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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey, a follow-up survey and a complaint investigation from 11/12/25 to 11/14/25.	D 000		
D 074	10A NCAC 13F .0306 (a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings that are clean, safe, and functional; 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 review, the facility failed to ensure the floors in the facility were kept clean and in good repair related to the carpet in the hallways on the A and D halls. The findings are: 1. Observation of the A hall on 11/12/25 at 10:00am revealed:	D 074		

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-There were ten resident rooms on the hall.
-All ten rooms were occupied.
-There were dark areas on the carpet in the hallway.
-At the threshold to each room, there were dark areas that extended into the hallway.
-In resident room 30, there were three large areas where the carpet was stained with a dark substance, in the middle of the two beds, in front of the dresser by the window, and in front of the refrigerator.

Interview with the resident who resided in room 30 on 11/12/25 at 10:40am revealed:
-The stains in her room had been there for several months.
-No one ever shampooed the carpet in her room or the hallways.

Interview with a second resident who resided on the A hall on 11/12/25 at 10:45am revealed:
-The carpet in the facility was dirty.
-The area outside her room had carpet that was very dirty.
-She thought they shampooed the carpet in the facility maybe once or twice a year.
-She thought the facility should have something other than carpet on the floors.

Refer to interview with a personal care aide (PCA) on 11/14/25 at 8:35am.

Refer to interview with the housekeeper on 11/13/25 at 2:54pm.

Refer to interview with the maintenance technician on 11/13/25 at 3:01pm.

Refer to interview with the Administrator on 11/14/25 at 9:30am.

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D 074	Continued From page 2 2. Observation of the D hall on 11/13/25 at 10:50am revealed: -There were ten resident rooms on the D hall. -All ten resident rooms on the D hall were occupied. -There was a long stretch of a darkened area down the middle of the hallway. -There were darkened areas at the threshold to all ten resident rooms on the D hall. -The darkened areas at each room's threshold extended into the hallway. -There was a stained area that was lighter than the rest of the carpet at the end of the D hall that was soccer ball in size. Interview with a resident that resided on the D hall on 11/13/25 at 10:50am revealed: -She thought the carpet in the hallways was very dirty and could use a good cleaning or needed to be replaced. -She recalled seeing someone shampoo the carpets, but it was rare and she did not think it was done as often as it should be done. Interview with a family member of a resident that resided on the D hall on 11/14/25 at 11:45am revealed: -The carpets in the facility were dirty and needed to be cleaned. -He had never witnessed anyone shampooing the carpet in the facility. Refer to interview with a personal care aide (PCA) on 11/14/25 at 8:35am. Refer to interview with the housekeeper on 11/13/25 at 2:54pm. Refer to interview with the maintenance	D 074		

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D 074	Continued From page 3 technician on 11/13/25 at 3:01pm. Refer to interview with the Administrator on 11/14/25 at 9:30am. _____ Interview with a personal care aide (PCA) on 11/14/25 at 8:35am revealed: -The facility was without a housekeeper for several months. -There was no carpet shampooing being done during the time there were no housekeepers. -She thought the carpet in the facility was very dirty, especially on the A and D halls. -She thought the carpet needed to be replaced. Interview with the housekeeper on 11/13/25 at 2:54pm revealed: -She just started at the facility as a housekeeper two weeks ago. -She vacuumed the carpet in the facility daily. -She thought the carpet in the facility was very dirty. -She had not been instructed to shampoo the carpet; she thought the maintenance technician did that. Interview with the maintenance technician on 11/13/25 at 3:01pm revealed: -He shampooed the carpet in the facility 2-3 weeks ago. -There was no schedule set for how often the carpets were to be shampooed that he was aware of. -He shampooed the hallways. -It was not normal for dirt to build up that quickly after shampooing. -He did not shampoo the carpet in the resident rooms. -He agreed the carpet at the resident rooms on the A hall and D hall were dirty.	D 074		

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D 074	Continued From page 4 Interview with the Administrator on 11/14/25 at 9:30am revealed: -She came to the facility in October 2025 and knew maintenance shampooed the carpet around that time. -The facility was without a housekeeper for awhile. -She agreed the carpets were soiled and needed to be cleaned. -She expected the carpet in the facility to be kept clean.	D 074		
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be at least 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge, and learning of new skills. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a minimum of 14 hours of group activities were provided each week for the residents. The findings are: Observation of the facility on 11/12/25 at 10:00am revealed there was an October 2025 activity calendar posted in the gift shop. Observation of the wall in the dining room on 11/14/25 at 11:43am revealed: -There was a November 2025 activity calendar	D 317		

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posted with start and end times for each activity listed.
-There were at least 14 hours of activities scheduled per week.

Interview with a resident on 11/12/25 at 10:05am revealed:
-There were no activities offered at the facility that week.
-There was a Halloween party held at the facility.
-There was not a current Activities Director.

Interview with a second resident on 11/12/25 at 10:12am revealed there were no activities and he did not know when the last activity was offered.

