a resident's temporary leave of absence. The policies and procedures shall facilitate safe administration by assuring that upon receipt of the medication for a leave of absence the resident or the person accompanying the resident is able to identify the medication, dosage, and administration time for each medication provided for the temporary leave of absence. The policies and procedures shall include the following provisions:
(1) The amount of resident's medications provided shall be sufficient and necessary to cover the duration of the resident's absence. For the purposes of this Rule, sufficient and necessary means the amount of medication to be administered during the leave of absence or only a current dose pack, card, or container if the current dose pack, card, or container has enough medication for the planned absence;
(2) written and verbal instructions for each medication to be released for the resident's absence shall be provided to the resident or the person accompanying the resident upon the medication's release from the facility and shall include:
(A) the name and strength of the medication;
(B) the directions for administration as prescribed by the resident's physician; and
(C) any cautionary information from the original prescription package if the information is not on the container released for the leave of absence;
(3) the resident's medication shall be provided in a capped or closed container that will protect the medications from contamination and spillage; and
(4) labeling of each of the resident's individual medication containers for the leave of absence shall be legible, include at least the name of the resident and the name and strength of the

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medication, and be affixed to each container.
The facility shall maintain documentation in the resident's record of medications provided for the resident's leave of absence, including the quantity released from the facility and the quantity returned to the facility. The documentation of the quantities of medications released from and returned to the facility for a resident's leave of absence shall be verified by signature of the facility staff and resident or the person accompanying the resident upon the medications' release from and return to the facility.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure the provision of medication for 2 of 2 sampled residents who went on temporary leave from the facility for a week without instructions of all medications to be administered (#3) and when medications were not reconciliation after medication were brought in from an outside pharmacy (#9).

The findings are:

Review of the facility's policy for Medications Leaving and Returning dated September 2021 revealed:
-When more than one dosage of medication was required for temporary leave of a resident, the medications would be packaged in their entirety by the medication staff.
-Staff would document all medication leaving the facility using the Medication Release form.
-Multi-dose packs, individual pill bottles and single dose blister packs were to be prepared according

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to the specific time period the resident would be out of the facility.
-The original container and directions for administration must be provided to the resident or responsible party.
-The resident/responsible party must sign the Medication Release Form with acknowledgement of receipt of the medications.
-Staff were to print a Resident Flow sheet to send with the Medication Release Form.
-Documentation would be kept in the facility, readily available, and would include the medication name, quantity released, and quantity returned.

The findings are:

1. Review of Resident #3's current FL2 dated 04/29/24 revealed diagnoses included Parkinson's disease.

Review of Resident #3's signed physician's orders dated 12/30/24 revealed:
-An order for acetaminophen (used to treat pain) 500mg three times a day.
-An order for arformoterol (used to treat chronic obstructive pulmonary disease) nebulizer solution 15mcg/2ml, two times a day.
-An order for aspirin (a blood thinner) 81mg, every day.
-An order for atorvastatin (used to treat high cholesterol) 40mg, at bedtime.
-An order for buspirone (used to treat anxiety) 5mg, two times a day.
-An order for carbidopa-levodopa (used to treat Parkinson's disease) 25-100mg, take 1-1/2 tablet four times a day.
-An order for certrazine (an allergy medications) 10mg, at bedtime.
-An order for cholecalciferol (used to treat vitamin

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D deficiency) 25mcg, two times a day.
-An order for diclofenac (used to treat pain) sodium, apply 4 grams topically three times a day to each knee.
-An order for famotidine (used to treat increased acid production) 40mg, at bedtime.
-An order for fluticasone (used to treat allergies) propionate 50mcg/actuation, 2 sprays in each nostril each day.
-An order for gabapentin (used to treat nerve pain) 250mg/5ml, take 7.5ml, two times a day.
-An order for levetiracetam (used to treat seizures) 100mg/ml, take 5mls, two times a day.
-An order for levothyroxine (used to treat a deficiency in the thyroid) 50mcg, every day.
-An order for montelukast (used to treat increased mucous), 10mg, every day.
-An order for multivitamin (used to treat vitamin deficiencies) every day.
-An order for omeprazole (used to treat increased stomach acid), 40mg every morning.
-An order for promethazine-dm (used to treat cough) 6.25-15mg/5ml, every 6 hours as needed for cough.
-An order for zinc gluconate (used to treat common cold), 50mg every day.
-An order for continuous oxygen at 2lt via nasal annual.

