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	FCL046030	A. BUILDING: _____ B. WING _____	R 10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONFIDENCE BUILDERS II	1135A AHOSHIE-COLFIED ROAD COFIELD, NC 27922

(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, follow up survey, and complaint investigation from 10/15/25 through 10/16/25 with an exit conference via telephone on 10/16/25.	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 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:	C 007		

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C 007	Continued From page 2 Based on observations, interviews, and record 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 2 of 4 sampled residents who did not exit the facility during a fire drill. The findings are: Review of the facility's license revealed: -The facility was licensed effective 01/01/25 for a capacity of 5 ambulatory residents. -The expiration date of the facility's license was 12/31/25. Observation of the facility on 10/16/25 from 11:09am to 11:17am revealed: -The Administrator used a long stick to activate the smoke detector in the laundry room. -Fire alarms could be heard throughout the facility. -Two residents came out of their individual bedrooms and exited through the back door and stood in the back yard at 11:10am. -Two additional residents that shared a bedroom remained in their bedroom with the bedroom door open. -One resident in the room said, "fire drill." -The state surveyor went to ask the residents what they did when they heard the fire alarm at 11:14am. -One resident was standing near his dresser, and the other resident was sleeping in his bed on his side. -The resident that was standing near his dresser said he thought it was a fire drill just because the state surveyors were at the house. -The two residents that shared a bedroom exited the facility by the back door at 11:17am.	C 007		

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C 007	Continued From page 3 Interview with the Administrator on 10/16/25 at 11:19am revealed: -She did not know why the two residents that shared a bedroom did not come out of their room. -When she conducted fire drills all the residents exited within at least 2 minutes. Telephone interview with the Administrator on 10/16/25 at 5:25pm revealed: -The residents usually exited the facility quickly when she ran a fire drill. -She had to remind them at times to exit the facility because it was a fire drill. -She probably needed to practice with the residents more often to ensure they knew when to exit the building when the fire alarm went off in the facility. -She was not aware that she needed to notify the construction division with DHSR about the residents' needing to be prompted during a fire drill. -She considered ambulatory status as each resident's abiltiy to walk independently to exit the faciltiy during a fire drill. Refer to Tag C0022 10A NCAC 13G .0302(b) Design and Construction.	C 007		
C 023	10A NCAC 13G .0302 (c) Design And Construction 10A NCAC 13G .0302 Design And Construction (c) A family care home shall not offer services for which the facility was not planned, constructed, equipped, or maintained.	C 023		

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C 023	Continued From page 4	C 023		

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure that the evacuation capabilities for 2 of 4 sampled residents (#3, #4), who did not respond to a fire alarm were in accordance with the evacuation capability listed on the facility's current license.

The findings are:

Review of the facility's license revealed:
-The facility was licensed effective 01/01/25 for a capacity of 5 ambulatory residents.
-The expiration date of the facility's license was 12/31/25.

Observation of the facility on 10/15/25 at 8:40am revealed:
-There were 4 residents present.
-There were 2 exits at the facility, a front door and back door.

Observation of the facility on 10/16/25 from 11:09am to 11:17am revealed:
-The Administrator used a long stick to activate the smoke detector in the laundry room.
-Fire alarms could be heard throughout the facility.
-Two residents came out of their individual bedrooms and exited the back door and stood in the back yard at 11:10am.
-Two additional residents that shared a bedroom remained in their bedroom with the bedroom door open.

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C 023	Continued From page 5 -One resident in the room said, "fire drill." -The state surveyor went to ask the residents what they did when they heard the fire alarm at 11:14am. -One resident was standing near his dresser, and the other resident was sleeping in his bed on his side. -The resident that was standing near his dresser said he thought it was a fire drill just because the state surveyors were at the house. -The two residents that shared a bedroom exited the facility by the back door at 11:17am. Review of Resident #3's current FL-2 dated 04/14/25 revealed: -Diagnoses included seizure confusion and Wernicke-Korsakoff syndrome. -The resident was ambulatory. -There was no documentation of the resident's disorientation status. Review of Resident #3's Care Plan dated 09/11/25 revealed: -The resident was sometimes disoriented. -The resident had significant memory loss and must be directed. Interview with Resident #3 at 11:18am revealed: -He kept sleeping when he heard the smoke detector. -He did not get up to leave the facility because he never heard the Administrator tell him to get up that it was a fire drill. Review of Resident #4's current FL-2 dated 08/08/25 revealed: -Diagnosis included dementia. -The resident was ambulatory and intermittently disoriented.	C 023		

