STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060184	A. BUILDING: _____ B. WING _____	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF PEACE FAMILY CARE HOME	3505 ORIOLE PLACE CHARLOTTE, NC 28269

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey from October 28, 2025 to October 30, 2025.	C 000		
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. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the evacuation capabilities of 2 of 3 sampled residents residing in the facility who had a cognitive impairments and required physical assistance (#2 and #3) were in accordance with the evacuation capability listed on the facility's current license. The findings are: Review of the facility's current license revealed the facility was licensed on June 5, 2025 due to a change of ownership and was for a capacity of 6 ambulatory residents.	C 023		

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C 023	Continued From page 1 Observations during the initial tour of the facility on 10/28/25 from 9:15am to 9:45am revealed: -There was a census of 5 residents. -The Co-Administrator and the Owner were in the facility. (We reference the Co-Administrator. Then who is the Administrator? If the Owner is also an administrator we should identify them as Administrator/Owner) Observation during a fire drill on 10/29/25 from 4:15pm to 4:30pm revealed: -The Co-Administrator or Owner sounded the fire alarm at 4:18pm. We don't know? -There were six staff present, consisting of medication aides (MAs), personal care aides (PCAs), a facility Nurse, the Co-Administrator and the Owner in the facility. -Resident #2 was in his bed in his room, and there was one family member in the room visiting. -Resident #3 was sitting at the dining room table with her rollator walker nearby. -Resident #3 was utilizing 5 liters of continuous oxygen with extensive oxygen tubing that extended from an oxygen concentrator in her nearby room at the dining room table. -There were two other residents and one staff member sitting at the dining room table with Resident #3, and they were all participating in a group activity. -There was another resident sitting in a lounge chair in the living room that was connected to the dining room. -Three staff emerged from a room where they were completing training with the facility nurse, and informed the residents "it's a fire drill, let's go!" -One staff member assisted Resident #3 from the dining room table to a standing position and positioned her rollator walker in front of her, disconnected Resident #3's oxygen tubing and	C 023		

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	FCL060184	A. BUILDING: _____ B. WING _____	10/30/2025

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C 023	Continued From page 2	C 023		

guided her towards the front door and out onto the front porch.
-The facility nurse and two other staff members went to Resident #2's room and transferred him to a wheelchair then assisted him to the front of the facility and out onto the front porch.
-The remaining three residents slowly walked towards the front door and exited with other staff who continuously provided verbal cues for everyone to get out of the facility and onto the porch.
-A staff member went back into the house and retrieved Resident #3's portable oxygen tank from her room and brought it outside for the resident's use.
-The Owner and three other staff members went back into the facility and closed all of the interior doors before exiting to the front porch to join the residents, other staff and one family member.
-All occupants of the facility were evacuated to the front porch by 4:21pm.
-Resident #2 was assisted by two staff into the facility via wheelchair and transferred back to bed.
-Resident #3 was assisted by one staff into the facility via her rollator walker, portable oxygen tank and tubing.

1. Review of Resident #2's current FL2 dated 04/24/25 revealed:
-Diagnoses included Alzheimer's disease, atrial fibrillation, osteoarthritis, and acid reflux.
-Resident #2 was semi-ambulatory.
-Resident #2 was constantly disorientated.
-Resident #2's level of care was assisted living.

Review of Resident #2's Resident Register revealed an admission date of 04/25/25.

Review of Resident #2's care plan dated 05/29/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060184	A. BUILDING: _____ B. WING _____	10/30/2025

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C 023	Continued From page 3	C 023		

revealed:
-Resident #2 required supervision with ambulation (walker).
-Resident #2 required limited assistance with bathing, toileting, dressing, grooming and transferring.

Review of Resident #2's record revealed he was admitted to hospice services on 06/30/25 and was bedbound.

Observation of Resident #2 on 10/28/25 from 9:30am to 9:35am revealed Resident #2 was in bed, being fed breakfast by staff, and presented with incoherent speech.

Interview with a MA on 10/29/25 at 7:10pm revealed:
-Resident #2 requires assistance with transfers from bed to wheelchair and could not evacuate the facility independently if there was an emergency.
-She did not know the difference between a resident who was ambulatory versus non-ambulatory.

Interview with the Co-Administrator on 10/29/25 at 5:30pm revealed:
-Resident #2 was highly functioning when he was admitted to the facility on 04/25/25.
-Resident #2 had a major health decline (cognition and physical ability) and was admitted to hospice care on 06/30/25.
-Resident #2 required extensive assistance with transfers in and out of bed and was considered non-ambulatory.
-Resident #2 could not participate in the fire drill independently due to his non-ambulatory status.

Interview with the Owner on 10/29/25 at 6:05pm

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C 023	Continued From page 4	C 023		

revealed:
-She was aware Resident #2 was considered non-ambulatory due to his cognition and bedbound status.
-She was awaiting a decision from the State Construction section on obtaining a waiver for Resident #2 to remain at the facility while receiving hospice care.

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

2. Resident #3's current FL2 dated 10/16/24 revealed:
-Diagnoses included chronic obstructive pulmonary disease, vascular dementia, and anemia.
-Resident #3 was semi-ambulatory.
-Resident #3 was intermittently disoriented.
-Resident #3's level of care was assisted living.

Review of Resident #3's Resident Register revealed an admission date of 10/21/24.