Review of Resident #3's signed physician's order dated 06/13/25 revealed an order for prednisone 10mg a day for 10 day and then 5mg a day for 10 days.

Review of Resident #3's June 2025 electronic medication administration record (eMAR) revealed Resident #'s medications were documented as Resident #3 was on "therapeutic leave from" 06/19/25 to 06/24/25.

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| D 411 | Continued From page 105<br>Review of Resident #3's record revealed there was no signed Medication Release Form.<br><br>Interview with Resident #3 on 07/24/25 at 2:50pm revealed:<br>-Sometime in the beginning of May 2025, she informed the medication aides (MA), Resident Care Coordinator (RCC) and the Administrator that she would be going out of town for a week and needed her medications ready.<br>-She needed to be ready by 6:00am on 06/19/25 in order to drive to the airport and catch a flight by 9:00am.<br>-She reminded the staff every week including the day before.<br>-On 06/19/24, a family member was at the facility at 5:00am to pick her up.<br>-When family member arrived, she had not had her levothyroxine and they had to hunt down a MA to get her early medication and the rest of her medications for the trip.<br>-There were to third shift MAs on duty that were not made aware of the plans and her medications were not ready.<br>-There was no note for the third shift MA about the medications needing to be ready.<br>-One of the MAs called the RCC and as told to get all of her medications ready for a 7 day stay.<br>-The third shift MA could not find all of her medications in the medication cart.<br>-She had some medications in a multidose pack, liquids, pill bottles and single dose blister packs.<br>-She was told by the MAs that there was not enough of her medications to be sent with her.<br>-A MA was on the phone with the RCC while the MA was pulling all kinds of medications out of the medication cart.<br>-The RCC gave her several clear plastic bags with pills, multidose packs, and bottles with liquids in them. | D 411 | | |

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| D 411 | Continued From page 106<br>-There was no instructions/eMAR and the RCC told her to read the bottles.<br>-They were late and they took the bags and left.<br>-When she arrived at the airport at her destination she took out the plastic bags to take her morning medications and realized that she did not have two of her medications, the levothyroxine and prednisone.<br>-The levothyroxine was the medication the MA had not given her that morning before she left for the airport and the prednisone was ordered by her pulmonologist due to an upper respiratory infection.<br>-A family member with her called her primary care provider's (PCP) office a the levothyroxine and prednisone was re-ordered and sent to a pharmacy close by the airport.<br>-She took a lot of medications so a family member asked her PCP about all of the medication she was on, when to take them and how much to take to make sure they had them all.<br><br>Telephone interview with Resident #3's family member on 07/24/25 at 3:58pm revealed:<br>-Sometime in the beginning of May 2025, he and Resident #3 told the MAs, RCC and the Administrator that Resident #3 would be leaving on a seven day trip and needed to have everything ready by 6:00am on 06/19/25.<br>-On 06/19/25 he arrived at 5:00am to get Resident #3 out the door and to the airport for a 9:00am flight.<br>-When he arrived Resident #3 had not had her morning medications and her medications were not ready.<br>-He called the Administrator six times without an answer.<br>-The third shift MAs had not been informed about the trip. | D 411 | | |

