STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL093001	A. BUILDING: _____ B. WING _____	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYD'S REST HOME #1	295 CARROLLTOWN ROAD MACON, NC 27551

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on September 16, 2025 through September 17, 2025 with a telephone exit on September 17, 2025.	C 000		
C 007	10A NCAC 13G .0206 Capacity 10A NCAC 13G .0206 Capacity (a) Pursuant to G.S. 131D-2.1(9), family care homes shall have a capacity of two to six residents. For the purposes of this Rule, "capacity" means the maximum number of residents permitted to live in a licensed family care home in accordance with the North Carolina Building Code and the evacuation capability of each resident. (b) The total number of residents shall not exceed the number shown on the license. The license shall indicate the facility's capacity for ambulatory and non-ambulatory individuals permitted to live in the facility. For the purposes of this Rule, "ambulatory" means the individual is able to respond and evacuate from the facility without verbal or physical assistance from others in the event of an emergency. "Non-ambulatory" means the individual is not able to respond and evacuate from the facility without verbal or physical assistance from others in the event of an emergency. (c) A request for an increase in capacity by adding rooms, remodeling, or without building modifications shall be made to the county department of social services and submitted to the Division of Health Service Regulation Construction Section and shall include two copies of blueprints or floor plans. One plan shall show the existing building with the current use of rooms, and the second plan showing the addition,	C 007		

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C 007	Continued From page 1	C 007		

remodeling, or change in use of spaces, and showing the use of every room. If new construction, the second plan shall show how the addition will be tied into the existing building and all proposed changes in the structure.
(d) When licensed facilities increase their designed capacity by the addition to or remodeling of the existing physical plant, the entire facility shall meet all current fire safety regulations required by city ordinances or county building inspectors.
(e) The licensee or the licensee's designee shall notify the Division of Health Service Regulation Adult Care Licensure Section if the evacuation capabilities of the residents changes and the facility no longer complies with the facility's licensed capacity as listed on the facility's license, or of the addition of any non-resident who will be living within the facility.
(f) If there is a temporary change in the capacity of the facility due to a resident's short term illness or condition that renders the resident temporarily non-ambulatory, such as end of life condition, the licensee or the licensee's designee shall immediately notify the Division of Health Service Regulation Construction Section upon the knowledge of the change in the resident's ambulatory status.

This Rule is not met as evidenced by:
Based on observations, interviews, and record

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C 007	Continued From page 2	C 007		

reviews, the facility failed to notify the Division of Health Service Regulation (DHSR) that the resident's evacuation capabilities were different from the evacuation capabilities listed on the facility's license for 1 of 2 sampled residents who did not exit the facility during a fire drill.

The findings are:

Review of the facility's current license effective 01/01/25 revealed the facility was licensed for 5 ambulatory residents.

Review of the facility's census on 09/16/25 revealed there were 5 residents.

Review of the facility's policy and procedure on fire drills revealed:
-The facility would conduct a minimum of 12 unannounced fire drills per year, with at least one drill conducted on each shift (day, evening, and night) to ensure all staff members were trained and prepared to respond.
-The purpose of these drills was to ensure that all staff and residents were familiar with the fire evacuation plan and emergency procedures.
-Practice the safe and efficient evacuation of residents, including those with mobility limitations and specialized needs.
-Assess staff response time and effectiveness in a simulated emergency.
-Drills would be conducted monthly, at a minimum, and would be unannounced to staff to simulate a real emergency; the four required annual drills would be spread across all three shifts (day, evening, and night).
-All staff would be trained upon employment and annually on the facility's fire evacuation plan, their specific roles and responsibilities, and the use of fire extinguishers.