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C 023	Continued From page 6 Review of Resident #4's Care Plan dated 01/01/25 revealed: -The resident was always disoriented. -The resident had significant memory loss and must be directed. Interview with Resident #4 at 11:20am revealed: -He hollered out "fire drill," but did not leave his room because he thought the Administrator was just testing the smoke detector since the state was at the facility. -He stayed in his room because he did not think it was a real fire drill. -He usually exited the home and went to the back yard when the smoke detector went off. Interview with the Administrator on 10/15/25 at 11:22am revealed: -She did not understand why Resident #3 or Resident #4 did not exit the facility when she performed the fire drill. -Resident #3 and Resident #4 both knew to exit the facility when they heard the smoke detector go off. -Sometimes she had to prompt the residents to exit the building. -She was not aware that she needed to practice the fire drills without prompting the residents to leave the facility.	C 023		
C 069	10A NCAC 13G .0312 (g) Outside Entrance And Exits 10A NCAC 13G .0312 Outside Entrance and Exits (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	C 069		

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C 069	Continued From page 7 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: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 2 exit doors accessible to a resident who was diagnosed with bipolar disorder and schizophrenia (#1), a resident who was diagnosed with dementia (#2), a resident who was diagnosed with seizure confusion and Wernicke-Korsakoff Syndrome (Wernicke-Korsakoff Syndrome is a chronic memory disorder caused by severe Vitamin B1 deficiency), (#3), and a resident that was diagnosed with dementia (#4) had a working alarm that was of sufficient volume that could be heard by staff when activated and responded to for the safety of residents. The findings are: Review of the facility's license revealed: -The facility was licensed effective 01/01/25 for a capacity of 5 ambulatory residents. -The expiration date of the facility's license was 12/31/25.	C 069		

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C 069	Continued From page 8 Observation of the facility on 10/15/25 intermittently from 8:45am to 12:30pm, and intermittently from 1:30pm to 4:15pm revealed: -There were 2 exit doors at the facility, the front door and back door. -There was an alarm at the upper left side of the front door that connected with an alarm on the door frame when the front door was closed. -When the front door was opened there was no audible alarm on the door. -There was no audible alarm upon entrance and exit of the facility through the front entrance. -Residents and staff were observed entering and exiting through the back door throughout the day. -3 residents were observed opening the front door and looking outside the front storm door, there was no audible alarm when the front door was opened. -The Administrator opened the front door once on the afternoon of 10/15/25 and there was no audible alarm on the door. Observation of the facility on 10/16/25 intermittently from 8:00am to 12:00pm revealed there was no audible alarm when the front door was opened. Observation of the facility on 10/16/25 intermittently from 12:45pm to 1:45pm revealed there was no audible alarm when the front door was opened. Review of Resident #1's current FL-2 dated 11/20/24 revealed: -Diagnoses included bipolar disorder and schizophrenia. -The resident was ambulatory and intermittently disoriented. Review of Resident #2's current FL-2 dated	C 069		

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C 069	Continued From page 9	C 069		

02/25/25 revealed:
-Diagnosis included dementia.
-The resident was ambulatory and intermittently disordered.
-The resident wandered.

Review of Resident #3's current FL-2 dated 04/14/25 revealed:
-Diagnoses included seizure confusion and Wernicke-Korsakoff syndrome.
-The resident was ambulatory.
-There was no documentation of the resident's disorientation status.

Review of Resident #4's current FL-2 dated 08/08/25 revealed:
-Diagnosis included dementia.
-The resident was ambulatory and intermittently disoriented.