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| D 411 | Continued From page 107<br>-It took at least an hour for the staff to get Resident #3's medications ready.<br>-He was told by the RCC that they did not have enough of Resident #3's medications available, yet somehow the RCC handed him several clear plastic bags of Resident #3's medications.<br>-The clear plastic bags had bottles containing liquid medications with instructions, "punched out single pills", single multidose packs torn apart from the main card.<br>-At the destination airport Resident #3 realized that her levothyroxine and prednisone were not with her medications.<br>-He called the facility and talked to the RCC and was told she could not help him so he called Resident #3's PCP and the pulmonologist and was able to re-order the levothyroxine and prednisone and pick it up at a local pharmacy.<br>-Resident #3's PCP was able to go over all of Resident #3's medications to provide instructions and to make sure all of the other medications were there.<br><br>Telephone interview with a MA on 07/24/25 at 1:10pm revealed:<br>-Around the middle of June 2025, Resident #3 was to leave at 6:00am but her medications were not ready and there was only enough for three days worth of Resident #3's medications.<br>-The RCC came in and told her to get medications from other residents that were the same at what Resident #3 took.<br>-She pulled medications from other residents, expired stock and the medication cabinet from the Assisted Living and Special Care Unit.<br>-She took the medications to the RCC and the RCC made plastic bags with medications for Resident #3 to take while out of the facility.<br>-The RCC prepared all of Resident #32's medications. | D 411 | | |

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| D 411 | Continued From page 108<br>-Third shift MAs were not notified about Resident #3 leaving for her trip and to have the medications ready.<br><br>Interview with the RCC on 07/24/25 at 4:30pm revealed:<br>-Resident #3 let her know she would be out of town for about a week and she would need her mediations ready by 6:00am so she could leave.<br>-On 06/19/25, a MA called her and told her that Resident #3's medications were not ready and that there was only 3 days worth of medication available to give to Resident #3.<br>-She came into the facility and had very little time to get Resident #3's medications ready to go.<br>-The MA only brought medications out of the medication cart and did not check the over flow which was where the cycle fill medication were kept to get ready for the next week.<br>-She pulled the medications that were in the multidose packs from there to get Resident #3 out the door.<br>-Resident #3 had enough of her liquid and other bottled medications to get her through the 7 days while she would be out of the facility.<br>-She placed the loose multi dose pack in bags with Resident #3's name on it and time to be administered.<br>-The other medications had labels on them and she thought that was ok to do.<br>-She did not send a copy of the eMAR and she did not know that she had forgotten the levothyroxine and prednisone.<br>-The levothyroxine was separate because it was a 6:30am medications and was not in the multidose packs and the prednisone was a new prescription.<br>She did not complete a Medication Release Form because there was no time. | D 411 | | |

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| D 411 | Continued From page 109<br><br>Interview with the Administrator on 07/29/25 at 1:15pm revealed:<br>-She did not know Resident #3's medications were not prepared per policy.<br>-She did not know until Resident #3's family member called and informed the RCC that Resident #3's was missing her levothyroxine and prednisone.<br><br>Attempted telephone interview with Resident #3's PCP on 07/24/25 at 4:15pm was unsuccessful.<br><br>Attempted telephone interview with Resident #3's pulmonologist on 07/24/25 at 4:20pm was unsuccessful.<br><br>Refer to interview with the Administrator on 07/29/25 at 1:15pm.<br><br>2. Review of Resident #9's current FL2 dated 12/31/25 revealed diagnoses included vascular dementia, coronary artery disease, hypertension and benign prostatic hyperplasia (an enlarged prostrate).<br><br>Review of Resident #9's Mental Health Provider's (MHP) signed physician orders revealed:<br>-On 06/11/25, there was an order to discontinue duloxetine (used to treat mood disorders) 20mg two times a day.<br>-There was an order for duloxetine 20mg every day at bedtime.<br>-There was an order for sertraline (used to treat depression) 25mg every day.<br>-On 06/25/25, there was an order to discontinue duloxetine 20mg at bedtime.<br>-On 07/23/25, there was an order for sertraline 50mg every day.<br><br>Interview with Resident #9's Power of Attorney | D 411 | | |