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C 007	Continued From page 3 -The drill would be initiated by activating the fire alarm system from a pull station. If a fire alarm system were not in place, an alternative audible notification method would be used as approved by the local fire marshal. -Residents would be assisted in evacuating to a designated assembly point outside the building, which was a safe distance away and did not obstruct fire department access. -Once at the assembly point, a staff member would take a final headcount of all residents and staff to ensure everyone had safely evacuated. -Immediately following the drill, the drill coordinator would conduct a critique with all participating staff members. This was an opportunity to evaluate the effectiveness of the drill, identify any issues or areas for improvement, and discuss what worked well. -The documentation for each drill must include the date of the drill, the time of the drill, the shift during which the drill was conducted (day, evening, or night), names of all staff members present, and a short description of the drill, including the simulated scenario and a summary of the outcome. Review of the facility's fire rehearsal schedule revealed: -On 01/12/25 at 6:00am, the time for evacuation was 5 minutes, and residents were evacuated to the safe zone; there was no information related to the number of residents. -On 02/05/25 at 3:00pm, there was no documentation of the number of residents present, evacuation time, or description of the fire drill. -On 03/04/25 at 3:15pm, there was no documentation of the number of residents present, evacuation time, or description of the fire drill.	C 007		

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C 007	Continued From page 4 -On 04/19/25, the first shift was circled; there was no documentation of the time, number of residents present, evacuation time, or description of the fire drill. -On 05/06/25 at 1:00am, the time for evacuation was 7 minutes; there was no information related to the number of residents or description of the fire drill. -On 06/20/25, the first shift was circled; there was no documentation of the time, number of residents present, evacuation time, or description of the fire drill. -On 07/09/25 at 2:00pm, there was no documentation of the number of residents present, evacuation time, or description of the fire drill. Observation of the facility 09/16/25 at 12:31pm revealed: -A resident was sitting on his bed. -The Co-Administrator activated the smoke detector. -An audible beeping noise could be heard throughout the facility. -The resident took off his shoes, adjusted his pillow, and lay down on the bed. Interviews with the Co-Administrator on 09/16/25 at 10:11am and 2:10pm revealed: -He conducted fire drills once a month. -He activated a smoke detector to do the fire drills. -All the residents exited the facility. -A [named] resident would exit the facility, but had to be guided once the resident was outside to the meeting location. -Three residents sometimes exited the facility on their own and sometimes the residents needed someone to tell them. -The facility had a buddy system for the residents	C 007		

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C 007	Continued From page 5 to make sure their roommates got out. Telephone interview with the Administrator on 09/17/25 at 12:30pm revealed: -There were two residents who had to be told to exit the facility during fire drills. -She knew residents had to be ambulatory and evacuate the facility without assistance during fire drills. -All the residents could walk it was "just their minds". -She did not know she needed to call construction because the residents needed to be told to exit the facility during a fire drill. Refer to Tag C0022 10A NCAC 13G .0302(b) Design and Construction.	C 007		
C 021	10A NCAC 13G .0302 (a) Design And Construction 10A NCAC 13G .0302 Design And Construction (a) A building licensed for the first time as a family care home, or a licensed family care home relicensed after the license is terminated for more than 60 days, shall meet the requirements of the North Carolina State Building Code: Residential Code in effect at the time of licensure or relicensure. Additionally, facilities requesting licensure or relicensure for four to six residents shall meet the North Carolina State Building Code: Building Code, Licensed Residential Care Facilities Section in effect at the time of licensure or relicensure. The North Carolina State Building Codes, which are hereby incorporated by reference, including all subsequent amendments and editions, may be purchased from the International Code Council online at	C 021		

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C 021	Continued From page 6 https://shop.iccsafe.org/ at a cost of eight hundred fifty-eight dollars ($858.00) or accessed electronically free of charge at https://codes.iccsafe.org/codes/north-carolina. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the residents' evacuation capabilities were in accordance with the evacuation capability listed on the facility's current license for 1 of 4 sampled residents including one resident who did not respond to a fire alarm (#1). The findings are: Review of the facility's current license effective 01/01/25 revealed the facility was licensed for 5 ambulatory residents. Review of the facility's policy and procedure on fire drills revealed: -The facility would conduct a minimum of 12 unannounced fire drills per year, with at least one drill conducted on each shift (day, evening, and night) to ensure all staff members were trained and prepared to respond. -The purpose of these drills was to ensure that all staff and residents were familiar with the fire evacuation plan and emergency procedures. -Practice the safe and efficient evacuation of	C 021		