Interview with the Administrator on 10/15/25 at 11:15am revealed:
-She was not aware that the front door exit alarm did not make an audible sound.
-She had a new alarm to put on the door but needed someone to help her place the new alarm on the front door, she expected to replace it later in the day.

Interview with the Administrator on 10/16/25 at 8:18am revealed:
-The front exit door still did not have an audible alarm on it that worked.
-She did not put the new alarm on the front door last night (10/15/25) or the morning of 10/16/25.
-She would have to have a family member or staff assist her with placing the alarm on the front door.
-A family member or staff should be able to help her install the alarm for the front door after

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C 069	Continued From page 10 5:00pm today 10/16/25. Telephone interview with the Administrator on 10/16/25 at 5:25pm revealed: -She was not aware that she needed an audible alarm on the exit doors. -She planned to have a family member or staff help her later this evening (10/16/25) install the exit door alarm.	C 069		
C 102	10A NCAC 13G .0317 (a) Building Service Equipment 10A NCAC 13G .0317 Building Service Equipment (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in a family care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure fire safety equipment was maintained in a safe operating condition for two smoke detectors that did not have an operable battery. The findings are: Review of the facility's license revealed:	C 102		

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C 102	Continued From page 11 -The facility was licensed effective 01/01/25 for a capacity of 5 ambulatory residents. -The expiration date of the facility's license was 12/31/25. Observation of the facility on 10/15/25 at 8:40am revealed: -There were 4 residents present. -There were 2 exits at the facility, a front door and back door. Review of a Fire Inspection Report for the facility dated 10/14/25 revealed: -A fire inspection was completed on 10/14/25 by the Office of the Fire Marshal. -There was documentation that the facility was compliant. -There was documentation that the facility had no violations. Observation of the facility on 10/15/25 intermittently from 8:45am to 11:14am revealed: -There was a loud beeping sound coming from two smoke detectors in the facility. -There were two smoke detectors beeping, one was in the laundry room and the second was in the bathroom connected to the staff bedroom. Observation of the facility on 10/15/25 at 11:15am revealed: -The Administrator and her family member replaced the battery of the smoke detector in the laundry room. -The smoke detector in the laundry room stopped beeping once a new battery was placed in the detector. Observation of the facility on 10/15/25 intermittently from 11:15am to 12:30pm and from 1:30pm to 4:15pm revealed the smoke detector	C 102		

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C 102	Continued From page 12 located in the bathroom connected to the staff bedroom continued to make a beeping sound throughout the facility. Interview with the Administrator on 10/15/25 at 1:30pm revealed: -She and a family member were unable to reach the smoke detector that continued to beep in the bathroom connected to the staff bedroom. -Another family member planned to come to the facility later to replace the battery on the smoke detector. Observation of the facility on 10/16/25 intermittently from 8:00am to 12:00pm and from 12:45pm to 1:45pm revealed the smoke detector located in the bathroom connected to the staff bedroom continued to make a beeping sound throughout the facility. Telephone interview with the Administrator on 10/16/25 at 5:25pm revealed: -Her family member attempted to replace the battery with the smoke detector last night (10/15/25), but it continued to make a beeping sound. -She was worried that the smoke detector was not working correctly and decided to call the local fire department to see if they would be able to provide her with assistance with the smoke detector. -The local fire department called her this afternoon (10/16/25) and a representative from the local fire department would visit the facility on 10/17/25 to see if they could fix the smoke detector. -She had not noticed either smoke detector beeping prior to the state surveyors bringing it to her attention. _____	C 102		

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C 102	Continued From page 13 The facility failed to ensure fire safety equipment was maintained in safe operating condition as evidenced by 2 beeping smoke detectors, one in a laundry room that was beeping due to an inoperable battery and one smoke detector that was unable to be fixed with a new battery that continued to make a beeping sound that was located in the staff bathroom connected to the staff bedroom . The facility's failure to ensure the safe operating condition of fire safety equipment was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on October 15, 2025, for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED November 30, 2025.	C 102		
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 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	C 120		