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| D 411 | Continued From page 110<br>(POA) on 07/25/25 at 11:30am revealed:<br>-There were so many issues with Resident #9's getting his medications ordered and who was ordering what.<br>-When she was notified that medications were ready to be picked up at the pharmacy, she would pick up the medications and bring them to the facility and give them to the MA.<br>-She did not receive a receipt and the MA did not compare the prescription to the provider's orders, the MA would just put them in the medication cart.<br>-If the MAs would have checked in the medications and checked the orders, then maybe the MAs would have noticed the medications had changed.<br><br>Refer to the interview with the Administrator on 07/29/25 at 1:15pm.<br><br>_____<br><br>Interview with the Administrator on 07/29/25 at 1:15pm revealed:<br>-The MAs were responsible to prepare a resident's medications when a resident would be out of the facility and would miss there medication administration times.<br>-The MAs or RCC were responsible to fill out a Medication Release Form, list all medications, dosages, administration times and quantity dispensed and give verbal instructions to the resident or responsible person.<br>-A copy of the eMAR would have been something the MA could send with the Resident or responsible party.<br>-She did not have a policy to check in medications from an outside pharmacy when the family brought in the medications. | D 411 | | |

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| D 451 | Continued From page 111 | D 451 | | |
| D 451 | 10A NCAC 13F .1212(a) Reporting of Accidents and Incidents<br><br>10A NCAC 13F .1212 Reporting of Accidents and Incidents<br>(a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid.<br><br>This Rule is not met as evidenced by:<br>Based on interviews and record reviews, the facility failed to notify the local county Department of Social Services (DSS) for incidents involving 4 of 7 sampled residents (Resident #2, #5, #7 and #8) who received injuries that required emergency medical treatment.<br><br>The findings are:<br><br>Review of the facility's accident and fall management policy dated September 2021 revealed:<br>-Send for or call for help.<br>-Evaluate the situation.<br>-Call 911, or have someone call 911, if necessary.<br>-Assess the resident.<br>-If injury is apparent or possible, do not move resident.<br>-Administer first aide as appropriate.<br>-Call/notify the resident's physician and responsible party.<br>-If injury, complete the report of accident and incident form. | D 451 | | |

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| D 451 | Continued From page 112<br>-If the accident or incident requires intervention greater than first aid, the accident and incident report form should be sent to the local county Department of Social Services within 48 hours.<br><br>1. Review of Resident #2's current FL2 dated 08/08/24 revealed:<br>-Diagnoses included dementia, altered mental status and unspecified behavioral involuntary movements.<br>-She was ambulatory.<br>-She was constantly disoriented.<br>-Her level of care was Special Care Unit (SCU).<br><br>Review of Resident #2's Accident/Incident Report dated 06/12/25 at 10:29am revealed:<br>-Resident #2 was found on the floor of her room.<br>-The incident was not witnessed by a staff member.<br>-She did not exhibit or complain of pain and/or injury.<br>-She would arouse when her name was called.<br><br>Review of Resident #2's Emergency Medical Service (EMS) encounter document dated 06/12/25 revealed:<br>-Resident #2's mental status was normal baseline for patient.<br>-She had no outward injuries and showed no signs of pain during palpation.<br>-She was assisted up and began to stand and move with little assistance.<br><br>Review of Resident #2's Emergency Department (ED) visit note dated 06/12/25 at 11:08am revealed:<br>-Resident #2 was not in acute distress.<br>-She had no fractures or injuries noted after evaluation<br>-She was ambulatory to her baseline. | D 451 | | |