Intermittent observations of Resident #3 on 10/28/25 from 9:30am to 4:30pm revealed:
-Resident #3 received assistance from staff during transferring from dining room chair to standing position and ambulating to her rollator walker.
-Resident #3 used her rollator walker to ambulate short distances at a very slow pace.
-Resident #3 used 5 liters of continuous oxygen via nasal cannula attached to tubing that was connected to her oxygen concentrator in her room.
-Resident #3 received two breathing treatments administered by staff.
-Resident #3 spent most of the day in a recliner in

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	FCL060184	A. BUILDING: _____ B. WING _____	10/30/2025

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C 023	Continued From page 5 her bedroom or sitting at the dining room table participating in an activity. Observation of Resident #3 on 10/29/25 revealed she ambulated slowly with her rollator walker a short distance from her bedroom to the bathroom, then called out for assistance while she was in the bathroom. Interview with the Co-Administrator on 10/29/25 at 5:35pm revealed: -She and the facility Nurse were responsible for conducting pre-screening assessments, updating care plans, and assessing for change in condition to determine resident appropriateness. -Resident #3 was admitted to the facility with hospice care already involved. -Resident #3 was able to ambulate her rollator walker without assistance. -Resident #3 had some confusion. -Resident #3 did not demonstrate she could disconnect her oxygen tubing, nor ambulate to her room to obtain the portable oxygen tank, before evacuating the facility during the fire drill. -She did not know staff assisted Resident #3 by obtaining her portable oxygen tank after the occupants of the facility evacuated to the front porch during the fire drill. Interview with the Owner on 10/29/25 at 6:05pm revealed: -The Co-Administrator was responsible for the overall operations of the faciity because the Administrator was not at the facility. -When the fire drill was activated, Resident #3 was sitting at the dining room table participating in a group activity of bingo. -She was made aware staff assisted Resident #3 out of the facility and staff later returned to obtain Resident #3's portable oxygen tank.	C 023		

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	FCL060184	A. BUILDING: _____ B. WING _____	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 023	Continued From page 6 -She did not believe Resident #3 would be able to maneuver her portable oxygen tank and rollator walker on her own during an evacuation. -She did not consider Resident #3 non-ambulatory due to her ability to ambulate independently with her rollator walker and perform certain tasks. Based on observations, record reviews, and interviews it was determined Resident #3 was not interviewable. Refer to Tag D 0188 10A NCAC 13G.0601 (g) Management and Other Staff (Type B Violation). _____ The facility failed to ensure the evacuation capabilities for 2 of 5 residents (#2 and #3) were consistent with the current license of 6 ambulatory residents, as evidenced by two residents residing in the facility with cognitive impairments requiring physical assistance during a fire drill. This failure was detrimental to the health, safety and well-being of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/29/25 for this violation. _____ CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, DECEMBER 14, 2025.	C 023		
C 120	10A NCAC 13G .0316 (f) Fire Safety and Emergency Preparedness Plan	C 120		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060184	A. BUILDING: _____ B. WING _____	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 120	Continued From page 7 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 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: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to ensure unannounced fire drills were completed that demonstrated how the residents of the facility shall evacuate in the event of a fire or other emergencies on all shifts. The findings are: Review of the facility fire drill records dated 03/31/25 revealed there was documentation the	C 120		

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	FCL060184	A. BUILDING: _____ B. WING _____	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 120	Continued From page 8 Co-Administrator informed each staff member of the emergency evacuation procedures including where staff and residents would evacuate to meet the emergency management team, who would provide transportation to a nearby nursing facility. Review of the facility fire drill records dated 06/04/25 revealed: -A fire safety training was facilitated by the local Fire Education Department. -There was documentation a physical walk-through of evacuation procedure and assembly location. -There was no documentation a fire drill took place. Review of the facility's staffing schedule revealed the facility had 5 shifts including: 7:00am to 3:00pm, 10:00am to 3:00pm, 3:00pm to 11:00pm, 3:00pm to 8:00pm and 11:00pm to 7:00am. Review of the facility's staffing schedules from 10/05/25 through 10/29/25 revealed: -One medication aide (MA) worked 8-hour shifts from 7:00am to 3:00pm. -One personal care aide (PCA) worked 5-hour shifts from 10:00am to 3:00pm. -A second MA worked 8-hour shifts from 3:00pm to 11:00pm. -One PCA worked 5-hour shifts from 3:00pm to 8:00pm. -One MA worked 8-hour shifts from 11:00pm to 7:00am. -The Owner worked various shifts during the work week. -The Co-Administrator/ SIC worked Monday to Friday 7:00am to 3:00pm. -There was no PCA scheduled for the 11:00pm to 7:00am.	C 120		

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	FCL060184	A. BUILDING: _____ B. WING _____	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 120	Continued From page 9 Review of facility records revealed there was a fire evacuation plan available for review and located in living room area. Review of facility fire drill records dated 07/08/25 revealed: -There was documentation the facility conducted fire emergency education preparedness session from 4:40pm to 5:00pm. -Four staff members and three residents gathered in the multi-purpose room and no evacuation was initiated due to elevated outdoor heat levels. -Residents and staff engaged in a "table top" sessions of questions and discussion related to alarm simulation, exit paths, fire extinguishers, assembly/evacuation routes, push/pull, aim/ squeeze, sweep hot/cold surfaces, accountability to know and account for everyone. Review of facility fire drill record dated 08/07/25 revealed: -The smoke alarm sounded loudly in bedroom #1(vacant) from 12:20pm to 12:22pm (first shift). -One staff member accounted for the whereabouts of all residents (two residents in their bedrooms and three residents in the living room). -The cause of smoke alarm was due to low battery. -All residents sheltered in place in the living room and it was determined not to be a true emergency. -The event was used as an opportunity to review and remind residents of appropriate actions in a fire emergency. -There was no documentation a fire drill took place. Review of facility fire drill record dated 09/12/25	C 120		

