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D 000	Initial Comments The Adult Care Licensure Section and the Macon County Department of Social Services conducted an annual, follow up, and complaint investigation on 09/23/25 through 09/25/25. The complaint investigation was initiated by the Macon County Department of Social Services on 09/18/25.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up for 2 of 5 sampled residents (#1, and #6) related to a resident who spilled coffee onto her lap, resulting in second degree burns on her upper thighs (#1), and a resident who had a fall resulting in a pubis fracture (#6). The findings are: Review of the facility's Medical Care Policy revised November 2022 revealed: -The shift Supervisor and medication aide (MA) are responsible for seeking immediate medical attention as appropriate for falls and medical crisis situations. -Recording actions in medical notes. -Notifying physicians, family and administrator.	D 273		

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1. Review of Resident #1's current FL2 dated 07/17/25 revealed:
-Diagnoses included dementia, hearing loss, psoriatic arthritis (a chronic inflammatory condition affecting the joints and skin, causing joint pain, stiffness and swelling), and general debility (a state of overall weakness, fatigue, and reduced physical capacity).
-Resident #1's recommended level of care was Special Care Unit (SCU).
-Resident #1 was constantly disoriented.
-Resident #1 was semi-ambulatory and incontinent of bladder and continent of bowel.

Review of Resident #1's Resident Register revealed an admission date of 11/30/17.

Review of Resident #1's Care Plan dated 07/17/25 revealed:
-Resident had limited range of motion in both hands.
- She required a wheelchair for mobility.
-She had significant memory loss and was constantly disoriented.
-She required limited assistance with eating.

Review of Resident #1's discharge instructions from the Emergency Room (ER) dated 09/17/25 revealed:
-Resident #1 was seen for second degree burn to her upper thighs.
-An order for mupirocin topical 2% ointment (used to treat and prevent infections) applied three times daily, and follow up with Primary Care Physician (PCP).

Review of Resident #1's Incident Report dated 09/14/25 revealed:
-Resident #1 was in the hallway drinking a fresh cup of coffee and spilled the cup of coffee on her

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lap.
-When the personal care aides (PCAs) provided incontinence care for the resident, they noticed burns on her inner thighs.
-An antibiotic ointment was applied.
-There was no documentation immediate medical attention was provided by the shift supervisor or the medication aide on 09/14/25.
-On 09/15/25, the PCP prescribed silver sulfa cream.
-There was no documentation the primary care physician (PCP) was notified on 09/14/25.
-On 09/17/25, Resident #1 was in a lot of pain due to the burns and was sent to the ER to be evaluated.

Review of Resident #1's charting notes dated 09/15/25 at 8:56am revealed:
-On 09/14/25, Resident #1 was given a cup of coffee by a dietary aide and Resident #1 spilled the cup of coffee onto her lap, causing a burn on her legs.
-On 09/14/25, there was documentation "cream" was applied.
-On 09/15/25 there was documentation Resident #1's PCP was notified.
-On 09/15/25 there was documentation the PCP prescribed a cream.
-The PCP saw Resident #1 on 09/16/25.

Review of Resident #1's charting note dated 09/17/25 at 3:49am revealed:
-Resident #1 woke up in severe pain from the wound on her upper thighs.
-Her skin was observed to be damaged and blistered.
-There was no prescription medication available to be administered.
-There was no documentation of any new orders received on 09/16/25.

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-Resident #1 was given tylenol until her PCP could be contacted.

Review of Resident #1's charting note dated 09/17/25 at 5:03am revealed:
-Tylenol was not effective for Resident #1's pain.
-Resident #1's Power of Attorney (POA) was contacted and the POA wanted her to be sent to the ER.
-Resident #1 was sent to the ER due to continued pain.

Review of Resident #1's charting note dated 09/17/25 at 2:56pm revealed:
-The ER ordered xeroform dressing and mupirocin for the burned areas.
-The facility could not apply xeroform dressing and requested a wound care consult form the PCP.

Observation in Resident #1's room on 09/24/25 at 1:11pm revealed:
-Resident #1 was lying in her bed.
-A Registered Nurse (RN) from a home health agency removed gauze bandages from areas on Resident #1's bilateral upper thighs.
-The wounds on Resident #1's bilateral upper thighs were composed of areas of redness with areas of brown scabbing with dry flaky skin.

Telephone interview with a Home Health Registered Nurse (RN) on 09/24/25 at 10:01am revealed:
-She began treating Resident #1's wounds on 09/19/25.
-The "burns were bad" when she began treatment, 11cm long by 4cm wide on initial visit on 09/19/25, and 10cm long by 4cm wide on 09/22/25, bilateral on inside of thighs.
-Some blisters were opened; some closed; some

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had popped, and they had a yellowish tint to them.

Interview with the Personal Care Aide (PCA) Supervisor on 09/18/25 at 11:45am revealed:
-She was in her office when Resident #1 spilled a cup of coffee in her lap when a dietary aide (DA) handed her a full cup of coffee.
-Resident #1 was unable to safely hold a cup of hot liquid.
-Resident #1 was taken immediately to her room, and an antibacterial cream was applied to the burn.
-She suggested a cold compress on the burn, but was unsure if that was completed.
-Resident #1 was burned on 09/14/25 and her Primary Care Physician (PCP) was notified on 09/15/25.
-The burn was pink when she saw it on 09/14/25, but the burn became worse as "time went on."

Telephone interview with a PCA on 09/24/25 at 10:41am revealed:
-Beverages were usually passed out around 10:00am by Dietary aides (DAs) and styrofoam cups were used.
-She did an assessment on Resident #1 at 11:00am on 09/14/25 and she noticed her clothes were wet near her upper thighs.
-She observed blisters and redness while she was providing incontinence care and reported to a medication aide (MA).

Interview with a second PCA on 09/24/25 at 1:33pm revealed:
-She began working at 3:00pm on 09/14/25.
-She observed red skin on Resident #1's upper thighs on 09/14/25.
-She did not observe any blisters on 09/14/25.