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C 120	Continued From page 14 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 maintain detailed fire rehearsal records which included a date the fire drill was conducted and a description of what the rehearsal involved. The findings are: Review of the facility's license revealed: -The facility was licensed effective 01/01/25 for a capacity of 5 ambulatory residents. -The expiration date of the facility's license was 12/31/25. Observation of the facility on 10/15/25 at 8:40am revealed: -There were 4 residents present. -There were 2 exits at the facility. -There was an exit on the front of the facility that led to the front yard. -There was an exit at the back of the facility that led to a back porch deck which led to the back yard. Review of the facility's Fire Drill 2025 log revealed:	C 120		

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C 120	Continued From page 15 -The sheet was used for fire drills and was titled Fire Drills 2025. -There was a month listed and time that the fire drill was conducted. -There was documentation under each month of how long it took the residents to complete the fire drill. -There were initials of which residents participated in the fire drill and which staff conducted the fire drill. -A fire drill was conducted in July 2025 at 8:00am; there was no specific date on the fire drill log. -There was no documentation of the description of what the fire drill involved. -Resident and staff initials were listed under the July 2025 heading. -A fire drill was conducted in August 2025 at 10:00pm; there was no specific date on the fire drill log. -There was no documentation of the description of what the fire drill involved. -Resident' and staff initials were listed under the August 2025 heading. -A fire drill was conducted in September 2025 at 1:00am; there was no specific date on the fire drill log. -There was no documentation of the description of what the fire drill involved. -Resident and staff initials were listed under the September 2025 heading. Telephone interview with the Administrator on 10/16/25 at 5:25pm revealed: -She was not aware that she needed to include a description of what the fire drill involved. -She was not aware that she needed to include the exact date of when the fire drill was conducted. -She conducted fire drills randomly. -When she conducted a fire drill if the residents	C 120		

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C 120	Continued From page 16 were slow coming out of the facility, she prompted them and encouraged them to leave the facility for the fire drill.	C 120		
C 148	10A NCAC 13G .0406 (a)(8) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (8) have an examination and screening for the presence of controlled substances completed in accordance with G.S. 131D-45 and results available in the staff person's personnel file; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure an examination and screening for the presence of controlled substances was completed for 1 of 6 (Staff F) prior to hire. The findings are: Review of Staff F's personnel record revealed: -Staff F was hired on 10/08/25. -Staff F was hired as a personal care aide (PCA). -There was no documentation of a completed drug screening. Telephone interview with the Administrator on 10/16/25 at 5:25pm revealed: -She was responsible for completing drug tests on all new staff by their hire date. -It was an oversight, and she forgot to complete a drug test for Staff F by her hire date.	C 148		

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C 246	Continued From page 17	C 246		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure follow up to meet the acute health care needs for 1 of 3 sampled residents (#2) requiring behavioral health services. The findings are: Review of Resident #2's current FL2 dated 02/25/25 revealed: -Diagnoses included dementia, hypertension, sinus bradycardia, elevated troponin, and benign prostatic hyperplasia with urinary retention. -The resident was ambulatory. -The resident was intermittently disoriented. Review of Resident #2's Care Plan dated 04/21/25 revealed: -Resident #2 received mental health services. - Resident #2 was injurious to self. -In the mental health comments, there was documentation that Resident #2 gets frustrated with himself and what he does not know to do; however, it is best for him to keep all appointments. -He would be monitored for changes in behavior and physical appearance. -Resident #2's primary care provider (PCP) reviewed and dated the care plan on 04/23/25. Review of Resident #2's facility progress note dated 03/22/25 revealed:	C 246		

