| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL049033 | A. BUILDING: _____ B. WING _____ | R 11/05/2025 |

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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on November 04, 2025-November 05, 2025. | D 000 | | |
| D 259 | 10A NCAC 13F .0802 (a) (c) Resident Care Plan<br><br>10A NCAC 13F .0802 Resident Care Plan<br><br>(a) The facility shall develop and implement a care plan for each resident based on the resident's assessment completed in accordance with Rule .0801 of this Section. The care plan shall be resident-centered and include the resident's preferences related to the provision of care and services. A copy of each resident's current care plan shall be maintained in a location in the facility where it can be accessed by facility staff who are responsible for the implementation of the care plan.<br>(c) The care plan shall include the following:<br>(1) a description of services, supervision, tasks, and level of assistance to be provided to address the resident's needs identified in the resident's assessment in Rule .0801 of this Section;<br>(2) frequency of the services or tasks to be performed;<br>(3) revisions of tasks and frequency based on reassessments in accordance with Rule .0801 of this Section;<br>(4) licensed health professional tasks required according to Rule .0903 of this Subchapter;<br>(5) a dated signature of the assessor upon completion; and<br>(6) a dated signature of the resident's physician or physician extender as defined in Rule .0102 of this Subchapter within 15 days of completion of the care plan certifying the resident is under this physician's care and has a medical diagnosis with associated physical or mental limitations | D 259 | | |

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| D 259 | Continued From page 1<br>warranting the provision of the personal care services in the above care plan in accordance with G.S. 131D-2.15. This shall not apply to residents assessed through the Medicaid State Plan Personal Care Services Assessment for the portion of the assessment covering tasks needed for each activity of daily living of this Rule for which care planning and signing are directed by Medicaid.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to ensure 2 of 5 sampled residents (#2 and #3) had a care plan completed annually.<br><br>The findings are:<br><br>1. Review of Residents #2's current FL2 dated 07/23/25 revealed:<br>-Diagnoses included neurogenic bladder, benign prostate hyperplasia, and paranoid schizophrenia.<br>-Resident #2 was admitted to the facility on 09/05/23.<br><br>Review of Resident #2's care plan dated 05/21/24 revealed:<br>-He was independent with eating, toileting, ambulation, bathing, dressing, grooming and transferring.<br>-He used a rollator walker when ambulating.<br><br>Review of Resident #2's chart revealed there was no updated care plan after 05/21/24.<br><br>Refer to the interview with the medication aide (MA) on 11/05/25 at 11:05am. | D 259 | | |

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| D 259 | Continued From page 2<br><br>Refer to the interview with the Administrator on 11/05/25 at 3:12pm.<br><br>2. Review of Residents #3's current FL2 dated 03/12/25 revealed diagnoses included Alzheimer's disease, hypertension and asthma.<br><br>Review of Resident #3's Resident Register revealed an admission date of 06/06/24.<br><br>Review of Resident #3's care plan dated 06/11/24 revealed:<br>-Resident #3 was independent with eating, ambulation, and transfers.<br>-Resident #3 required limited assistance with toileting, bathing, dressing and grooming.<br><br>Review of Resident #3's chart revealed there was no updated care plan after 06/11/24.<br><br>Refer to the interview with the medication aide (MA) on 11/05/25 at 11:05am.<br><br>Refer to the interview with the Administrator on 11/05/25 at 3:12pm.<br><br>_____<br>Interview with the medication aide (MA) on 11/05/25 at 11:05am revealed:<br>-Care plans were completed by the Resident Care Coordinator (RCC).<br>-She did not know who was doing care plans now because the RCC left several weeks ago.<br><br>Interview with the Administrator on 11/05/25 at 3:12pm revealed:<br>-She was responsible for care plans being completed.<br>-The RCC left October 14, 2025, and told her everything was caught up. | D 259 | | |