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D 273	Continued From page 5 Interview with a MA on 09/23/25 at 3:21pm revealed: -She worked on 09/14/25. -On 09/14/25, a PCA informed her that Resident #1 had burns to her upper thighs. -The skin on Resident #1's upper thighs was red but she did not observe any blisters. -She applied a cold cloth and applied antibiotic ointment. -She did not contact the PCP because it was a weekend, and she did not think she could notify him on a weekend. -She did not have his phone number. -She did not report to her supervisors because she did not think the burn was bad and could wait until the next morning. -She did not think Resident #1 needed to go to the ER because she observed only redness on Resident #1's upper thighs. -She reported to the MA supervisors on 09/15/25 that Resident #1 had burns to her upper thighs. -She had not been told by her supervisors what to do in situations such as a burn. -On 09/15/25, the PCP prescribed Resident #1 silver sulfa cream for the burn. -The cream was not available from the pharmacy. -She was not sure if the PCP was informed that the cream was not available right away. -Staff used antibiotic cream on Resident #1. -She did not know if the cream the PCP prescribed ever came in. Interview with a MA Supervisor on 09/23/25 at 3:41pm revealed: -The PCP was not contacted on 09/14/25 because on the weekends the office was closed and it was difficult for the PCP to be notified when the office was closed. -The PCP wrote an order for a topical cream on 09/15/25.	D 273		

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-On 09/15/25, she observed blisters on Resident #1's upper thighs.
-She expected staff to send an email to notify PCPs on the weekends.
-She expected staff to have sent Resident #1 to the ER on 09/14/25.

Interview with the Special Care Coordinator (SCC) on 09/24/25 at 4:03pm revealed:
-On 09/15/25, she was informed Resident #1 spilled coffee onto her lap and was burned on 09/14/25.
-On weekends, the MAs should report incidents to their supervisors, leave a message for PCP either by phone or email, and write a note in the chart.

Interview with the Manager on 09/24/25 at 12:40pm revealed:
-She was notified about Resident #1 getting burned by coffee on 09/14/25 on 09/15/25.
-She expected staff to send residents out in emergencies.
-Resident #1's PCP office was closed on the weekends.
-She was not sure if the PCP had a plan for weekend emergencies.
-Only supervisors usually contacted the PCP.
-Supervisors were not notified by the MA until 09/15/25.
-Staff "usually did not bother" supervisors on the weekends.
-She expected staff to cover themselves by sending residents to ER when in doubt.

Telephone interview with the facilities contracted pharmacy on 09/24/25 at 9:48am revealed:
-They received an order for silver sulfa cream on 09/15/25.
-They had to order the cream because they did

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not have the cream available.
-They notified the facility that the cream was not available on 09/15/25.
-The cream was received on 09/18/25 at 1:37am.
-The cream was discontinued on 09/19/25.

Telephone interview with Resident #1's PCP on 09/23/25 at 3:06pm revealed:
-He was notified Resident #1 was burned by coffee on 09/15/25.
-He assessed Resident #1 on 09/16/25.
-He saw a second degree burn with blisters on her upper thighs.
-He did not think she needed to be sent to the ER on 09/16/25.
-He did not remember getting a phone call from the facility saying the pharmacy was out of the cream.
-He did not realize she never got the cream he ordered.
-He expected staff to inform him when medications were not available from the pharmacy.

Interview with the Administrator on 09/24/25 at 5:23pm and on 09/25/25 at 11:26am revealed:
-She expected the MAs to notify the residents PCP and supervisors immediately for residents who were burned.
-She thought the MAs notified the supervisors on 09/14/25 when Resident #1 was burned.
-She expected staff to send Resident #1 to the ER for pain and if blisters had formed.
-Everyone should have the PCP's phone number and email addresses to call or send messages in emergencies.
-The MA supervisor was expected to make sure MAs knew the PCP's email address and the email addresses could always be used, including weekends.

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-She expected staff to notify the PCP immediately when medications were not available from the pharmacy.

Attempted telephone interview with Resident #1's Power of Attorney on 09/23/25 at 2:57pm was unsuccessful.

Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable.

2. Review of Resident #6's current FL2 dated 06/11/25 revealed:
-Diagnoses included, bi-polar disorder, depressive disorder, coronary artery disease and obstructive sleep apnea.
-There was documentation she was intermittently disoriented.
-An order for naproxen 220mg daily as needed for pain.
-An order for Tylenol extra strength 500mg, one tablet every 4 hours as needed for mild pain.

Review of Resident #6's Resident Register revealed:
-She was admitted to the facility on 09/03/24.
-She was assigned a guardian through the Department of Social Services.

Review of Resident #6's Care Plan dated 06/11/25 revealed she required limited assistance with ambulation and used a rollator.

Interview with Resident #6 on 09/23/25 at 9:26am revealed:
-She fell a week ago in the hall by the dining room and hurt her groin.
-She was assisted off the floor by staff.
-She told the facility Manager she was hurting

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and "needed to go to the doctor".
-The facility Manager told her she could not see a physician until her guardian was called.

Review of Resident #6's record revealed an order dated 09/23/25 for an x-ray of the left leg to evaluate pain.

Interview with the Manager on 09/24/25 at 3:41pm revealed:
-Resident #6 fell on 09/17/25 by the dining room.
-Resident #6 told her she was "okay".
-She could not remember if she told the medication aide (MA) supervisor or the MA to inform the guardian of the fall, "if needed".

Telephone interview with Resident #6's guardian on 09/24/25 at 3:08pm revealed:
-She was notified of Resident #6's 09/17/25 fall on 09/23/25 by the Special Care Coordinator (SCC).
-The SCC was notified by staff about the fall on 09/22/25.
-She told the facility when Resident #6 was admitted to the facility they should contact her before they ever sent Resident #6 for any evaluation outside the facility because Resident #6 had a history of requesting to go to the hospital when nothing was wrong.
-Resident #6 had a history of reporting she fell when she did not actually fall.
-She was told on 09/24/25 Resident #6 refused to go for an x-ray so the facility was having her transported to the hospital via emergency medical services (EMS) so an x-ray could be completed.

Review of Resident #6's charting notes revealed:
-There was documentation by a MA on 09/17/25 at 9:28am "Aide had reported to me that resident fell".