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C 246	Continued From page 18 -The Administrator contacted the local magistrate office regarding Resident #2 walking into the middle of the road on 03/22/25. -The Administrator requested an involuntary commitment (IVC) from the magistrate. -The magistrate stated that the incident only happened once and that she was not going to issue an IVC. -No other information was provided. Review of Resident #2's hospital after visit summary (AVS) dated 09/02/25 revealed: -The reason for the visit was involuntary commitment. -His diagnoses were depression, unspecified depression type. -His testing consisted of an electronic cardiogram, comprehensive metabolic panel urine drug screen, and ethanol. -He was discharged back to the facility on 09/02/25. Review of Resident #2's behavior health note dated 06/02/25 revealed: -Diagnoses were severe dementia with agitation. -Major depressive disorder with current active episode. -Discussed the importance of Resident #2 attending medical appointments and therapy sessions. -Encouraged Resident #2 to engage in new activities such as art or community groups. -Resident #2 appeared to comprehend what was asked of him during the therapy session. -Supportive counseling was provided. -The plan and recommendations were to begin sessions with behavioral health and provide Resident #2 with information regarding mobile crisis services should he need 24/7 crisis intervention services.	C 246		

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-The behavioral health staff were to consult with Resident #2's PCP regarding medication evaluation to address and better manage current symptoms.
-Resident #2 was amenable to medication intervention and the goal start date was 06/02/25.
-Resident #2 was encouraged to contact behavioral health and PCP as indicated and attend all scheduled appointments.
-The Administrator did not schedule a return appointment for Resident #2.

Interview with Resident #2 on 10/16/25 at 10:00am revealed:
-He liked to get out and walk but "they think I am trying to leave".
-His brother lived a few houses down and he liked going to visit with him.
-He liked to get out of the facility because there was nothing to do.
-He told the Administrator that he was walking to see his brother, and he would return the day the emergency staff came but he could not recall the date that happened.
-The Administrator said to him "no, come on back, you ain't going nowhere".
-He did not mean any harm; he just wanted to get out of the facility.
-He would love to get out into the community more and go to a day program and just be around others.
-He remembered speaking with a therapist once but could not recall when it was.
-He wanted to see a therapist more to talk about his feelings but did not know why he was not seeing one.

Telephone interview with Resident's #2's PCP triage nurse on 10/15/25 at 3:46pm revealed:
-There was no note about Resident #2's 03/22/25

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behavioral episode.
-Resident #2 next PCP visit after the behavioral episode was three months later on 06/25/25.
-The PCP did expect staff to contact her for residents' outburst episodes.
-If the PCP does not know about the episodes they cannot be addressed.
-The PCP would have made an assessment to see if a urinary tract affection (UTI) was causing the cognitive agitation.
-There was nothing in Resident #2's chart that discussed his outburst to her knowledge.

Telephone interview with Resident #2's behavior health staff (BHS) on 10/16/25 at 8:45am revealed:
- Resident #2 attended a behavioral health session on 06/02/25.
-Supportive counseling was provided.
-Resident #2 was able to engage and communicate with the BHS.
-Resident #2 shared he would like to get into the community more.
-The BHS recommended Resident #2 begin sessions with the behavioral health provider.
-The Administrator did not want to schedule a return appointment for Resident #2.

Interview with the Administrator on 10/15/25 at 11:11am revealed:
-on 03/22/25, Resident #2 became agitated and walked out of the facility and did not sign out.
-The Administrator could not say why he was agitated that day.
-She followed him, and he walked out into the middle of the road then he crossed the road and walked into the woods.
-She was unable to redirect Resident #2, and she called 911 for assistance.
-The Sheriff came and drove Resident #2 back to

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C 246	Continued From page 21 the facility. -The Administrator contacted the magistrate to request an IVC but the magistrate denied the request because it was a one-time incident. Second interview by telephone with the Administrator on 10/16/25 at 5:25pm revealed: -She did not contact Resident #2's PCP after the 03/22/25 incident. -On 09/02/25, Resident #2 became agitated and walked away from the facility twice on that date, and she could not recall why he was upset. -She contacted 911 for assistance. -The second time he walked away that day she got him into the car and took him to the sheriff office to do an IVC. -She did not contact Resident #2's PCP after the 09/02/25 incident. -She went with Resident #2 into the therapy session on 06/02/25. -Her understanding about a second appointment was to call the behavioral health provider if Resident #2 needed to be seen or call when you wanted to make an appointment. -She did not attempt a second appointment with therapist because Resident #2 was not a talkative person. -She was not aware that Resident #2 wanted to speak with someone about his feelings. Attempted telephone interview with Resident #2's family member on 10/15/25 at 11:09am was unsuccessful.	C 246		
C 288	10A NCAC 13G .0905(a) Activities Program 10A NCAC 13G .0905 Activities Program (a) Each family care home shall develop a program of activities designed to promote the	C 288		