Interview with a third resident on 11/12/25 at 10:21am revealed:
-There was not an Activity Director but the Transportation Coordinator took residents on outings.
-Activities were not offered every day.

Interview with a personal care aide (PCA) on 11/14/25 at 11:10am revealed:
-There were activities offered to the residents but there was not an Activity Director.
-The activities were not "regular" like they used to be.
-She did not think there were 14 hours of activities per week.
-The residents mostly had outings but there were not many in-house activities.

Interview with a second PCA on 11/14/25 at 11:15am revealed:
-The Transportation Coordinator took the residents on outings.
-There were no other regular activities.
-Residents were encouraged to participate in

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D 317	Continued From page 6 activities but there were not at least 14 hours of activities per week. -There was not a full-time Activity Director. Interview with the Administrator on 11/14/25 at 11:35am revealed: -There were activities offered to the residents and there were at least 14 hours of scheduled activities per week. -There was not a full-time Activity Director but there was a part-time Activity Director. -She and other staff encouraged residents to participate in activities. -She thought there were scheduled activities going on since she became the Administrator in October 2025.	D 317		
D 364	10A NCAC 13F .1004 (g) Medication Administration 10A NCAC 13F .1004 Medication Administration (g) The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered within one hour before or after the scheduled times for 2 of 5 residents (#4 and #5). The findings are: 1. Review of Resident #4's current FL2 dated 02/25/25 revealed diagnoses included generalized weakness, diabetes type 2, hypertension, benign prostatic hyperplasia, mixed	D 364		

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hyperlipidemia and polyneuropathy type 2 dementia.

Review of Resident #4's signed physician order dated 04/12/25 revealed:
-There was an order for atorvastatin 20mg (used to treat high cholesterol) one tablet at bedtime.
-There was an order for gabapentin 100mg (used to treat pain) one tablet at bedtime.

Review of Resident #4's October electronic Medication Administration Record (eMAR) revealed:
-There was an entry for atorvastatin 20mg one tablet scheduled at bedtime.
-Atorvastatin 20mg was documented as administered at 7:00pm.
-There was an entry for gabapentin 100mg one tablet scheduled at bedtime.
-Gabapentin 100mg was documented as administered at 7:00pm.

Interview with Resident #4's family member on 11/13/25 at 1:57pm revealed:
-Resident #4 reported to him that he gets his 8:00pm medications late.
-This happened last month in October 2025.
-The staff had awakened Resident #4 as late as 11:00pm to administer medications.
-He complained to the staff, but nothing was done.

2. Review of Resident #5's FL2 dated 04/01/25 revealed diagnoses included congestive obstructive pulmonary disease, hypertension, osteoarthritis, dementia without disturbance, abnormal gait mobility, anxiety and depression.

Review of Resident #5's signed physician order dated 04/01/25 revealed there was an order for

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alprazolam .25mg (a controlled drug used to treat anxiety) one tablet twice daily at 7:00am and 7:00pm.

Interview with Resident #5 on 11/12/25 at 9:00am revealed:
-Several weeks ago, she had difficulty getting her pain medication at night.
-She rang the call bell at 10:30pm to let someone know she needed her medication and was told the medication aide (MA) would be there soon.
-She did not get her medication until 11:30pm and was told they were short-staffed.

Review of Resident #5's October electronic Medication Administration Record (eMAR) revealed:
-There was an entry for alprazolam .25mg twice daily with a scheduled administration time at 7:00am and 7:00pm.
-There was documentation alprazolam .25mg was administered from 10/01/25 to 10/31/25 at 7:00am and 7:00pm

Review of Resident #5's October Controlled Substance Count Sheet revealed:
-On 10/12/25 there was documentation that alprazolam .25mg was administered at 11:00pm.
-On 10/13/25 there was documentation that alprazolam .25mg was administered at 9:00pm.
-On 10/14/25 there was documentation that alprazolam .25mg was administered at 11:00pm.
-On 10/15/25 there was documentation that alprazolam .25mg was administered at 11:00pm.
-On 10/16/25 there was documentation that alprazolam .25mg was administered at 2:00am.
-On 10/16/25 there was documentation that alprazolam .25mg was administered at 11:00pm.
-On 10/17/25 there was documentation that alprazolam .25mg was administered at 2:00am.

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D 364	Continued From page 9 -On 10/17/25 there was documentation that alprazolam .25mg was administered at 11:00pm. Interview with a MA on 11/14/25 at 10:22am revealed: -She never administered medication more than one hour before or after the scheduled administration time. -Residents had complained to her last month about getting medications late during second and third shift. Interview with a personal care aide (PCA) on 11/14/2025 at 11:00am revealed: -She was aware of residents getting their night medications after 10:00pm. -This happened during the month of October because the facility was short-staffed. -She had not had any complaints from residents during the month of November 2025. Interview with the Administrator on 11/14/2025 at 11:30am revealed: -She was not aware residents were administered medications with an administration time of 7:00pm and as late as 2:00am. -The MA should administer medications within one hour before or after the scheduled administration time. -She expected medications to be administered as ordered and within a one-hour timeframe.	D 364		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the	D 366		

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staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited.