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C 021	Continued From page 7	C 021		

residents, including those with mobility limitations and specialized needs.
-Assess staff response time and effectiveness in a simulated emergency.
-Drills would be conducted monthly, at a minimum, and would be unannounced to staff to simulate a real emergency; the four required annual drills would be spread across all three shifts (day, evening, and night).
-All staff would be trained upon employment and annually on the facility's fire evacuation plan, their specific roles and responsibilities, and the use of fire extinguishers.
-The drill would be initiated by activating the fire alarm system from a pull station. If a fire alarm system were not in place, an alternative audible notification method would be used as approved by the local fire marshal.
-Residents would be assisted in evacuating to a designated assembly point outside the building, which was a safe distance away and did not obstruct fire department access.
-Once at the assembly point, a staff member would take a final headcount of all residents and staff to ensure everyone had safely evacuated.
-Immediately following the drill, the drill coordinator would conduct a critique with all participating staff members. This was an opportunity to evaluate the effectiveness of the drill, identify any issues or areas for improvement, and discuss what worked well.
-The documentation for each drill must include the date of the drill, the time of the drill, the shift during which the drill was conducted (day, evening, or night), names of all staff members present, and a short description of the drill, including the simulated scenario and a summary of the outcome.

Review of the facility's fire rehearsal schedule

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C 021	Continued From page 8 revealed: -On 01/12/25 at 6:00am, the time for evacuation was 5 minutes, and residents were evacuated to the safe zone; there was no information related to the number of residents. -On 02/05/25 at 3:00pm, there was no documentation of the number of residents present, evacuation time, or description of the fire drill. -On 03/04/25 at 3:15pm, there was no documentation of the number of residents present, evacuation time, or description of the fire drill. -On 04/19/25, the first shift was circled; there was no documentation of the time, number of residents present, evacuation time, or description of the fire drill. -On 05/06/25 at 1:00am, the time for evacuation was 7 minutes; there was no information related to the number of residents or description of the fire drill. -On 06/20/25, the first shift was circled; there was no documentation of the time, number of residents present, evacuation time, or description of the fire drill. -On 07/09/25 at 2:00pm, there was no documentation of the number of residents present, evacuation time, or description of the fire drill. Review of Resident #1's FL2 dated 08/14/25 revealed: -Diagnoses included diabetes, high blood pressure, and intellectual disability. -He required assistance from staff with bathing and dressing. -He was ambulatory. -He was incontinent of bladder. Review of Resident #1's Resident Register	C 021		

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C 021	Continued From page 9 revealed an admission date of 03/29/22. Review of Resident #1's care plan dated 07/05/25 revealed: -The resident was ambulatory. -He required extensive assistance from staff with bathing, dressing, and grooming. -He was oriented to name and place. -There was no documentation for memory. -The care plan was not signed by the primary care provider (PCP). Observation of the facility 09/16/25 at 12:31pm revealed: -Resident #1 was sitting on his bed. -The Co-Administrator activated the smoke detector. -An audible beeping noise could be heard throughout the facility. -Resident #1 took off his shoes, adjusted his pillow, and lay down on the bed. Interview with the Co-Administrator on 09/16/25 at 2:10pm revealed Resident #1 had mental health challenges and sometimes had to be told to exit the facility during fire drills. Telephone interview with Resident #1's family member on 09/16/25 at 3:31pm revealed: -Resident #1 had memory problems. -Resident #1 was not educated, but now that he had a "touch of Alzheimer's," his memory was worse. -He thought Resident #1 would know what a smoke alarm sound was, but with his Alzheimer's disease, it was hard to tell what he knew. -He thought the memory changes he saw in Resident #1 were related to Alzheimer's disease. Telephone interview with the Administrator on	C 021		