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	FCL060184	A. BUILDING: _____ B. WING _____	10/30/2025

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HOUSE OF PEACE FAMILY CARE HOME	3505 ORIOLE PLACE CHARLOTTE, NC 28269

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C 120	Continued From page 10 revealed: -There was documentation the facility conducted a fire drill from 2:30pm to 3:00pm (first shift). -Four staff members, one family member, and five residents were present in the facility and 100% of the facility's occupants evacuated to the end of the driveway. -There was documentation the fire drill evacuation lasted from 2:30pm to 2:35pm. -The fire department was not activated. -There was documentation of lack of communication between staff, whereas facility doors were not closed, a resident's oxygen was not transitioned immediately. -There was documentation the facility planned to conduct a re-training drill within 14 days. -There was no documentation that another drill was conducted within 14 days of 09/12/25. Interview with the Co-Administrator on 10/30/25 at 5:35pm revealed: -She was responsible for facilitating the facility fire drills. -One staff training related to fire drill evacuation occurred on 06/04/25. -One "table top" discussion with staff and residents took place on 07/08/25. -One fire drill demonstration was conducted on 09/12/25 from 3:00pm to 11:00pm (second shift). -She knew they were supposed to complete fire drills on each shift, and they were planning to do one on third but thought they had until then of the year. -She was aware a third shift (11:00pm to 7:00am shift) fire drill had not been conducted. Interview with the Owner on 10/29/25 at 6:05pm revealed: -The Co-Administrator was responsible for the overall operations of the faciity because the	C 120		

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	FCL060184	A. BUILDING: _____ B. WING _____	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 120	Continued From page 11 Administrator was not at the facility. -The Co-Administrator was responsible for coordinating and conducting the facility's fire drills. -She was aware there were recent changes in the fire safety rule and thought the facility was complying with rule changes. -She was aware a third-shift fire drill had not been conducted and thought she had more time to conduct one. -She expected all required fire drills to be conducted in accordance with the state rules. Refer to Tag D 0022 10A NCAC 13G .0302 (b) Design and Construction (Type B Violation). Refer to Tag D 0188 10A NCAC 13G .0601 (g) Management and Other Staff (Type B Violation). _____ The facility failed to ensure unannounced fire drills were conducted on all shifts, and completed so they demonstrated how the residents of the facility shall evacuate in the event of a fire or other emergencies so all of the residents could be evacuated in a safe manner. The facility's failure was detrimental to the safety and welfare of the residents, which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/29/25 for this violation. _____ CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, DECEMBER 14, 2025.	C 120		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060184	A. BUILDING: _____ B. WING _____	10/30/2025

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C 188	Continued From page 12	C 188		
C 188	10A NCAC 13G .0601 (g) Management And Other Staff 10A NCAC 13G .0601 Management And Other Staff (g) Additional staff shall be employed as needed for housekeeping and the supervision and care of the residents in accordance with the rules of this Subchapter. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure additional staff were always in the facility for the safety and supervision for 2 of 3 sampled residents who required verbal prompting, physical assistance and were unable to evacuate in an emergency without staff assistance (#2 and #3). The findings are: Review of the facility's current license revealed the facility was licensed for a capacity of 6 ambulatory residents. Observations during the initial tour of the facility on 10/28/25 from 9:15am to 9:45am revealed: -There was no sprinkler system located in the facility. -There was a census of five residents. -The Co-Administrator and the Owner were in the	C 188		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060184	A. BUILDING: _____ B. WING _____	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 188	Continued From page 13 facility. -A resident was in his bed in his room being fed by staff. -A second resident was sitting at the dining room table. -A third resident was also sitting at the dining room table. -A fourth resident was sitting at the dining room table. -The fifth resident was sitting in the living room. Observation during a fire drill on 10/29/25 from 4:15pm to 4:30pm revealed: -The Co-Administrator or Owner sounded the fire alarm at 4:18pm. -There were six staff present, consisting of medication aides (MAs), personal care aides (PCAs), a facility Nurse, the Co-Administrator, and the Owner were present in the facility. -Resident #2 was in his bed in his room, and there was one family member in the room visiting. -Resident #3 was sitting at the dining room table with her rollator walker nearby. -Resident #3 was utilizing 5 liters of continuous oxygen with extensive oxygen tubing that extended from an oxygen concentrator in her nearby room at the dining room table. -There were two other residents and one staff member sitting at the dining room table with Resident #3, and they were all participating in a group activity. -There was another resident sitting in a lounge chair in the living room that was connected to the dining room. -Three staff emerged from a room where they were completing training with the facility nurse, and informed the residents "it's a fire drill, let's go!" -One staff member assisted Resident #3 from the dining room table to a standing position and	C 188		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060184	A. BUILDING: _____ B. WING _____	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 188	Continued From page 14	C 188		

positioned her rollator walker in front of her, disconnected Resident #3's oxygen tubing and guided her towards the front door and out onto the front porch.
-The facility nurse and two other staff members went to Resident #2's room and transferred him to a wheelchair then assisted him to the front of the facility and out onto the front porch.
-The remaining three residents slowly walked towards the front door and exited with other staff who continuously provided verbal cues for everyone to get out of the facility and onto the porch.
-A staff member went back into the house and retrieved Resident #3's portable oxygen tank from her room and brought it outside for the resident's use.
-The Owner and three other staff members went back into the facility and closed all of the interior doors before exiting to the front porch to join the residents, other staff and one family member.
-All occupants of the facility were evacuated to the front porch by 4:21pm.
-Resident #2 was assisted by two staff into the facility via wheelchair and transferred him back to bed.
-Resident #3 was assisted by one staff into the facility via her rollator walker, portable oxygen tank and tubing.