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D 273	Continued From page 10 -There was documentation by the SCC on 09/23/25 at 8:50am Resident #6 reported leg pain and the PCP was notified. -There was documentation by the SCC on 09/23/25 at 9:06am "PCP has given a verbal order for x-ray of her leg". -There was documentation by the SCC on 09/23/25 at 10:49am "updated guardian on the leg pain and x-ray". -There was documentation by the SCC on 09/24/25 at 11:42am Resident #6 was still reporting pain in her groin but declined an ice pack. -There was documentation by the SCC on 09/24/25 at 1:33pm Resident #6 was sent to the ER. Review of Resident #6's ER discharge instructions dated 09/24/25 revealed: -There was documentation Resident #6 came to the hospital with complaints of hip pain and swelling. -A computerized tomography (CT) of the pelvis was completed and identified a nondisplaced left pubis fracture. -There was an order for tramadol 50mg (a medication to treat moderate to severe pain) every six hours as needed for pain. Telephone interview with a MA on 09/24/25 at 5:31pm revealed: -She was working when Resident #6 fell on 09/17/25. -She was administering medications to other residents when an aide informed her Resident #6 had fallen. -She assessed Resident #6 and helped her stand up. -Resident #6 told her she did not think she had broken anything but she requested pain	D 273		

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medication after the fall so naproxen was administered.
-She informed her supervisor about the incident and she expected them to make a call if necessary.
-Resident #6 reported pain related to the fall around 7:00am on 09/22/25 and asked to go to the ER so she administered pain medication and she told her supervisor.

Interview with the SCC on 09/24/25 at 3:47pm revealed:
-Resident #6 never complained about pain until 09/22/25.
-When the SCC was leaving work at the end of the day on 09/22/25, Resident #6 reported she was in pain so she instructed an MA to administer tylenol.
-Resident #6 "complains of pain constantly on a good day".

Interviews with the MA supervisor on 09/24/25 at 3:50pm and 09/25/25 at 12:08pm revealed:
-She did not know about Resident #6's fall until she was reviewing the chart notes on 09/18/25.
-On 09/18/25 or 09/19/25 Resident #6 was complaining of groin pain so the MA administered naproxen and tylenol.

Interview with the MA supervisor on 09/25/25 at 2:48pm revealed:
-Resident #6 was not transported on 09/23/25 because there was not a PCA available to transport her.
-They planned to transport her on 09/24/25 but a PCA was still was not available to transport her.
-When Resident #6's pain continued to increase on 09/24/25, EMS was called to transport her to the hospital so the x-ray could be obtained as ordered.

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D 273	Continued From page 12 Telephone interview with Resident #6's PCP on 09/25/25 at 12:57pm revealed: -The first time he was informed about Resident #6's 09/17/25 fall was when the facility contacted him on 09/23/25 to request an x-ray. -He did not know the x-ray ordered on 09/23/25 for Resident #6 was not completed until 09/24/25 when she was in so much pain that she needed to be transported via EMS. Interview with the Administrator on 09/25/25 at 11:51am revealed: -She was informed of Resident #6's 09/17/25 fall "a few days ago" by a resident. -Per the facility's medical care policy, if a pain reliever was administered and it did not relieve the pain, the resident should be sent out for evaluation. _____ The facility failed to ensure referral and follow-up to to meet the routine and acute healthcare needs of Resident #1 who spilled coffee onto her lap, burning her upper thighs resulting in redness and blisters. Resident #1 did not receive a topical prescription medication and was not taken to the ER for evaluation until the third day after the spill resulting in Resident #1 experiencing extreme pain and developing wounds that required daily wound care from home health. Resident #6 fell in the hallway and complained about groin pain and the PCP was not notified for six days and she was not transported to the hospital for an additional 28 hours after an x-ray was ordered that identified a pubis fracture resulting in Resident #6 experiencing pain for seven days. This failure resulted in serious injury and neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in	D 273		

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D 273	Continued From page 13 accordance with G.S. 131D-34 on 09/24/25 for this violation. CORRECTION DATE FOR TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 26, 2025.	D 273		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to have a matching therapeutic diet menus for food service guidance for 2 of 4 sampled residents (#3 & #5) who had a physician's order for a lactose-free diet (#3) and a pureed diet (#5). The findings are: 1. Review of Resident #5's current FL2 dated 07/29/25 revealed diagnoses included delirium due to physiological condition, anemia and gastrointestinal hemorrhage. Review of Resident #5's Resident Register revealed she was admitted to the facility on	D 296		

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D 296	Continued From page 14 07/31/25. Review of Resident #5's record revealed a physician's order dated 08/11/25 for a pureed diet. Interview with Resident #5's family member on 09/23/25 at 12:08pm revealed she was on a pureed diet and "sometimes" food came to her room that was not pureed. Review of the facility's therapeutic diet menus dated 2020 revealed a pureed menu was not available for food service guidance. Interview with a cook on 09/23/25 at 12:42pm revealed: -A pureed menu was not available for staff to reference. -He and the other dietary staff "just knew" how to prepare foods for a pureed diet. -He pureed the foods that the residents received on a regular diet except foods like slaw, rice or "anything that did not blend well". Interview with a dietary aide on 09/23/25 at 12:46 revealed: -He worked at the facility for about 10 years and there was never a pureed menu to reference. -Staff "always just pureed the regular menu". Interview with the Dietary Manager (DM) on 09/24/25 at 7:57am revealed: -A pureed menu was not available for reference when she began working at the facility two months ago. -The facility Manager was responsible for providing the menus but she never told her she needed a pureed menu. -She did not ask the Administrator about	D 296		

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obtaining a pureed menu.
-The cooks pureed whatever was on the regular menu since they did not have a pureed menu to reference.

Interview with the Administrator on 09/23/25 at 1:02pm and revealed:
-She never noticed if the menu books included a pureed menu to reference.
-Dietary staff used the regular menu for reference when they prepared pureed food.

Interview with the facility Manager on 09/23/25 at 3:30pm and 09/24/25 at 12:14pm revealed:
-She was responsible for preparing the menu books for the kitchen.
-The facility's therapeutic menu spreadsheet never included a pureed menu.
-The cooks used the regular menu as a reference to puree food.
-She "thought" the Administrator had a pureed menu in her office.

Refer to interview with the Administrator on 09/25/25 at 10:25am.

Based on observations, interviews and record review Resident #6 was not interviewable.