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C 021	Continued From page 10 09/16/25 at 12:30pm revealed: -Resident #1's memory was very bad. -Resident #1 had to be told everything. -The facility had a buddy system in place, never leave a buddy behind. -The residents who were able to assist others were told to do the best they could to get their buddy to go outside with them during fire drills. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable. Attempted telephone interview with Resident #1's PCP on 09/16/25 at 1:02pm was unsuccessful. _____ The facility failed to ensure it was equipped and maintained in accordance with its licensed capacity to allow a resident (#1), who was known to require prompting, to evacuate independently in case of an emergency, such as a fire. As a result, the resident did not evacuate during a fire drill. This failure was detrimental to the health, safety, and well-being of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/17/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 1, 2025.	C 021		
C 069	10A NCAC 13G .0312 (g) Outside Entrance And Exits 10A NCAC 13G .0312 Outside Entrance and Exits	C 069		

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C 069	Continued From page 11 (g) In facilities with at least one resident who is determined by a physician or is otherwise observed by staff to be disoriented or exhibiting wandering behavior, all outside entrance/exit doors shall have a continuously sounding device that is activated when the door is opened. The sound shall be audible throughout the facility. If a central system of remote sounding devices is provided, the control panel for the system shall be powered by the facility's electrical system, and be located in an area accessible to staff. Notwithstanding the requirements of Rule .0301 of this Section, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 2 exit doors that were accessible to a resident who was known to have exit-seeking behavior (#1) had alarms that were of sufficient volume that could be heard by staff when activated and responded to for the safety of the resident. The findings are: Observation of the entrance/exit door to the facility on 09/16/25 at various times between 8:15am-3:00pm revealed no alarm sounded when the door to the facility was opened and closed. Observation of a second entrance/exit door to the facility on 09/16/25 at 8:23am revealed the door was in the kitchen, and no alarm sounded when	C 069		

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the door was opened and closed.

Interview with three residents on 09/16/25 between 1:30pm-2:00pm revealed they had not heard door alarms at the facility.

Review of Resident #1's FL2 dated 08/14/25 revealed:
-Diagnoses included diabetes, high blood pressure, and intellectual disability.
-He required assistance with bathing and dressing.
-He was ambulatory.
-He was incontinent of bladder.

Review of Resident #1's Resident Register revealed an admission date of 03/29/22.

Review of Resident #1's care plan dated 07/05/25 revealed:
-The resident was ambulatory.
-He required extensive assistance from staff with bathing, dressing, and grooming.
-He was oriented to name and place.
-There was no documentation for memory.
-The care plan was not signed by the primary care provider (PCP).

Review of Resident #1's incident and accident report dated 03/07/25 revealed:
-Resident #1 wandered off in the middle of the night.
-Resident #1 was last seen around 3:45am.
-Resident #1 was noticed missing around 5:30am.
-Resident #1 returned to the facility around 7:02am.
-The sheriff deputies were looking for Resident #1 until he returned.
-This was the first time Resident #1 had walked