Review of the facility's staffing schedule revealed the facility had 5 shifts including: 7:00am to 3:00pm, 10:00am to 3:00pm, 3:00pm to 11:00pm, 3:00pm to 8:00pm and 11:00pm to 7:00am.

Review of the facility's staffing schedules from 10/05/25 through 10/29/25 revealed:
-One medication aide (MA) worked 8-hour shifts from 7:00am to 3:00pm.
-One personal care aide (PCA) worked 5-hour

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060184	A. BUILDING: _____ B. WING _____	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 188	Continued From page 15	C 188		

shifts from 10:00am to 3:00pm.
-A second MA worked 8-hour shifts from 3:00pm to 11:00pm.
-One PCA worked 5-hour shifts from 3:00pm to 8:00pm.
-One MA worked 8-hour shifts from 11:00pm to 7:00am.
-There were no PCAs scheduled from the 11:00pm to 7:00am.
-The Owner worked various shifts during the work week.
-The Co-Administrator worked Monday to Friday 7:00am to 3:00pm.

1. Review of Resident #2's current FL2 dated 04/24/25 revealed:
-Diagnoses included Alzheimer's disease, atrial fibrillation, osteoarthritis, and acid reflux.
-Resident #2 was semi-ambulatory.
-Resident #2 was constantly disorientated.
-Resident #2's level of care was assisted living.

Review of Resident #2's Resident Register revealed an admission date of 04/25/25.

Review of Resident #2's record revealed he was admitted to hospice services on 06/30/25 and was bedbound.

Review of Resident #2's care plan dated 05/29/25 revealed:
-Resident #2 required supervision with ambulation (walker).
-Resident #2 required limited assistance with bathing, toileting, dressing, grooming and transferring.
-There was no updated care plan identifying Resident #2's change in condition that prompted his hospice admission.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060184	A. BUILDING: _____ B. WING _____	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 188	Continued From page 16 Observation of Resident #2 on 10/28/25 from 9:30am to 9:35am revealed Resident #2 was in bed, being fed breakfast by staff, and presented with incoherent speech. Interview with a MA on 10/29/25 at 7:10pm revealed Resident #2 requires assistance with transfers from bed to wheelchair and could not evacuate the facility if there was an emergency. Telephone interview with another MA on 10/29/25 at 1:58pm revealed: -She worked alone on third shift (11:00pm to 7:00am) four times per week since she began working at the facility. -She never conducted a fire drill on third shift. -She was able to physically transfer Resident #2 from his bed to his wheelchair and out of the facility along with the rest of the residents, in the case of an emergency. Interview with the Co-Administrator on 10/29/25 at 5:35pm revealed: -Resident #2 was highly functioning when he was admitted to the facility on 04/25/25. -Resident #2 had a major health decline (cognition and physical ability) and was admitted to hospice care on 06/30/25. -Resident #2 required extensive assistance with transfers in and out of bed and was considered non-ambulatory. -She did not believe additional staff were needed on third shift since Resident#2 was asleep on third shift. -Additional staff were in the facility during the first and second shift. -She did not know additional staff were required on third shift for increased safety and supervision of residents who were considered non-ambulatory.	C 188		

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	FCL060184	A. BUILDING: _____ B. WING _____	10/30/2025

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C 188	Continued From page 17 Interview with the Owner on 10/29/25 at 6:05pm revealed: -She told the Co-Administrator to activate the fire drill. -She was aware Resident #2 was considered non-ambulatory due to his cognition and bedbound status. Based on observations, record reviews, and interviews and it was determined Resident #2 was not interviewable. Refer to interview with the Co-Administrator on 10/29/25 at 5:35pm. Refer to interview with the Owner on 10/29/25 at 6:05pm. 2. Review of Resident #3's current FL2 dated 10/16/24 revealed: -Diagnoses included chronic obstructive pulmonary disease, vascular dementia, and anemia. -Resident #3 was semi-ambulatory. -Resident #3 was intermittently disoriented. -Resident #3's level of care was assisted living. Review of Resident #3's Resident Register revealed an admission date of 10/21/24. Review of Resident #3's record revealed she was admitted to hospice services 09/12/24, before she transferred to the facility. Observation of Resident #3 on 10/28/25 from 9:30am to 4:30pm revealed: -Resident #3 received assistance from staff during transferring from dining room chair to standing position and ambulating to her rollator	C 188		

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	FCL060184	A. BUILDING: _____ B. WING _____	10/30/2025