2. Review of Resident #3's current FL2 dated 03/09/25 revealed:
-Diagnoses included gastroparesis (ineffective neuromuscular contractions of the stomach).
-A lactose-free diet order.

Interview with Resident #3 on 09/23/25 at 9:14am and 11:40am revealed:
-She was ordered a lactose-free diet that the facility "mostly followed".
-She did not eat the foods that were served to her

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D 296	Continued From page 16 that contained cheese. Review of the facility's therapeutic diet menus dated 2020 revealed a lactose-free menu was not available for food service guidance. Interview with the Dietary Manager (DM) on 09/24/25 at 7:57am revealed: -A lactose-free menu was not available for reference when she began working at the facility two months ago. -The facility Manager was responsible for providing the menus but she never told her she needed a lactose-free menu. -She did not ask the Administrator about obtaining a lactose-free menu. -The dietary staff knew that menu items that contained milk and cheese should not be served to Resident #3; but they did not have a specific menu to follow. Interview with the facility Manager on 09/24/25 at 12:14pm revealed: -She was responsible for preparing the menu books for the kitchen. -A lactose-free menu was not included in the therapeutic menu book. -A Registered Dietitian (RD) met with the dietary staff in April 2024 and September 2024 to instruct them on Resident #3's lactose-free diet. -The staff that currently work in the kitchen were not the staff that the RD met with in 2024. Interview with a Registered Dietitian (RD) on 09/25/25 at 10:55am revealed she met with dietary staff in 2024 to discuss how to prepare food for a lactose-free diet. Refer to interview with the Administrator on 09/25/25 at 10:25am.	D 296		

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D 296	Continued From page 17 Interview with the Administrator on 09/25/25 at 10:25am revealed: -A consulting Registered Dietitian (RD) worked with and instructed the dietary staff on special diets "in the past", but that staff no longer worked at the facility. -The only menus the facility had were the ones already printed and in the kitchen. -The facility manager was responsible for keeping the menu books updated. -The facility's food representative told her about corporate menus that were available on their website but she did not know how to access them.	D 296		
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages shall be offered in accordance with each residents' prescribed diet or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to provide snacks to all residents between meals for a total of three	D 298		

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snacks per day.

The findings are:

Interview with a resident on 09/23/25 at 9:26am revealed:
-Drinks like coffee and juice were offered three times a day.
-She would enjoy a low sugar, low calorie food item at snack but that type of snack was not offered.

Interview with a second resident on 09/23/25 at 9:10am revealed:
-He was offered coffee and water at snack times.
-Food snacks were not offered.

Interview with a third resident on 09/23/25 at 9:15am revealed:
-Snacks were not offered three times a day.
-He was hungry between meals.

Interview with a fourth resident on 09/23/25 at 9:35am revealed:
-Juice, coffee, and water were offered to him three times a day.
-When the kitchen had extra desserts left over from the meals, they would serve those to the residents as bedtime snacks.

Interview with a fifth resident on 09/23/25 at 9:46am revealed:
-Food was not served during snack times.
-He would like crackers or some type of foods to eat in between meals.

Interview with a sixth resident on 09/23/25 at 9:50am revealed:
-The staff brought snacks around to her room twice a day.

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-The snack offered usually consisted of a beverage only.

Interview with a seventh resident on 09/23/25 at 9:56am revealed:
-Staff came around between meals and offered them coffee and juice.
-Sometimes the staff would bring a piece of cake or crackers for snack.

Interview with an eighth resident on 09/25/25 at 8:09am revealed:
-Food snacks were not offered so he kept things like pudding, ham and cheese in his refrigerator so he did not get hungry.
-He spoke to the Administrator and kitchen staff about this issue in the past but nothing ever changed.

Interview with a personal care aide (PCA) on 09/24/25 at 10:42am revealed:
-The beverage cart was offered three times a day.
-Food was never offered at snacktime because so many residents were at risk of choking.

Review of the facility's 2020 menus revealed:
-The regular menu documented three snacks between meals.
-The morning snack was documented as 4 ounces of vegetable juice or 1/2 cup of raw vegetables.
-The afternoon and evening snack was documented as 4 ounces of fruit juice or one piece of fresh fruit.
-The therapeutic diet menu documented only an evening snack consisting of 1/2 cup sugar free canned fruit or a blueberry muffin.

Observation in the hallway on 09/23/25 at

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D 298	Continued From page 20 10:11am revealed: -The Dietary Manager (DM) was pushing a rolling cart in the hallway. -The DM stopped at each resident room and offered residents their choice of beverage from the cart. -There was a large thermal container of coffee with individual servings of cream, sugar, and sugar substitute available. -There were three types of 100% juice available including cranberry, grape, and pineapple. -There were small bottles of water available on the cart. -There were no food items available on the snack cart. Interview with the DM on 09/23/25 at 10:15am revealed: -Beverages were offered at 10:00am, 2:00pm and 6:00pm. -Only beverages were offered at snack because the raw vegetables and fruit on the snack menus were not appropriate for the residents that lived at the facility. -She and the Administrator talked about offering a food item with the beverages when she first started working as the DM about two months ago. -She was not sure why offering food at snacks was not implemented yet. Observation of the kitchen on 09/25/25 at 8:25am revealed: -Chips, gelatin and packages of pudding were on the pantry shelves. -A variety of canned fruit were in the canned food rack. -Fresh fruit was in the refrigerator. Interview with the DM on 09/25/25 at 8:25am revealed:	D 298		

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-The small pudding cups and cookies she ordered to use at snacktime came with the food truck delivery..
-They had packages of pudding in the pantry they could make and serve in souffle cups.

Observation of the snack cart on 09/25/25 at 10:43am revealed:
-Beverages from the snack cart were being distributed by a dietary aide.
-Coffee, tea, water and juice were available for the residents to choose.
-No food was available on the snack cart.

Interview with a dietary aide on 09/25/25 at 10:43am revealed:
-He was told about food being added to the beverage cart the other day but it was not instituted yet because the DM just recently ordered pudding and cookies.
-He was not aware the pudding and cookies were delivered earlier today.