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C 069	Continued From page 13 off. -The Co-Administrator talked to Resident #1 ' s PCP and family member about areas of opportunity for protecting the resident from future wandering incidents. -Resident #1's family member was advised that staff members would keep a watchful eye on Resident #1 going forward. -All staff were briefed on this matter and would be diligent in this matter. Review of Resident #1's 911 communication log dated 03/07/25 revealed: -A call was made to 911 at 5:43am regarding a missing resident, Resident #1. -The resident was last seen at the facility at 3:00am. -At 6:15am, a drone was going to be deployed. -At 6:30am, the resident was reported back at the facility. -At 6:32am, emergency medical services (EMS) were dispatched. -The resident was reported to have been outside for 3 hours, was shaking, cold, and bleeding from his hands and mouth. Telephone interview with Resident #1's family member on 09/16/25 at 3:31pm revealed: -Resident #1 had memory problems. -Resident #1 was not educated, but now that he had a "touch of Alzheimer's", his memory was worse. -He thought the memory changes he saw in Resident #1 were related to Alzheimer's disease. -The Co-Administrator called him when Resident #1 walked away from the facility. -The Co-Administrator assured him he would put measures in place so it would not happen again. -He did not know what the measures were but trusted the Co-Administrator.	C 069		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 069	Continued From page 14 Confidential telephone interview with a staff member revealed: -The facility did not have door alarms. -Staff members kept an eye on all the residents to make sure they were not lost. -No residents had walked away from the facility that she was aware of. -She did not know Resident #1 had left the facility in March 2025. -Resident #1 had memory problems. -If she had known Resident #1 had walked away, she would have made sure he was being watched closely. Interviews with the Co-Administrator on 09/16/25 at 12:32pm and 2:30pm revealed: -He was working at the facility when Resident #1 was discovered missing from the facility. -It was the first time Resident #1 had ever wandered away from the facility. -"Something hit his mind, and he went out in the dark." -He put the buddy system (residents assisted each other) in place after Resident #1 left the facility; everybody was alert to make sure they knew where Resident #1 was. -Resident #1 was moved to the sister facility next door after the incident, but the resident was doing fine, so he moved him back into this facility, and he had been doing fine since then. -The facility never had door alarms. -He thought he might have been in the bathroom cleaning with a buffing machine, and because of the noise, he would not have heard Resident #1 leave the facility. Telephone interview with the Administrator on 09/17/25 at 12:30pm revealed: -Resident #1's memory was very bad.	C 069		

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C 069	Continued From page 15 -Resident #1 had to be told everything. -The facility did not have door alarms. -The sister facility, next door, had door alarms. -The staff were supposed to check on residents every hour to ensure the residents were in the facility or on the premises. -She thought Resident #1 was moved to the sister facility after the incident. -She did not know Resident #1 had been moved back to the facility without door alarms. Attempted telephone interview with Resident #1's PCP on 09/16/25 at 1:02pm was unsuccessful. _____ The failure of the facility to ensure the exit doors to the facility had an audible sounding device when activated resulted in a resident who had left the facility on 03/07/25 and returned with bleeding from his hands and mouth, having access to the door and possibly eloping again (#1). This failure was detrimental to the health, safety, and well-being of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/17/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 1, 2025.	C 069		
C 120	10A NCAC 13G .0316 (f) Fire Safety and Emergency Preparedness Plan 10A NCAC 13G .0316 Fire Safety and Emergency Preparedness Plan (f) There shall be at least four unannounced fire	C 120		

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C 120	Continued From page 16 drills of the fire evacuation plan every year on each shift. For the purpose of this Rule, a fire drill is the method of practicing how occupants of the facility shall evacuate in the event of a fire or other emergency. Documentation of the fire drills shall be maintained by the administrator or their designee in the facility and be made available upon request to the Division of Health Service Regulation, county department of social services, and the local fire code enforcement official. The documentation shall include the date and time of the fire drill, the shift, the names of staff members present, and a short description of drill. Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure that fire drills were unannounced and that residents evacuated without staff prompting, resulting in 1 of 2 residents (#4) who did not respond to the smoke detector alarm during the drill. The findings are: Review of the facility's current license effective 01/01/25 revealed the facility was licensed for 5 ambulatory residents. Review of the facility's policy and procedure on fire drills revealed: -The facility would conduct a minimum of 12 unannounced fire drills per year, with at least one drill conducted on each shift (day, evening, and	C 120		