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| D 259 | Continued From page 3<br>-She did not check the charts after the RCC left and was not aware care plans were not completed. | D 259 | | |
| D 451 | 10A NCAC 13F .1212(a) Reporting of Accidents and Incidents<br><br>10A NCAC 13F .1212 Reporting of Accidents and Incidents<br>(a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid.<br><br>This Rule is not met as evidenced by:<br>Based on interviews and record reviews, the facility failed to notify the county Department of Social Services (DSS) of incidents resulting in injury requiring emergency medical evaluation and treatment for 3 of 5 sampled residents (#2, #3, and #5).<br><br>The findings are:<br><br>1. Review of Resident #2's current FL2 dated 07/23/25 revealed diagnoses included paranoid schizophrenia, neurogenic bladder and benign prostatic hyperplasia (BPH).<br><br>Review of an incident/accident report for Resident #2 dated 10/26/25 revealed:<br>-Resident #2 tripped and stepped on his catheter and pulled it out. | D 451 | | |

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| D 451 | Continued From page 4 | D 451 | | |

-Resident #2's penis was split.
-Resident #2 was transported by Emergency Medical Services (EMS) to the hospital.

Review of Resident #2's Emergency Department (ED) Discharge Summary dated 10/27/25 revealed:
-Resident #2 was seen in the ED for a wound to the penis due to the resident tripping on his catheter and pulling the catheter out of the penis.
-He had a tear and the catheter was replaced.

Telephone interview with the local county Adult Home Specialist on 11/04/25 at 3:01pm revealed:
-The facility had 24 hours to send incident/accident reports to her when they sent residents out to the hospital for emergency services.
-She did not receive an incident/accident report for Resident #2's ED visit on 10/26/25.

Refer to the interview with a medication aide (MA) on 11/05/25 at 1:04pm.

Refer to the interview with the Administrator on 11/05/25 at 3:12pm revealed:

2. Review of Resident #3's current FL2 dated 03/12/25 revealed diagnoses included Alzheimer's disease, hypertension and asthma.

Review of an incident/accident report for Resident #3 dated 10/29/25 revealed:
-Resident #3 had an unwitnessed fall.
-Resident #3 received a laceration (cut) to the right side of her temple.
-Resident #3 was transported by Emergency Medical Services (EMS) to the hospital.

Review of Resident #3's ED Discharge Summary

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| D 451 | Continued From page 5 | D 451 | | |

dated 10/29/25 revealed:
-Resident #3 was seen in the ED for a complex laceration (a wound that may include exposed bones or tendons and excessive bleeding) of the forehead due to an unwitnessed fall.
-She had a one-inch laceration to her forehead and received 8 sutures.

Telephone interview with the local county Adult Home Specialist on 11/04/25 at 3:01pm revealed:
-The facility had 24 hours to send incident/accident reports to her when they sent residents out to the hospital for emergency services.
-She did not receive an incident/accident report for Resident #3's fall on 10/29/25.

Refer to the interview with a medication aide (MA) on 11/05/25 at 1:04pm.

Refer to the interview with the Administrator on 11/05/25 at 3:12pm revealed:

3. Review of Resident #5's current FL2 dated 01/02/25 revealed diagnoses included dementia, venous insufficiency and congestive obstruction pulmonary disease.

Review of an incident/accident report for Resident #5 dated 10/09/25 revealed:
-Resident #5 slipped and fell in the shower.
-She had a bump on her forehead.
-Resident #5 was transported by EMS to the hospital.

Review of Resident #5's ED Discharge Summary dated 10/09/25 revealed:
-Resident #5 was seen in the ED for a hematoma (wound caused by bleeding under the skin) on her forehead.

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| D 451 | Continued From page 6<br><br>Telephone interview with the local county Adult Home Specialist on 11/04/25 at 3:01pm revealed:<br>-The facility had 24 hours to send incident/accident reports to her when they sent residents out to the hospital for emergency services.<br>-She did not receive an incident/accident report for Resident #5's ED visit on 10/09/25.<br><br>Refer to the interview with a medication aide (MA) on 11/05/25 at 1:04pm.<br><br>Refer to the interview with the Administrator on 11/05/25 at 3:12pm revealed:<br><br>_____<br>Interview with a medication aide (MA) on 11/05/25 at 1:04pm who prepared incident/accident reports revealed:<br>-She was responsible for filling out an incident/accident report on everything that happened on the unit where she was working.<br>-She turned the report into the resident care coordinator (RCC) or the Administrator.<br>-She was not aware DSS needed to have a copy of them.<br><br>Interview with the Administrator on 11/05/25 at 3:12pm revealed:<br>-She was responsible for faxing the incident/accident reports to DSS.<br>-The facility was faxing them to DSS and was not aware they were not getting them. | D 451 | | |