Interview with a local Registered Dietitian (RD) on 09/25/25 at 10:55am revealed:
-Snacks that were available in the facility needed to meet the dietary needs of all the residents.
-Snacks needed to be more substantial than a glass of juice; things like pudding, fruit, cookies, crackers and chips.
-Raw vegetables, as a snack, were not appropriate for most of the residents that lived at the facility.

Interview with the Administrator on 09/23/25 at 1:02pm revealed:
-She thought the lack of food at snacktime had been resolved and that appropriate foods were being served along with the beverages.
-She thought the kitchen staff were serving soft

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D 298	Continued From page 22 snack foods that were appropriate for residents therapeutic diets because the snack items such as raw fruits and vegetables listed on the menu were inappropriate for the residents that lived at the facility.	D 298		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews the facility failed to ensure therapeutic diets were served as ordered to 2 of 4 sampled residents (#3 & #5) related to a pureed diet and nectar-thickened liquids (#5), and a lactose-free diet (#3). The findings are: 1. Review of Resident #5's current FL2 dated 07/29/25 revealed diagnoses included delirium due to physiological condition, anemia and gastrointestinal hemorrhage. Review of Resident #5's Resident Register revealed she was admitted to the facility on 07/31/25. a. Review of Resident #5's record revealed a	D 310		

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physician's order dated 08/11/25 for a pureed diet.

Observation of Resident #5's lunch meal service on 09/23/25 at 12:08pm revealed she was served pureed fish, pureed mixed vegetables, pureed potato casserole and a 4-ounce container of diced mixed fruit.

Interview with Resident #5's family member on 09/23/25 at 12:08pm and 09/24/25 at 7:57am revealed:
-Resident #5 needed assistance to eat her meals and a family member had been available to help Resident #5 with every meal since she was admitted.
-He knew Resident #5 needed pureed food so he would not give her the diced mixed fruit.
-The pureed food was usually sticky and stuck to the spoon if he turned the spoon upside down.
-Breakfast oatmeal was always very thick and whole oat flakes were still visible.
-Resident #5 was incapable of eating the oatmeal unless it was thinned down so he usually thinned it and mashed it up.
-A few days ago she was served scrambled eggs for breakfast that were not pureed, so he used a fork and mashed them up until he thought they were pureed consistency.

Interview with a cook on 09/23/25 at 12:18pm revealed:
-He plated Resident #5's food for lunch on 09/23/25 but he did not put diced fruit on her tray.
-The dietary aides were responsible for putting desserts on residents trays and giving it to the personal care aides (PCA) to deliver to the resident's room.

Interview with the Dietary Manager (DM) on

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D 310	Continued From page 24 09/23/25 at 12:22pm and 09/24/25 at 8:00am revealed: -Resident #5 should not have received diced fruit on her lunch tray. -She "guessed" the fruit was put on the tray accidentally because it was on the side table in the kitchen but she did not know who was responsible for putting it on the tray -The diced fruit that was on the side table belonged to another resident and was not a food they served to the residents. -The cook should have pureed strawberries for Resident #5 because that was the dessert on the regular menu. -The cooks did not puree oatmeal, and she thought the consistency of regular oatmeal was okay for someone on a puree diet. -"Sometimes" the cooks pureed other breakfast items like eggs and sausage but if oatmeal was on the menu, that was all that was served. Interview with another cook on 09/24/25 at 8:00am revealed he did not puree Resident #5's oatmeal because he thought the consistency was appropriate. Review of the facility's therapeutic diet menus dated 2020 revealed a pureed menu was not available to determine what should be served to a resident ordered a pureed diet. Interview with a personal care aide (PCA) on 09/23/25 at 12:37pm revealed: -PCAs were responsible for delivering trays to residents who ate in their rooms. -Dietary staff prepared the trays and handed them to the PCAs to deliver. -The cook gave her Resident #5's tray at lunch on 09/23/25 and she took it to Resident #5's room and a family member helped her with her meal.	D 310		

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D 310	Continued From page 25 Interview with Resident #5's hospice registered nurse (RN) case manager on 09/24/25 at 1:15pm revealed: -Resident #5 was ordered pureed food because she lost weight, her dentures no longer fit and she had trouble chewing food. -Pureed oatmeal should be smooth or Resident #5 could choke on it. -Choking could cause aspiration (accidentally inhaling food or liquid into the airway instead of swallowing it) that could in turn lead to pneumonia (an infection in one or both lungs). -Eating diced fruit could cause Resident #5 to choke and need the Heimlich maneuver. -Resident #5's family was very involved with her care and were always the ones to assist at meals and knew what foods she was capable of eating and "probably" would not have given her the diced fruit. Refer to interview with the Administrator on 09/23/25 at 1:02pm and 09/25/25 at 10:25am. b. Review of Resident #5's physician's order dated 09/23/25 revealed nectar thickened liquids. Observation of a medication aide (MA) during the 8:00am medication pass on 09/24/25 at 7:56am revealed: -The MA prepared one oral medication for Resident #5 by crushing the medication and mixing it with applesauce in a small medication cup. -The MA took the medication cup into Resident #5's room. -There were two clear plastic cups with lids and straws located on Resident #5's bedside table. -One cup contained a brown liquid thickened to honey consistency.	D 310		

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-The second cup contained water that was not thickened.
-The MA picked up the cup which contained water that was not thickened and approached Resident #5 to administer the medication mixed in applesauce.

Interview with the MA on 09/24/25 at 7:57am revealed:
-The MA did not know Resident #5 had a new physician's order for nectar thickened liquids.
-She would ask the kitchen staff about the new order for Resident #5.

Observation outside Resident #5's room on 09/24/25 at 8:00am revealed:
-The MA returned to Resident #5's room carrying a clear plastic cup with a lid and straw filled half full of milk.
-The milk was not thickened to nectar consistency.

Interview with the MA on 09/24/25 at 8:01am revealed:
-The Dietary Manager (DM) confirmed there was a new order for Resident #5 for nectar thickened liquids.
-The DM prepared the cup of thickened milk for Resident #5.
-She did not know how to prepare thickened liquids.
-She did not know how to determine if a liquid was nectar thick in consistency.
-The kitchen staff were responsible for preparing thickened liquids.