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night) to ensure all staff members were trained and prepared to respond.
-The purpose of these drills was to ensure that all staff and residents were familiar with the fire evacuation plan and emergency procedures.
-Practice the safe and efficient evacuation of residents, including those with mobility limitations and specialized needs.
-Assess staff response time and effectiveness in a simulated emergency.
-Drills would be conducted monthly, at a minimum, and would be unannounced to staff to simulate a real emergency; the four required annual drills would be spread across all three shifts (day, evening, and night).
-All staff would be trained upon employment and annually on the facility's fire evacuation plan, their specific roles and responsibilities, and the use of fire extinguishers.
-The drill would be initiated by activating the fire alarm system from a pull station. If a fire alarm system were not in place, an alternative audible notification method would be used as approved by the local fire marshal.
-Residents would be assisted in evacuating to a designated assembly point outside the building, which was a safe distance away and did not obstruct fire department access.
-Once at the assembly point, a staff member would take a final headcount of all residents and staff to ensure everyone had safely evacuated.
-Immediately following the drill, the drill coordinator would conduct a critique with all participating staff members. This was an opportunity to evaluate the effectiveness of the drill, identify any issues or areas for improvement, and discuss what worked well.
-The documentation for each drill must include the date of the drill, the time of the drill, the shift during which the drill was conducted (day,

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evening, or night), names of all staff members present, and a short description of the drill, including the simulated scenario and a summary of the outcome.

Review of the facility's fire rehearsal schedule revealed:
-On 01/12/25 at 6:00am, the time for evacuation was 5 minutes, and residents were evacuated to the safe zone; there was no information related to the number of residents.
-On 02/05/25 at 3:00pm, there was no documentation of the number of residents present, evacuation time, or description of the fire drill.
-On 03/04/25 at 3:15pm, there was no documentation of the number of residents present, evacuation time, or description of the fire drill.
-On 04/19/25, the first shift was circled; there was no documentation of the time, number of residents present, evacuation time, or description of the fire drill.
-On 05/06/25 at 1:00am, the time for evacuation was 7 minutes; there was no information related to the number of residents or description of the fire drill.
-On 06/20/25, the first shift was circled; there was no documentation of the time, number of residents present, evacuation time, or description of the fire drill.
-On 07/09/25 at 2:00pm, there was no documentation of the number of residents present, evacuation time, or description of the fire drill.

Review of Resident #4's FL2 revealed:
-Diagnoses included paranoid schizophrenia and obsessive-compulsive disorder.
-Orientation was marked as not applicable.

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C 120	Continued From page 19 -He required assistance from staff with bathing and dressing. -He was ambulatory. Review of Resident #4's Resident Register revealed an admission date of 01/30/20; there was no family member or guardian listed. Review of Resident #4's care plan dated 06/06/25 revealed: -The resident was ambulatory. -He required limited assistance from staff with toileting, bathing, dressing, and grooming. -He was oriented, and his memory was adequate. -The care plan was not signed by the primary care provider (PCP). Observation of the facility 09/16/25 at 12:31pm revealed: -The Co-Administrator activated the smoke detector. -An audible beeping noise could be heard throughout the facility. -Resident #4 was sitting on his bed and did not exit the facility. Interview with Resident #4 on 09/16/25 at 12:40pm revealed: -The facility did not have fire drills. -He had heard a smoke alarm before. -When asked what he did when he heard the smoke alarm, he responded "nothing". -He did not know why he did nothing. Second interview with Resident #4 on 09/16/25 at 1:43pm revealed: -Staff did not use smoke detectors during fire drills, "they just tell us". -The staff told the residents to go outside.	C 120		

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C 120	Continued From page 20 Interview with another resident on 09/16/25 at 1:36pm revealed: -Fire drills were done about every 4 months. -The staff told the residents it was a fire drill, and everyone went outside. -No one needed to be told to go outside; everyone went out when they were told it was a fire drill. Interview with a third resident on 09/16/25 at 1:55pm revealed: -Staff told the residents to go outside when the "bell rang". -There had never been a fire drill at night. -Every so often, the staff did a fire drill. -Staff did a fire drill recently, but he did not recall any other information. Confidential telephone interview with a staff member revealed: -She had performed fire drills at the facility. -She would say, "fire, fire"and she would then get all the residents to the front yard of the adjoining lot. -None of the residents had to be prompted to leave after she said "fire, fire" everyone left the facility. -Resident #4 always left the facility when she said "fire, fire". Interview with the Co-Administrator on 09/16/25 at 2:10pm revealed: -Resident #4 did not exit the facility during the fire drill because he had mental health challenges. -Sometimes Resident #4 exited the facility during a fire drill, and sometimes he did not; that was why he implemented the buddy system. -The buddy system was for the residents to make sure their roommates exited the facility during fire drills.	C 120		