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C 288	Continued From page 22 residents' active involvement with each other, their families, and the community. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to develop and implement an activity program to engage residents with each other and the community. The findings are: Observation on 10/16/25 from 9:00am to 5:00pm revealed: -An October 2025 activity calendar was posted on the wall in the dining room area. -There were activities listed on the October 2025 calendar. -Music movie and food were listed on that day. -There were no activities offered on 10/16/25. Interview with a resident on 10/15/25 at 9:06am revealed: -There were not many activities offered in the facility. -He mostly watched television in his room. Interview with a second resident on 10/16/25 at 10:00am revealed: -There were no activities to do with other residents. -Sometimes he played cards alone to stay busy but not every day. -He liked to get out of the facility because there was nothing to do. Interview with the Administrator on 10/16/25 at 5:50pm revealed: -There were activities to do every day to get their hours in.	C 288		

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C 288	Continued From page 23 -She had community days, and this was to get the residents out into the community with others. -There were no activities on 10/16/25 because the surveyors were in the facility. -She was responsible for the facility activity program.	C 288		
C 444	10A NCAC 13G .1213 Reporting Of Accidents And Incidents 10A NCAC 13G .1213 Reporting of Accidents and Incidents (a) A family care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to notify the county Department of Social Services (DSS) of incidents or accidents (I/A) resulting in an involuntary commitment (IVC) due to behavioral issues for 1 of 3 sampled residents (#2). The findings are: Review of Resident #2's current FL2 dated 02/25/25 revealed: -Diagnoses included dementia, hypertension, sinus bradycardia, elevated troponin, and benign prostatic hyperplasia with urinary retention.	C 444		

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-The resident was ambulatory.
-The resident was intermittently disoriented.

Review of Resident #2's Care Plan dated 04/21/25 revealed:
-Resident #2 received mental health services.
- Resident #2 was injurious to self.
-In the mental health comments, there was documentation that Resident #2 gets frustrated with himself and what he does not know to do; however, it is best for him to keep all appointments.
-He would be monitored for changes in behavior and physical appearance.
-Resident #2's primary care provider (PCP) reviewed and dated the care plan on 04/23/25.

Review of Resident #2's hospital after visit summary (AVS) dated 09/02/25 revealed:
-The reason for the visit was involuntary commitment.
-His diagnoses were depression, unspecified depression type.
-His testing consisted of an electronic cardiogram, comprehensive metabolic panel urine drug screen, and ethanol.
-He was discharged back to the facility on 09/02/25.

Interview with Resident #2 on 10/16/25 at 10:00am revealed he told the Administrator that he was walking to see his brother, and he would return the day the emergency staff came but he could not recall the date that happened.

Interview with the Administrator on 10/15/25 at 11:11am revealed:
-on 03/22/25, Resident #2 became agitated and walked out of the facility and did not sign out.
-The Administrator could not say why he was

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C 444	Continued From page 25 agitated that day. -She followed him, and he walked out into the middle of the road then he crossed the road and walked into the woods. -She was unable to redirect Resident #2, and she called 911 for assistance. Second interview by telephone with the Administrator on 10/16/25 at 5:25pm revealed: -She did not contact Resident #2's PCP after the 03/22/25 incident. -On 09/02/25, Resident #2 became agitated and walked away from the facility twice on that date, and she could not recall why he was upset. -She contacted 911 for assistance. -The second time he walked away that day she got him into the car and took him to the sheriff office to do an IVC. -She did not complete an Incident/Accident (I/A) report to send to Department of Social Services. -She thought she only had to do an I/A report if a resident was bleeding and needed to go to the hospital.	C 444		