Interview with the DM on 09/24/25 at 8:03am revealed:
-She used powdered food and beverage thickener to thicken the milk for the MA to serve

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to Resident #5.
-She did not know the scoop provided in the powdered thickener had a teaspoon and tablespoon measurement.
-She did not know there was a usage chart on the back of the powdered thickener which provided instructions on how to prepare liquids to the desired consistency.
-She used a spoon to add the thickener powder to prepare the milk for Resident #5.
-She did not know after adding thickener powder to milk the thickener powder instructions recommended the milk stand for 5-10 minutes before serving.
-This was the first resident with orders for thickened liquids since she started working at the facility.

Interview with the same MA on 09/24/25 at 8:50am revealed orders for thickened liquids were not visible on the electronic medication record (eMAR) screen primarily used to administer medications.

Interview with the MA Supervisor on 09/24/25 at 10:41am revealed:
-Resident #5's nectar thickened liquids order was a new order on 09/23/25.
-The Special Care Coordinator (SCC) was primarily responsible for entering a chart note into the eMAR system when the new order for thickened liquids was received.
-The MAs were instructed to review the chart notes for their assigned residents prior to starting their shifts.
-The chart notes concerning the new thickened liquids order for Resident #5 were not entered into the eMAR system until mid-morning on 09/24/25.
-The SCC was also responsible for making a note

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in the eMAR informational orders section so the order would be visible to the MAs during medication administration.
-The personal care aide (PCA) Supervisor would post written notes at the time clock to communicate changes to the MA and PCA staff.
-The PCA Supervisor did not work on 09/23/25 and a written note was not posted to inform the MAs and PCAs of the order change.

Telephone interview with Resident #5's hospice registered nurse (RN) case manager on 09/24/25 revealed:
-The MA Supervisor reported to her Resident #5 was choking on thin liquids.
-She obtained an order for Resident #5 for nectar thickened liquids on 09/23/25.
-Resident #5 was at risk for aspiration (accidentally inhaling food or liquid into the airway instead of swallowing it) if she drank liquids not thickened to nectar consistency.
-Aspiration of fluids could lead to pneumonia.

Refer to interview with the Administrator on 09/23/25 at 1:02pm and 09/25/25 at 10:25am.

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

2. Review of Resident #3's current FL2 dated 03/09/25 revealed:
-Diagnoses included gastroparesis (ineffective neuromuscular contractions of the stomach).
-A lactose-free diet order.

Review of Resident #3's Resident Register revealed she was admitted to the facility on 04/11/12.

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Observation of Resident #3's lunch meal service on 09/23/25 at 11:40am revealed:
-She was served a sandwich with meat, mixed vegetables, potato casserole and diced pears.
-There was cheese in the potato casserole.

Interview with Resident #3 on 09/23/25 at 9:14am and 11:40am revealed:
-She was ordered a lactose-free diet that the facility "mostly followed".
-She did not eat the foods that were served to her that contained cheese.

Review of the facility's therapeutic diet menus dated 2020 revealed a lactose-free menu was not available to determine what should be served to a resident ordered a lactose-free diet.

Interview with the cook on 09/23/25 at 11:52am revealed:
-The potato casserole contained cheese and sour cream.
-He knew Resident #3 was not supposed to be served the potato casserole.
-He did not put the potato casserole on her plate and did not know who did.

Interview with the Dietary Manager (DM) on 09/23/25 at 11:59am revealed:
-A lactose-free menu was not available for the cooks to reference.
-The dietary staff knew that menu items that contained milk and cheese should not be served to Resident #3.

Interview with a personal care aide (PCA) on 09/23/25 at 12:37pm revealed:
-PCAs were responsible for delivering trays to residents who ate in their rooms.
-Dietary staff prepared the trays and handed

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them to the PCAs to deliver.
-The cook gave her Resident #3's tray at lunch on 09/23/25 and she took it to Resident #3's room.

Interview with the facility Manager on 09/24/25 at 12:14pm revealed:
-A Registered Dietitian (RD) met with the dietary staff in April 2024 and September 2024 to instruct them on Resident #3's lactose-free diet.
-The staff that currently worked in the kitchen were not the staff that the RD met with in 2024.
-Resident #3 had a long history of not following her diet order.

Interview with a local Registered Dietitian (RD) on 09/25/25 at 10:55am revealed she instructed dietary staff in 2024 on the requirement to provide a lactose-free diet for Resident #3.

Interview with Resident #3's primary care provider (PCP) on 09/24/25 at 11:55am revealed:
-Resident #3 was ordered a lactose-free diet due to her history of multiple gastrointestinal symptoms.
-Not adhering to a lactose-free diet could cause her to experience gas, bloating and burping and she had medications she could use to relieve those symptoms if she chose to deviate from her diet, which she was known to do.

Refer to interview with the Administrator on 09/23/25 at 1:02pm and 09/25/25 at 10:25am.

_____

Interview with the Administrator on 09/23/25 at 1:02pm and 09/25/25 at 10:25am revealed:
-Dietary staff had no excuse for serving therapeutic diets incorrectly.
-The cook and the DM were experienced and knew how to correctly prepare foods and beverages for therapeutic diets.

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D 310	Continued From page 31 -She expected staff to serve diets correctly. _____ The facility failed to ensure a pureed diet and nectar thickened liquids was served as ordered to Resident #5 who had weight loss recently and no longer able to chew food because her dentures no longer fit. She was at risk of choking or aspirating on food and beverages which could lead to pneumonia. This failure was detrimental to the health, safety and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/23/25 for this violation. CORRECTION DATE FOR TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 09, 2025.	D 310		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure residents were treated with respect and dignity for 1 of 2 sampled residents (Resident #4) after he exited the facility and was placed in the Special Care Unit (SCU) without consulting the primary care provider (PCP) or mental health provider (MHP).	D 338		

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The findings are:

Review of Resident #4's current FL2 dated 05/08/25 revealed:
-Diagnoses included mild cognitive impairment with psychotic symptoms, cerebral vascular accident, acute cerebral infarct x2, anxiety disorder, and psychosis.
-The resident was documented as intermittently disoriented, ambulatory, with a history of wandering behaviors.
-The recommended level of care was special care unit.

Review of Resident #4's Resident Register revealed:
-There was an admission date of 11/01/19.
-The resident was his own responsible person.