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C 120	Continued From page 21 -Fire drills were unannounced. -All the residents had left the facility without assistance for the past 3-6 months. -There were three named residents who had mental health challenges and at times may need prompting. -He had told the residents the scenario of what to do during a fire drill, but did not tell them during the fire drill. Telephone interview with the Administrator on 09/16/25 at 12:30pm revealed: -The facility had a buddy system in place, never leave a buddy behind. -The residents who were able to assist others were told to do the best they could to get their buddy to go outside with them during fire drills. Attempted telephone interview with Resident #4's PCP on 09/16/25 at 1:02pm was unsuccessful.	C 120		
C 236	10A NCAC 13G .0802 (a) (c) Resident Care Plan 10A NCAC 13G .0802 Resident Care Plan (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 of the care plan. (c) The care plan shall include the following: (1) a description of services, supervision, tasks, and level of assistance to be provided to address	C 236		

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C 236	Continued From page 22 the resident's needs identified in the resident's assessment in Rule .0801 of this Section; (2) frequency of the services or tasks to be performed; (3) revisions of tasks and frequency based on reassessments in accordance with Rule .0801 of this Section; (4) licensed health professional tasks required according to Rule .0903 of this Section; (5) a dated signature of the assessor upon completion; and (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. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure that 3 of 3 sampled residents (#1,#2, #3) had a signature from their primary care provider (PCP) within 15 days of completing the care plan. The findings are: 1. Review of Resident #1's FL2 dated 08/14/25	C 236		

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revealed:
-Diagnoses included diabetes, high blood pressure, and intellectual disability.
-He required assistance with bathing and dressing.
-He was ambulatory.
-He was incontinent of bladder.

Review of Resident #1's care plan dated 07/05/25 revealed:
-The resident was ambulatory.
-He required extensive assistance from staff with bathing, dressing, and grooming.
-The care plan was not signed by the PCP.

Attempted telephone interview with the facility's contracted nurse on 09/16/25 at 1:00pm was unsuccessful.

Attempted telephone interview with Resident #1's PCP on 09/16/25 at 1:02pm was unsuccessful.

Refer to the interview with the Co-Administrator on 09/16/25 at 2:10pm.

Refer to the telephone interview with the Administrator on 09/17/25 at 12:30pm.

2. Review of Resident #2's FL2 dated 12/11/24 revealed:
-Diagnoses included schizophrenia, hypertension, and type 2 diabetes.
-He was total care.
-He was ambulatory.
-He was incontinent of bowel and bladder.

Review of Resident #2's care plan dated 07/01/25 revealed:
-The resident was ambulatory.
-The resident required limited assistance from

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staff with toileting.
-He required extensive assistance from staff with bathing, dressing, and grooming.
-The care plan was not signed by the PCP.

Attempted telephone interview with the facility's contracted nurse on 09/16/25 at 1:00pm was unsuccessful.

Attempted telephone interview with Resident #2's PCP on 09/16/25 at 1:02pm was unsuccessful.

Refer to the interview with the Co-Administrator on 09/16/25 at 2:10pm.

Refer to the telephone interview with the Administrator on 09/17/25 at 12:30pm.

3. Review of Resident #3's FL2 dated 12/11/24 revealed:
-Diagnoses included hypertension, seizure disorder, childhood polio, and chronic kidney disease.
-He required assistance with bathing and dressing.
-He was ambulatory.
-He was continent of bowel and bladder.