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C 188	Continued From page 18 walker. -Resident #3 used her rollator walker to ambulate short distances at a very slow pace. -Resident #3 used 5 liters of continuous oxygen. -Resident #3 received two breathing treatments administered by staff. -Resident #3 spent most of the day in her recliner in her bedroom or sitting at the dining room table participating in an activity. Observation of Resident #3 on 10/29/25 revealed she ambulated slowly via her rollator walker a short distance from her bedroom to the bathroom, then called out for assistance while she was in the bathroom. Interview with the Co-Administrator on 10/29/25 at 5:35pm revealed: -Resident #3 was able to ambulate with her rollator walker without assistance most of the time. -Resident #3 had some confusion. -She was aware staff assisted Resident #3 by obtaining her portable oxygen tank after the occupants of the facility evacuated to the front porch. -Resident #3 did not demonstrate she could disconnect her oxygen tubing, nor ambulate to her room to obtain the portable oxygen tank, before evacuating the facility during the fire drill. Interview with the Owner on 10/29/25 at 6:05pm revealed: -She told the Co-Administrator to activate the fire drill. -When the fire drill was activated, Resident #3 was sitting at the dining room table participating in a group activity of bingo. -She was made aware staff assisted Resident #3 out of the facility and staff later returned to obtain	C 188		

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	FCL060184	A. BUILDING: _____ B. WING _____	10/30/2025

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C 188	Continued From page 19 Resident #3's portable oxygen tank. -She did not believe Resident #3 would be able to maneuver her portable oxygen tank and rollator walker without assistance during an emergency evacuation. -As a result of how Resident #3 responded to the fire drill with increased need for physical assistance (switching her oxygen concentrator to her portable oxygen tank, while using her rollator walker) when exiting the facility during the fire drill on 10/29/25, she understood how Resident #2 was considered non-ambulatory at that time. -She did not know additional staff were required on third shift for increased safety and supervision of Resident#3, who was considered non-ambulatory. Based on observations, record reviews, and interviews it was determined Resident #3 was not interviewable. Refer to interview with the Co-Administrator on 10/29/25 at 5:35pm. Refer to interview with the Owner on 10/29/25 at 6:05pm. [Refer to tag 0022, 10A NCAC 13G .0302(b) Design and Construction (Type B Violation)]. _____ Interview with the Co-Administrator on 10/29/25 at 5:35pm revealed: -She and the facility Nurse were responsible for conducting pre-screening assessments, updating care plans, and assessing for change in condition to determine resident appropriateness according to the facility's non-ambulatory license. -She believed since residents were usually asleep on third shift, more than one staff was not	C 188		

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	FCL060184	A. BUILDING: _____ B. WING _____	10/30/2025

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C 188	Continued From page 20 needed. -She believed having one staff member on third shift was adequate to meet the needs of all residents during an emergency. -She did not know more than one staff member was required on third shift for increased safety and supervision of residents who were considered non-ambulatory. Interview with the Owner on 10/29/25 at 6:05pm revealed: -The Co-Administrator was responsible for the overall operations of the faciity because the Administrator was not at the facility. -Residents received additional assistance during the fire drill because multiple staff members happened to be at the facility for training and had an instinct to help evacuate residents during the drill. -There were usually two staff members and third-party providers at the facility during the day and evening hours. -Although third shift was staffed with one MA and no PCAs, she did not know additional staff were needed to meet the needs of residents who were considered non-ambulatory. _____ The facility failed to ensure additional staff were always in the facility to supervise and assist Resident #2 and #3 who required additional verbal cueing and physical assistance in order to evacuate the facility safely. This failure was detrimental to the residents' health, safety, and welfare, which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/29/25 for this violation.	C 188		

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	FCL060184	A. BUILDING: _____ B. WING _____	10/30/2025

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C 188	Continued From page 21 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, DECEMBER 14, 2025.	C 188		
C 202	10A NCAC 13G .0702 (a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination, and Immunizations (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 1 of 3 sampled residents (#3) completed a two-step tuberculosis (TB) testing in compliance with the control measures of the Commission for Health Services. The findings are: Resident #3's current FL2 dated 10/16/24 revealed diagnoses included chronic obstructive pulmonary disease, vascular dementia, and anemia. Review of Resident #3's Resident Register revealed an admission date of 10/21/24.	C 202		

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	FCL060184	A. BUILDING: _____ B. WING _____	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 202	Continued From page 22 Review of Resident #3's TB testing revealed: -There was documentation from a primary care physician's office (PCP) of one negative TB test completed on 10/21/24. -There was no documentation of a second TB skin test result. Interview with the Co-Administrator on 10/30/25 at 4:00pm revealed: -She was responsible for ensuring residents had completed TB testing on admission to the facility with documentation in each of the residents' records. -The facility was under the impression since Resident #3 transferred from another facility, her TB test from the previous facility was adequate and a step-two was not necessary.	C 202		
C 203	10A NCAC 13G .0702 (b) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tubercluosis Test And Medical Examination And Immunizations (b) Each resident shall have a medical examination completed by a licensed physician or physician extender prior to admission to the home and annually thereafter. For the purposes of this Rule, "physician extender" means a licensed physician assistant or licensed nurse practitioner. The medical examination completed prior to admission shall be used by the facility to determine if the facility can meet the needs of the resident.	C 203		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060184	A. BUILDING: _____ B. WING _____	10/30/2025

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C 203	Continued From page 23	C 203		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure 1 of 3 sampled residents (#3) had a medical examination completed annually.

The findings are:

Review of Resident #3's current FL2 dated 10/16/24 revealed:
-Diagnoses included chronic obstructive pulmonary disease, vascular dementia, and anemia.
-Resident #3 was semi-ambulatory.
-Resident #3 was intermittently disoriented.
-Resident #3's level of care was assisted living.

Review of Resident #3's Resident Register revealed an admission date of 10/21/24.