Review of Resident #4's Care Plan dated signed by the PCP on 05/08/25 revealed:
-Resident #4 was documented to be verbally abusive and received medications for mental illness/behavior and services for mental health.
-Resident #4 was documented to have had a recent vascular event causing extreme confusion needing SCU placement.
-Resident #4 was documented to have significant memory loss and was always disoriented.
-Resident #4 was legally blind in the left eye, had occasional bladder incontinence, and used a cane.
-Resident #4 required extensive staff assistance with eating, toileting, bathing, dressing, and grooming/personal hygiene.

Interview with Resident #4 on 09/23/25 at 3:42pm revealed:
-A couple months ago, he got "weird" and wanted to "get out of here."

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-He lived on the assisted living side of the facility at that time.
-He went out the side door and "just kept going."
-Some of the facility staff started running after him.
-After the incident, he was placed in the SCU.
-The staff were "good" to him and the other residents.
-But he did not like being "couped up" all the time.

Review of Resident #4's charting note entry dated 04/24/25 at 11:36am revealed staff reported Resident #4 was not "acting right" and "seemed confused."

Review of Resident #4's charting note entry dated 04/24/25 at 12:01pm revealed:
-Resident #4's blood pressure was 167/104 and he complained of neck pain.
-Resident #4 requested to go to the hospital for evaluation.

Review of Resident #4's hospital discharge summary dated 04/24/25 at 12:48pm revealed:
-Resident #4 was evaluated for hypertension.
-Resident #4's last recorded vitals were temperature 98.2, heart rate 87, respiratory rate 16, blood pressure 143/92, oxygen saturation was 94%.
-There was an order to follow up with PCP with no specified time frame.

Review of Resident #4's charting note entry dated 04/24/25 at 1:37pm Resident #4 returned to the facility from hospital evaluation.

Review of Resident #4's PCP visit note dated 04/25/25 at 10:00am revealed:
-The visit was for a follow-up to a hospital visit for confusion.

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-Nursing reports the patient went to the hospital yesterday (04/24/25) for confusion, tremor, and hypertension.
-The hospital sent the patient back without intervention.
-A family member took the patient back to the hospital this morning (04/25/25) because of the same symptoms.
-The hospital diagnosed the patient with increased ketones (chemicals produced when the body breaks down fat for energy).

Review of Resident #4's hospital discharge summary dated 04/25/25 at 2:58pm revealed:
-Resident #4 was evaluated for altered mental status.
-Resident #4's last recorded vitals were temperature 97.2, heart rate 72, respiratory rate 13, blood pressure 139/94, and oxygen saturation 93%.
-A portable chest x-ray was performed with no evidence of acute cardiopulmonary process.
-A CT Head (a medical imaging procedure that uses x-rays to create detailed images of the brain) was completed with no acute intracranial abnormality identified.
-There was an order to follow up with PCP with no specified time frame.

Review of Resident #4's charting note entry dated 04/25/25 at 3:28pm revealed:
-Resident #4's family member came in today and took the resident back to the hospital.
-Resident #4 was shaky and confused.
-The hospital evaluated Resident #4 and sent him back saying he had high ketones.

Review of Resident #4's charting note entry dated 04/25/25 at 6:06pm revealed:
-Resident #4 was confused and did not know

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where he was.
-Resident #4 left the building and was found at the stop sign.
-He was brought back to the facility and placed in the SCU "for his own safety."

Review of Resident #4's charting note entry dated 04/25/25 at 6:21pm revealed:
-A staff member spoke with Resident #4's family member and made him aware of the situation.
-The family member was in agreement with placing Resident #4 in the SCU.

Review of Resident #4's record revealed there was no documentation of contact or consultation with the PCP or MHP on 04/25/25 prior to placing Resident #4 into the SCU.

Review of Resident #4's MHP visit note dated 05/01/25 revealed:
-Staff report resident was noted to be acting strangely and more confused about a week ago.
-He was sent to the hospital where urinalysis and further labs were done.
-He was sent back in the same condition.
-A family member took him back to the hospital the next day and a CT and further labs were done.
-The CT showed nothing significant.
-He continued to have flat affect and blank stare.
-He was incontinent and had difficulty performing any kind of tasks.
-He was not eating more than a few bites at a time.
-He was having delusions.
-He left the building and walked down the driveway.
-When staff caught up with him, he was very confused and did not know where to go.
-He was then moved to the SCU.

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-He had a history of cerebral vascular accident and this could be another episode.

Review of Resident #4's physician communication dated 05/09/25 revealed:
-Resident #4 has been placed in the SCU due to an acute decline in cognitive impairment and elopement risk.
-The document was not signed by the PCP or MHP.

Interview with the Special Care Coordinator (SCC) on 09/23/25 at 4:55pm revealed:
-She had completed Resident #4's physician communication dated 05/09/25.
-She had forgotten to go back and finish the order by having Resident #4's PCP sign the order.

Telephone interview with Resident #4's family member on 09/24/25 at 1:30pm revealed:
-He had visited Resident #4 on 04/25/25 and he was "off with his thoughts."
-Resident #4 was "not in his right mind."
-On 04/25/25, the facility told him they had placed Resident #4 on the SCU for his safety.
-The facility staff said after speaking with his "doctors" Resident #4 should be in the SCU.
-Resident #4 might do better if he went back to AL.
-Resident #4 was "locked up" in the SCU and could not get out or go outside.
-He thought going outside would help Resident #4.

Telephone interview with Resident #4's MHP on 09/24/25 at 3:40pm revealed:
-Resident #4 very much wanted to leave the SCU.
-There was concern Resident #4 would exit the building and cause harm to himself if he moved

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back to AL.
-He was placed in the SCU for his safety, but she would be willing to try moving him back to AL if the staff could supervise him.

Interview with the SCC on 09/24/25 at 4:44pm revealed:
-Resident #4 was placed in the SCU on 04/25/25 for his safety.
-On 04/25/25, Resident #4 was confused, had eloped, and was hallucinating.
-Resident #4's family member was notified about the move to the SCU on 04/25/25.
-Her main thought on 04/25/25 was how to keep Resident #4 safe.
-She did not remember if she contacted the MHP or PCP prior to moving Resident #4 into the SCU.
-She would have texted the PCP and MHP to communicate with them.
-She did not keep her text messages back as far as April 2025.
-She did not know when the PCP was made aware.
-She probably had a meeting with the Administrator.
-The Administrator would have made the decision to move Resident #4 into the SCU for his safety.
-She did not know when the first time the MHP knew Resident #4 was moved to the SCU.
-Resident #4's PCP would have seen Resident #4 in the SCU on 05/08/25 when he signed off on the new FL2.
-She knew Resident #4 wanted to go back to AL.