Review of Resident #3's care plan dated 03/04/25 revealed:
-The resident required supervision with ambulation and transferring.
-He required limited assistance from staff with bathing, dressing, and grooming.
-The care plan was not signed by the primary care provider (PCP).

Attempted telephone interview with the facility's contracted nurse on 09/16/25 at 1:00pm was unsuccessful.

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C 236	Continued From page 25 Attempted telephone interview with Resident #3's PCP on 09/16/25 at 1:02pm was unsuccessful. Refer to the interview with the Co-Administrator on 09/16/25 at 2:10pm. Refer to the telephone interview with the Administrator on 09/17/25 at 12:30pm. _____ Interview with the Co-Administrator on 09/16/25 at 2:10pm revealed: -The facility's contracted nurse completed the residents' care plans annually. -After the care plans were completed, he was supposed to give them to the PCP to review and sign. -He did not realize the care plans had not been signed. Telephone interview with the Administrator on 09/17/25 at 12:30pm revealed: -The Co-Administrator was responsible for making sure the residents' care plans were completed. -The Co-Administrator should have followed up with the PCP to make sure the care plans were signed.	C 236		
C 257	10A NCAC 13G .0904(a)(1) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (a) Food Procurement and Safety in Family Care Homes: (1) Food services shall comply with Rules Governing the Sanitation of Residential Care Facilities set forth in 15A NCAC 18A .1600 which are hereby incorporated by reference, including	C 257		

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C 257	Continued From page 26 subsequent amendments, assuring storage, preparation, and serving food under sanitary conditions. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the food storage areas were clean and free from contamination including disposable food containers being reused, leftover food not labeled and dated, expired food, crumbs and dried liquid in the refrigerator, a build-up of ice in the freezer, and dried food containers which had a build-up of dirt and grime. The findings are: Observation of the refrigerator on 09/16/25 at 11:25am revealed: -There was a non-reusable jug that contained water. -There was a reusable food container that contained spaghetti that was not labeled or dated. -There was a package of meat that was not sealed or dated when opened. -There was a package of bacon bits with a use-by date of 07/17/25. -The drawers and shelves had food crumbs and dried liquid.	C 257		

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BOYD'S REST HOME #1	295 CARROLLTOWN ROAD MACON, NC 27551

(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
C 257	Continued From page 27 -The gaskets on the inside of the door had a build-up of dirt and grime, a dried black substance, and the gasket was broken in several places. Observation of the freezer on 09/16/25 at 8:42am revealed there was a build-up of frost and ice. Observation of the food pantry on 09/16/25 at 11:28am revealed there were four opaque storage containers that contained bulk dry food products; each container was covered in a build-up of dirt and grime. Interview with the cook on 09/16/25 at 11:31am revealed: -She had not cleaned the bulk food containers "in a while". -It had been three weeks or so since she cleaned the bulk food containers. -She should have covered the meat in the refrigerator; she did not recall when the meat had been used. -She did not know that a non-reusable jug could not be used for water. -She did not recall the last time she cleaned the refrigerator. -She did not know when the freezer had been defrosted. -She was not the only staff member who worked in the kitchen. Interview with the Co-Administrator on 09/16/25 at 2:36pm revealed: -Whoever was working was responsible for cleaning the kitchen and making sure the food in the refrigerator was covered, labeled, and dated. -He checked behind the staff, had fussed until he was tired of fussing, and even cleaned himself. -He did not know the storage containers needed	C 257		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL093001	A. BUILDING: _____ B. WING _____	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 257	Continued From page 28 to be cleaned. -He did not know milk jugs could not be washed and used for water. Telephone interview with the Administrator on 09/17/25 at 12:30pm revealed: -She was at the facility every day between 3 and 4 hours. -She had checked the kitchen to ensure it was clean but had not looked at the storage containers. -The staff members should be cleaning the kitchen, whoever was working. -Between the two staff members, the kitchen should have been clean.	C 257		