Interview with the Co-Administrator on 10/30/25 at 4:00pm revealed:
-She was responsible for assuring the residents had a medical examination completed annually.
-Her process involved contacting the physician to request an updated FL2 before it became overdue.
-She did not realize Resident #3's FL2 was outdated.
-She believed she didn't request an updated FL2 because she was fulfilling multiple roles at once.

Interview with the Owner on 10/29/25 at 2:10pm revealed:
-The Co-Administrator was responsible for monitoring the dates on FL2s, contacting the physician to request the residents had an annual

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	FCL060184	A. BUILDING: _____ B. WING _____	10/30/2025

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C 203	Continued From page 24 medication examination and their FL2s were updated. -She was not aware Resident #3's FL2 was outdated. -She expected the facility to have all required paperwork updated.	C 203		
C 206	10A NCAC 13G .0702 (e) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test And Medical Examination and Immunizations (e) The result of the medical examination required in Paragraph (b) of this Rule shall be documented on the North Carolina Medicaid Adult Care Home FL-2 form which is available at no cost on the Department's Medicaid website at https://medicaid.ncdhhs.gov/media/6549/open. The Adult Care Home FL-2 shall be signed and dated by the physician or physician extender completing the medical examination. The medical examination shall include the following: (1) resident's identification information, including the resident's name, date of birth, sex, admission date, county and Medicaid number, current facility and address, physician's name and address, a relative's name and address, current level of care, and recommended level of care; (2) resident's admitting diagnoses, including primary and secondary diagnoses and dates of onset; (3) resident's current medical information, including orientation, behaviors, personal care assistance needs, frequency of physician visits, ambulatory status, functional limitations, information related to activities and social needs, neurological status including orders for therapeutic diets; (4) special care factors, including physician	C 206		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060184	A. BUILDING: _____ B. WING _____	10/30/2025

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C 206	Continued From page 25 orders for blood pressure, diabetic urine testing, physical therapy, range of motion exercises, a bowel and bladder program, a restorative feeding program, speech therapy, and restraints; (5) resident's medications, including the name, strength, dosage, frequency and route of administration of each medication; (6) results of x-rays or laboratory tests determined by the physician or physician extender to be necessary information related to the resident's care needs; and (7) additional information as determined by the physician or physician extender to be necessary for the care of the resident. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 1 of 3 sampled residents (#1) medication orders were clarified when they were not included on the resident's FL2 upon admission or available in the resident's record. The findings are: Review of Resident #1's current FL2 dated 01/23/25 revealed: -Diagnoses included major recurrent depression, anxiety and congestive heart failure. -Resident #1 was ambulatory. -Resident #1's level of care was assisted living. -There was no entry of Resident #1's medication orders.	C 206		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060184	A. BUILDING: _____ B. WING _____	10/30/2025

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C 206	Continued From page 26 Review of Resident #1's Resident Register revealed an admission date of 01/30/25. Review of Resident #1's record revealed: -There was no documentation of a physician's order summary. -There was no documentation medication orders on the FL2 dated 01/23/25 were clarified. Interview with the Co-Administrator on 10/30/25 at 4:00pm revealed: -She was responsible for reviewing the residents' FL2s to make sure they were complete. -If medication orders on an FL2 needed to be clarified, she would contact the physician to get the FL2 updated. -She did not realize Resident #1's FL2 was missing a medication order list. -She did not realize Resident #1's six-month physician's order summary had not been received at the facility. -She believed she missed clarifying Resident #1's FL2 medication orders because she was fulfilling multiple roles at once. -She usually administered Resident #1's medications via the electronic medication administration record (eMAR) and medication bubble pack.	C 206		
C 231	10A NCAC 13G .0801 (c) Resident Assessment 10A NCAC 13G .0801 Resident Assessment (c) When a facility identifies a change in a resident's baseline condition based upon the factors listed in Parts (1)(A) through (M) of this Paragraph, the facility shall monitor the resident's condition for no more than 10 days to determine if a significant change in the resident's condition	C 231		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060184	A. BUILDING: _____ B. WING _____	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 231	Continued From page 27 has occurred. The facility shall conduct an assessment of a resident within three days after the facility identifies that a significant change in the resident's baseline condition has occurred. The facility shall use the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows: (1) Significant change is one or more of the following: (A) deterioration in two or more activities of daily living including bathing, dressing, personal hygiene, toileting, or eating; (B) change in ability to walk or transfer, including falls if the resident experiences repeated falls, meaning more than one, on the same day, or multiple falls that occur over several days to weeks, new onset of falls not attributed to an identifiable cause, a fall with consequent change in neurological status, or physical injury; (C) Pain worsening in severity, intensity, or duration, occurring in a new location, or new onset of pain associated with trauma; (D) change in the pattern of usual behavior, new onset of resistance to care, abrupt onset or progression of agitation or combative behavior, deterioration in affect or mood, or violent or destructive behaviors directed at self or others. (E) no response by the resident to the intervention for an identified problem; (F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period; (G) when a resident has been enrolled in hospice; (H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an	C 231		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060184	A. BUILDING: _____ B. WING _____	10/30/2025