Interview with a medication aide (MA) Supervisor on 09/25/25 at 9:50am revealed:
-She was involved in a medication pass on 04/25/25 about 5:00pm, when Resident #4 "walked off."
-Resident #4 had not been feeling himself and

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had been sent to the hospital a few times before and the hospital had sent him back.
-Resident #4 was talking and it did not make sense.
-He kept saying he wanted to go home.
-Resident #4 was placed in the SCU until they could figure out what was wrong with him.

Telephone interview with Resident #4's PCP on 09/25/25 at 10:04am revealed:
-Resident #4 would go in and out of a catatonic state (a medical condition characterized by significant disturbances in motor behavior, consciousness, and cognitive function).
-Sometimes when he visited Resident #4, he was "normal" and some visits Resident #4 was a totally different person.
-He felt it was safe for Resident #4 to be in the SCU now.

Interview with the SCC on 09/25/25 at 12:00pm revealed:
-She did not have documentation of notification of the PCP.
-She did not think she contacted the PCP on 04/25/25, because the incident with Resident #4 occurred after 5:00pm on a Friday.

Telephone interview with the MHP on 09/25/25 at 12:35pm revealed:
-Resident #4 was placed in the SCU for his safety after the elopement.
-The Administrator decided he should stay there until further notice.
-She did not remember when the facility notified her about the move to the SCU.
-She was at the facility on 05/01/25 and they told her what happened.

Telephone interview with the PCP on 09/25/25 at

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW MANOR CARE CENTER	150 CRISP STREET FRANKLIN, NC 28734

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 39 12:50pm revealed: -He was "certain" staff notified him about moving Resident #4 to the SCU. -He was available to the staff 24 hours a day/7 days as week to discuss emergency situations. -He did not know the exact date the staff notified him. -Staff would have texted him and then talked to him about it on his routine visit to the facility. -He did not keep all the texts and voicemails he received going back to April 2025 due to the volume of messages he received. -He was in the facility to see Resident #4 on 05/08/25. Interview with the Administrator on 09/25/25 at 2:15pm revealed: -She was sure she was asked by the staff about placing Resident #4 in the SCU on 04/25/25. -She was sure the staff contacted Resident #4's family member before placing Resident #4 in the SCU on 04/25/25. -The family member was aware and accepting of placing Resident #4 in the SCU on 04/25/25. _____ The facility failed to ensure Resident #4 was treated with dignity and respect by placing him in the special care unit without consultation or approval from the PCP or MHP. The PCP and MHP were not notified until they arrived at the facility for scheduled visits, which were more than a week after placement. The resident was his own responsible person and indicated he did not want to be in the SCU. The PCP signed an FL2 indicating SCU was needed on 05/08/25, two weeks after Resident #4 was placed in the SCU by the facility. This failure was detrimental to the welfare of Resident #4 and constitutes a Type B Violation. _____	D 338		

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D 338	Continued From page 40 The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/25/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 9, 2025.	D 338		
D 463	10A NCAC 13F .1306 Admission To The Special Care Unit 10A NCAC 13F .1306 Admission To The Special Care Unit In addition to meeting all requirements specified in the rules of this Subchapter for the admission of residents to the home, the facility shall assure that the following requirements are met for admission to the special care unit: (1) A physician shall specify a diagnosis on the resident's FL-2 that meets the conditions of the specific group of residents to be served. (2) There shall be a documented pre-admission screening by the facility to evaluate the appropriateness of an individual's placement in the special care unit. (3) Family members seeking admission of a resident to a special care unit shall be provided disclosure information required in G.S. 131D-8 and any additional written information addressing policies and procedures listed in Rule .1305 of this Subchapter that is not included in G.S. 131D-8. This disclosure shall be documented in the resident's record. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to document a pre-admission screening by the facility to evaluate the appropriateness of an individual's placement in	D 463		

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D 463	Continued From page 41	D 463		

the special care unit (SCU) for 1 of 2 sampled residents (Resident #4).

The findings are:

Review of the facility's SCU policies (no date indicated) revealed:
-A mini-cognitive assessment that screen positive for dementia must be done within 10 days before or upon admission.
-A Geriatric Depression Scale must be completed within 10 days before or upon admission.
-The family and facility personnel agree upon the admission status of the resident using "The Global Deterioration Scale for Assessment of Primary Degenerative Dementia."

Review of Resident #4's current FL2 dated 05/08/25 revealed diagnoses included mild cognitive impairment with psychotic symptoms, cerebral vascular accident, acute cerebral infarct x2, anxiety disorder, and psychosis.

Review of Resident #4's charting note entry dated 04/25/25 at 6:06pm revealed:
-Resident #4 was "super confused" and had no idea where he was.
-Resident #4 left the building and was found at the stop sign.
-He was brought back to the facility and placed in the SCU for "his own safety."

Review of Resident #4's mini-cognitive assessment dated 09/23/25 revealed:
-The interpretation was a positive screen.
-Abnormal clock drawing test was documented.
-Less than 3 items recalled correctly or no items recalled correctly was documented.

Review of Resident #4's examination for

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D 463	Continued From page 42 detecting mild cognitive impairment and dementia dated 09/23/25 revealed: -The total score was 16. -A score of 1-20 was documented to indicate dementia. Review of Resident #4's Geriatric Depression Scale dated 09/23/25 revealed: -The total score documented was two. -A score of more than five indicated a more thorough clinical investigation should be undertaken. Interview with the Special Care Coordinator (SCC) on 09/23/25 at 4:55pm revealed: -She was responsible for completing a SCU pre-admission screening per facility policy on each new admission. -She had forgotten to obtain the SCU pre-admission screening when Resident #4 was admitted to the SCU. Interview with the Administrator on 09/25/25 at 4:30pm revealed the SCC was responsible for completing the SCU pre-admission screening per facility policy.	D 463		