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| D 451 | Continued From page 113<br>-She was discharged back to the facility.<br>-The Accident/Incident report was not completed until 06/23/25.<br>-It was documented on the Accident/Incident report that it was emailed to DSS at an unknown date, but DSS did not receive it.<br><br>Interview with the local county DSS Adult Home Specialist (AHS) on 07/07/24/25 at 10:00am revealed she did not receive an Accident/Incident Report from the facility for Resident #2's fall occurring 06/12/25, which required an emergency medical evaluation and medical treatment other than first aid.<br><br>Interview with the Special Care Coordinator (SCC) on 07/29/25 at 10:40am revealed:<br>-The MA completed an "event" form in the online documentation system, notified the provider and notified family members.<br>-The Administrator was responsible for sending the Accident/Incident report to DSS.<br>-She was not sure who would be responsible for sending the form if the Administrator was not in the building.<br><br>Interview with the Administrator on 07/29/25 at 3:00pm revealed:<br>-Her expectation was that staff must notify her first of all accidents or injuries in the building, even if they are not reportable to DSS.<br>-If a PCA witnessed an event, they were responsible for reporting this to the MA "in its entirety."<br>-The RCC or SCC reviews the Accident/Incident report first and they can add observations in the online system.<br>-She reviews most of the Accident/Incident reports and all of the reportable ones, which she sends to DSS. | D 451 | | |

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| D 451 | Continued From page 114<br>-She believed she had 3 days to fax the reports to DSS and that she first had to wait until the report was completed.<br>-She did not realize an Accident/Incident report was documented as completed late on 06/23/25 but was not received by DSS.<br><br>2. Review of Resident #5's current FL2 dated 01/25/25 revealed:<br>-Diagnoses included essential hypertension, hypothyroidism and hypercholesterolemia.<br>-He was intermittently disoriented.<br>-He was semi-ambulatory.<br>-His recommended level of care was domiciliary.<br><br>Review of Resident #5's Resident Register revealed an admission date of 01/02/23.<br><br>Review of Resident #5's Care Plan dated 01/16/25 revealed:<br>-He was ambulatory with aide or devices with a walker and wheelchair listed.<br>-He was sometimes disorientated.<br>-He was forgetful and needed reminders.<br>-He required limited assistance with eating, toileting, dressing, grooming and transfers.<br>-He required extensive assistance with bathing.<br><br>Review of Resident #5's Accident and Incident report dated 05/09/25 revealed:<br>-He was sent to the ED due to an unwitnessed fall where he was observed laying on his back, beside his bed.<br>-There was no documentation the local county DSS had been notified.<br>-No was documented for care plan updated.<br><br>Review of Resident #5's ED visit note dated 05/09/25 revealed: | D 451 | | |

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| D 451 | Continued From page 115<br>-He was sent to the ED due to an unwitnessed fall where he was found on the floor.<br>-He was evaluated and discharged back to the facility.<br><br>Review of Resident #5's staff charting note dated 05/09/25 at 9:25am revealed he was sent to the local ED due to a fall.<br><br>Interview with the AHS at the county DSS on 07/24/25 at 4:15pm revealed she had not been notified or had received an accident/incident report for Resident #5's 06/09/25 fall that required emergency treatment at the local hospital.<br><br>Refer to the interview with the Administrator on 07/29/25 at 2:33pm.<br><br>3. Review of Resident #7's current FL-2 dated 02/15/24 revealed:<br>- Diagnoses included: dementia without behavioral disturbances, irritability/agitation/depression, hyperlipidemia (high cholesterol), hypothyroidism (underactive thyroid gland), osteoporosis, rheumatoid arthritis, aortic valve disorder and hyperglyceridemia (elevated levels of triglycerides or a fat in the blood).<br>- She was ambulatory and constantly disoriented.<br><br>Review or Resident #7's Resident Register revealed an admission date of 02/15/24.<br><br>Review of Resident #7 staff progress note dated 07/16/25 revealed she fell and was sent out to the ED for evaluation.<br><br>Review of Resident #7 ED Provider notes dated | D 451 | | |

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| D 451 | Continued From page 116 | D 451 | | |

07/16/25 revealed:
- She reported she was getting up to go to the bathroom and fell but did not hit her head.
- There was no acute fracture or multilevel degenerative changes from previous encounter.
- She was sent back to the facility.

Review of the local county DSS records revealed the facility did not report Resident #7's fall on 07/16/25 which required emergency medical evaluation to the agency, until 07/24/25.