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(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 231	Continued From page 28 abrasion, blister or shallow crater, or any pressure ulcer determined to be greater than Stage II; (I) a new diagnosis of a condition which affects the resident's physical, mental, or psychosocial well-being; (J) improved behavior, mood or functional health status to the extent that the established plan of care no longer meets the resident's needs; (K) new onset of impaired decision-making; (L) continence to incontinence or indwelling catheter; or (M) the resident's condition indicates there may be a need to use a restraint in accordance with Rule .1301 of this Subchapter and there is no current restraint order for the resident. (2) Significant change does not include the following: (A) changes that resolve with or without intervention; (B) an acute illness or episodic event. For the purposes of this Rule "acute illness" means symptoms or a condition that develops quickly and is not a part of the resident's baseline physical health or mental health status; (C) an established, predictable, cyclical pattern; or (D) steady improvement under the current course of care. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 1 of 3 sampled residents (#2) had an assessment conducted within three days of recognizing the resident had a deterioration in their activities of daily living and required an admission to hospice care.	C 231		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL060184	A. BUILDING: _____ B. WING _____	10/30/2025

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C 231	Continued From page 29 The findings are: Review of Resident #2's current FL2 dated 04/24/25 revealed: -Diagnoses included Alzheimer's disease, atrial fibrillation, osteoarthritis, and acid reflux. -Resident #2 was semi-ambulatory. -Resident #2 was constantly disorientated. -Resident #2's level of care was assisted living. Review of Resident #2's Resident Register revealed an admission date of 04/25/25. Review of Resident #2's record revealed he was admitted to hospice services on 06/30/25 and was bedbound. Review of Resident #2's care plan dated 05/29/25 revealed: -Resident #2 required supervision with ambulation (walker). -Resident #2 required limited assistance with bathing, toileting, dressing, grooming and transferring. Observation of Resident #2 on 10/28/25 from 9:30am to 9:35am revealed Resident #2 was in bed, being fed breakfast by staff, and presented with incoherent speech. Observation of Resident #2 on 10/29/25 at 4:18pm, during a fire drill, revealed the facility nurse and two other staff members went to Resident #2's room and transferred him to a wheelchair then assisted him to the front of the facility and out onto the front porch. Review of Resident #2's record revealed there was no documentation the care plan was updated to reflect a change in condition that prompted his	C 231		

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C 231	Continued From page 30 hospice admission on 06/30/25. Interview with the Co-Administrator on 10/30/25 at 4:00pm revealed: -She was responsible for updating the care plan if there was a change in condition for any resident. -After it was determined Resident #2 had a change in condition, his Primary Care Provider should have been notified, and his care plan should have been updated. -Resident #2's change in condition should have been documented within ten days of when it was decided he was to start with hospice services, and it was missed. Interview with the Owner on 10/29/25 at 2:10pm revealed: -She was not aware of Resident 2's change in condition was not documented on her medical record within ten days of the change. -She expected the Co-Administrator to contact the provider and update care plans after a change in condition was determined.	C 231		
C 236	10A NCAC 13G .0802 (a) (c) Resident Care Plan 10A NCAC 13G .0802 Resident Care Plan (a) The facility shall develop and implement a care plan for each resident based on the resident's assessment completed in accordance with Rule .0801 of this Section. The care plan shall be resident-centered and include the resident's preferences related to the provision of care and services. A copy of each resident's current care plan shall be maintained in a location in the facility where it can be accessed by facility staff who are responsible for the implementation of the care plan.	C 236		

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C 236	Continued From page 31 (c) The care plan shall include the following: (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; (2) frequency of the services or tasks to be performed; (3) revisions of tasks and frequency based on reassessments in accordance with Rule .0801 of this Section; (4) licensed health professional tasks required according to Rule .0903 of this Section; (5) a dated signature of the assessor upon completion; and (6) a dated signature of the resident's physician or physician extender as defined in Rule .0102 of this Subchapter within 15 days of completion of the care plan certifying the resident is under this physician's care and has a medical diagnosis with associated physical or mental limitations warranting the provision of the personal care services in the above care plan in accordance with G.S. 131D-2.15. This shall not apply to residents assessed through the Medicaid State Plan Personal Care Services Assessment for the portion of the assessment covering tasks needed for each activity of daily living of this Rule for which care planning and signing are directed by Medicaid. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 1 of 3 sampled residents (#1) care plans were completed annually and signed by the physician within fifteen days. The findings are:	C 236		

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C 236	Continued From page 32 Review of Resident #1's current FL2 dated 01/23/25 revealed: -Diagnoses included major recurrent depression, anxiety and congestive heart failure. -Resident #1 was ambulatory. -Resident #1's level of care was assisted living. Review of Resident #1's Resident Register revealed an admission date of 01/30/25. Review of Resident #1's care plan dated 08/26/25 revealed: -There was documentation Resident #1 was independent with bathing, toileting, dressing, and transferring. -There was documentation Resident #1 required supervision with ambulation and grooming. -There was documentation Resident #1 required limited assistance with bathing. -There was documentation the assessor completed and signed the care plan on 08/26/25. -There was documentation the physician did not sign the care plan until 10/03/25. Review of Resident #1's record revealed no documentation the facility followed up with the physician to obtain a signature for Resident #1's care plan. Interview with the Co-Administrator on 10/30/25 at 4:00pm revealed: -She was responsible for completed care plans were signed by the physician. -She did not have a system in place to follow up on care plans being signed by physicians within fifteen days of care plan completions. -She believed she missed following up with Resident #1's physician because she was fulfilling multiple roles at once.	C 236		

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C 236	Continued From page 33 Interview with the Owner on 10/29/25 at 2:10pm revealed: -The Co-Administrator was responsible for ensuring care plans were completed annually and signed by the physician withing fifteen days of completion. -She expected all care plans to be signed by the physician within fifteen days of completion.	C 236		
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure medications were clarified for 1 of 3 sampled residents (#1) related to a medication used to treat lung condition. The findings are: Resident #3's current FL2 dated 10/16/24	C 315		