4. Review of Resident #8's current FL2 dated 09/12/24 revealed:
- Diagnoses included Alzheimer's disease, type II diabetes mellitus, generalized anxiety disorder and hypercholesterolemia (high blood cholesterol).
-She was semi-ambulatory and intermittently disoriented.

Review of Resident #8's Resident Register revealed an admission date of 10/09/23.

Review of Resident #8's progress notes dated 07/20/25 revealed she was found on the floor and was sent out to the ED for evaluation following a fall.

Review of Resident #8's Emergency Department provider notes from 07/20/25 revealed:
-She was seen at the ED for a suspected fall after staff found her on the ground near her wheelchair.
- There was no evidence of acute intracranial abnormality found.
- She was not admitted to the hospital and returned to the facility.

Review of local county DSS records revealed that

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| D 451 | Continued From page 117<br>facility did not report that Resident #8 fell on 07/20/25 and required an emergency medical evaluation.<br><br>Refer to the interview with the Administrator on 07/29/25 at 2:33pm.<br><br>_____<br>Interview with the Administrator on 07/29/25 at 2:33pm revealed:<br>- When an accident or incident occurred, the staff member who witnessed it was supposed to report it to the MA, who was to complete an incident and accident report.<br>- The RCC and the SCC were required to review incident and accident reports and add additional information as needed.<br>- Once the form was completed and reviewed by the RCC or SCC, she signed them and then faxed them to DSS.<br>- She was not aware that the report needed to be sent to DSS within 48 hours of the incident. | D 451 | | |
| D 465 | 10A NCAC 13F .1308(a) Special Care Unit Staff<br><br>10A NCAC 13F .1308 Special Care Unit Staff<br>(a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident.<br><br>This Rule is not met as evidenced by:<br>Based on interviews and record reviews, the | D 465 | | |

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| D 465 | Continued From page 118 | D 465 | | |

facility failed to ensure required staffing hours were met on all three shifts in the Special Care Unit (SCU) based on a census of 21 residents for 6 out of 42 shifts.

The findings are:

Review of the facility's current license by the Division of Health Service Regulation effective 01/01/25 revealed the facility was a licensed Special Care Unit (SCU) with a capacity of 32 residents.

Review of the facility's census from 06/03/25 to 06/16/25 revealed there was a census of 21 residents which required 21 staff hours on first and second shifts, and 16.8 staff hours on third shift.

Review of the staff time records from 06/03/25 to 06/16/25 revealed:
-On 06/07/25, the census was 21 requiring 21 hours on second shift and a total of 11.75 hours were provided leaving a shortage of 9.25 staff hours.
-On 06/08/25, the census was 21 requiring 21 staff hours on first shift and a total of 19 hours were provided leaving a shortage of 2 staff hours.
-On 06/10/25, the census was 21 requiring 21 staff hours on first shift and a total of 16 hours were provided leaving a shortage of 5 staff hours.
-On 06/11/25, the census was 21 requiring 16.8 staff hours on third shift and a total of 15 hours were provided leaving a shortage of 1.8 staff hours.
-On 06/14/25, the census was 21 requiring 21 staff hours on first shift and a total of 16.5 hours were provided leaving a shortage of 4.5 staff hours.
-On 06/16/25, the census was 21 requiring 16.8

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| D 465 | Continued From page 119<br>staff hours on third shift and a total of 15.75 hours were provided leaving a shortage of 1.05 staff hours.<br><br>Interview with the Administrator on 07/29/25 at 2:33pm revealed:<br>-The Resident Care Coordinator (RCC) was responsible for completing the schedule and ensuring coverage for the unit.<br>-Call outs are to be made to the RCC.<br>-The RCC was responsible for finding coverage and/or coming in to ensure there is proper staffing on the unit.<br>-The medication aide (MA) supervisors were able to make changes to the schedule to move staff around to ensure coverage for the shift.<br>-Any changes the MA supervisors made to the schedule were reported to the RCC.<br>-The RCC was responsible for updating the staffing schedule and providing the Administrator with a copy. | D 465 | | |