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C 315	Continued From page 34 revealed: -Diagnoses included chronic obstructive pulmonary disease, vascular dementia, and anemia. -Resident #3 was semi-ambulatory. -Resident #3 had an order for two liters continuous oxygen. -Resident #3 was intermittently disoriented. -Resident #3's level of care was assisted living. Review of Resident #3's Resident Register revealed an admission date of 10/21/24. Review of Resident #3's physician orders dated 10/03/25 revealed an order for (duoneb) ipratropium 0.5mg-albuterol 3mg (a medication used to treat/ prevent airway narrowing) nebulization solution every six hours as needed. Review of Resident #3's physician orders dated 10/10/25 revealed an order for duoneb every twelve hours (8:00am and 8:00pm) for seven days then continue as needed. (Since this is the most current order it looks like this is a clarfication issue because the facility did not clarify what "as needed" after the 7days meant. A prn order for as needed should have a stated indication for use) Review of Resident #3's hospice physician orders dated 10/08/25 revealed an active order for (duoneb) ipratropium 0.5mg-albuterol 3mg/ 3ml nebulization solution every six hours as needed. Review of Resident #3's eMAR from 10/15/25 to 10/28/25 revealed: -There was an entry for albuterol / ipratropium 2.5mg/ 0.5mg/ 3ml respiratory inhalation solution, take one solution twice daily (8:00am and 8:00pm).	C 315		

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C 315	Continued From page 35 - There was documentation Resident #3 refused her duoneb on 10/15/25 (8:00am and 8:00pm), 10/16/25 (8:00pm) and 10/23/25 (8:00pm). -There was documentation Resident #3 was administered duoneb on 10/16/25 (8:00am), from 10/17/25 to 10/23/25 (8:00am), from 10/24/25 to 10/28/25 (8:00am to 8:00pm). -There was no documentation the scheduled duoneb every twelve hours (8:00am and 8:00pm) was discontinued after seven days. -There was no documentation of an active order for duoneb as needed. Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/30/25 at 3:30pm revealed: -Resident #3's active order for (duoneb) ipratropium 0.5mg-albuterol 3mg/ 3ml nebulization solution every six hours "as needed" dated 10/03/25 was faxed to the pharmacy on 10/06/25. -There were 30 vials of duoneb 90ml dispensed to the facility on 10/06/25 and 10/28/25. -The pharmacy did not have an order for scheduled duoneb treatments to be given twice daily for seven days. Interview with the Co-Administrator on 10/30/25 at 4:00pm revealed: -She was responsible for monthly medication cart audits and checking the eMAR for accuracy and did not keep a log of the audits. -The MAs were responsible for administering Resident #3's duoneb treatments twice daily. -She did not realize Resident #3's duoneb order for a scheduled treatment twice daily for seven days, then as needed after seven days because it took place when she was on vacation. -She should have contacted the provider to clarify the duoneb order.	C 315		

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C 315	Continued From page 36 -She spoke to Resident #3's hospice nurse on 10/29/25 and was informed the duoneb was supposed to be given as needed and there was no harm in it being given twice daily. -She expected all medication orders to be followed as ordered. Interview with the Owner on 10/29/25 at 2:00pm revealed: -She was not aware Resident 3#'s duoneb treatments were changed from scheduled to "as needed". -The Co-Administrator was responsible for reviewing physician orders and updating the eMAR and the pharmacy. -She expected all medication orders to be followed as ordered and eMARs to be correct.	C 315		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering	C 342		

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C 342	Continued From page 37 the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure the electronic medication record was accurate for 1 of 3 sampled residents (#1) related to oxygen administration. The findings are: Resident #3's current FL2 dated 10/16/24 revealed: -Diagnoses included chronic obstructive pulmonary disease, vascular dementia, and anemia. -Resident #3 was semi-ambulatory. -Resident #3 had an order for two liters continuous oxygen. -Resident #3 was intermittently disoriented. -Resident #3's level of care was assisted living. Review of Resident #3's Resident Register revealed an admission date of 10/21/24. Review of Resident #3's hospice physician orders dated 10/08/25 revealed an active order for five liters continuous oxygen via nasal cannula. (I maybe missing something- the resident had an order for 5 liters of O2 and was receiving 5 liters of O2. The problem is the MAR had not been updated/accurate) Observations of Resident #3 from 10/28/25 to 10/30/25 revealed Resident #3 was receiving 5 liters continuous oxygen via nasal cannula.	C 342		

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C 342	Continued From page 38 Review of Resident #3's electronic medication administration record (eMAR) from August 2025 to October 2025 revealed there was no entry for an order for continuous oxygen 5 liters via nasal cannula. Interview with the Co-Administrator on 10/30/25 at 4:00pm revealed: -She was responsible for monthly medication cart audits and checking the eMAR for accuracy and did not keep a log of the audits. -She did not know oxygen orders were supposed to be on the eMAR. -She expected all medication orders to be followed as ordered and eMARs to be accurate. Interview with the Owner on 10/29/25 at 2:00pm revealed: -She did not know oxygen orders were supposed to be on the eMAR. -The Co-Administrator was responsible for reviewing physician orders and updating the eMAR and the pharmacy. -She expected all medication orders to be followed as ordered and eMARs to be correct.	C 342		