This Rule is not met as evidenced by:
Based on observations, record review, and interviews, the facility failed to ensure the medication aide (MA) observed a resident taking their medications for 1 of 5 sampled residents (#1), and failed to ensure staff who administered medications were qualified.

The findings are:

Review of the facility's undated policy titled, Medication Administration on 11/14/25 at 9:30am revealed, in part, staff would provide documentation on the electronic medication administration record (eMAR) after observing the residents take the medications, and, only staff who have demonstrated competency according to State rules may prepare and administer medications.

1. Review of Resident #1's current FL2 dated 03/25/25 revealed:
-Diagnoses included hypothyroidism, atrial fibrillation (a-fib), hypertension, mitral valve disorder, and benign prostatic hyperplasia (BPH).
-There was an order for doxazosin (used to treat BPH) 2mg at bedtime.
-There was an order for diltiazem extended release (ER) (used to treat high blood pressure and irregular heart rhythms) 300mg daily.
-There was an order for levothyroxine (used to

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treat hypothyroidism) 50mcg daily.
-There was an order for vitamin D3 (used to treat low vitamin D levels) 50mcg daily.

a. Observation of Resident #1's room on 11/12/25 at 3:00pm revealed:
-Resident #1 was sitting in a chair in his room looking out the window.
-There was a paper souffle cup on the top of Resident #1's dresser.
-There was one pink colored tablet inside the paper souffle cup.

Review of Resident #1's November 2025 eMAR from 11/01/25 to 11/14/25 revealed:
-There was an entry for doxazosin 2mg at bedtime with a scheduled administration time of 7:00pm.
-Doxazosin 2mg was documented as administered from 11/01/25 to 11/13/25.

Interview with Resident #1 on 11/12/25 at 3:05pm revealed:
-He did not know what times he took his different medications, but he knew he took a medication at night.
-The MA sometimes would leave the medications in the room if he was asleep or in the bathroom.
-He was not aware there was a pill in the cup on top of his dresser.

Interview with a MA on 11/12/25 at 3:15pm revealed:
-The pill in the cup on Resident #1's dresser was his doxazosin 2mg.
-Resident #1 took the doxazosin 2mg at bedtime.
-The night shift MA would have been responsible for administering the doxazosin.

Interview with the 7:00pm to 7:00am MA on

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D 366	Continued From page 12 11/14/25 at 8:10am revealed: -Sometimes she had to wake Resident #1 up to administer his medications. -She did not leave Resident #1's medications in his room; she knew she was supposed to make sure the resident took their medications. Interview with the Administrator on 11/14/25 at 9:30am revealed: -The MAs were not to leave medications at residents' bedsides. -The MAs were expected to administer medications and make sure the residents took all their medications. -It was important to make sure residents took their medications. b. Observation of Resident #1's room on 11/13/25 at 7:40am revealed: -Resident #1 was in the bathroom with the door closed. -There was not a MA present in the room. -There was a paper souffle cup on Resident #1's dresser. -There was a blue capsule and two white pills inside the paper souffle cup on Resident #1's dresser. Review of Resident #1's November 2025 eMAR from 11/01/25 to 11/14/25 revealed: -There was an entry for diltiazem ER 300mg daily with a scheduled administration time of 7:00am. -There was an entry for levothyroxine 50mcg daily with a scheduled administration time of 6:00am. -There was an entry for vitamin D3 50mcg daily with a scheduled administration time of 7:00am. Interview with Resident #1 on 11/13/25 at 7:55am revealed someone left the pills on his nightstand a little bit ago.	D 366		

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D 366	Continued From page 13 Interview with the 7:00pm to 7:00am MA on 11/14/25 at 8:10am revealed: -Sometimes she had to wake Resident #1 up to administer his medications. -She did not leave Resident #1's medications in his room; she knew she was supposed to make sure the resident took their medications. Interview with the Administrator on 11/14/25 at 9:30am revealed: -The MAs were not to leave medications at residents' bedsides. -The MAs were expected to administer medications and make sure the residents took all their medications. -It was important to make sure residents took their medications. 2. Review of Resident #4's current FL2 dated 02/25/25 revealed diagnoses included generalized weakness, diabetes type 2, hypertension, benign prostatic hyperplasia, mixed hyperlipidemia and polyneuropathy type 2 dementia. Review of Resident #4's progress notes on 11/13/25 at 3:00pm revealed: -There was a note written and signed by the Administrator on 10/13/25 at 1:46pm. -The note referred to a complaint from Resident #4 to the Administrator that a personal care aide (PCA) administered medication to him instead of the MA. -The MA who was also the Supervisor, admitted to asking the PCA to administer the medication because the Supervisor arrived to work late and was trying to catch up. -The Administrator gave the MA a verbal warning and told her she could not allow PCAs to pass	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL076027	A. BUILDING: _____ B. WING _____	11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE	1195 PINEVIEW ROAD RANDLEMAN, NC 27317

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 366	Continued From page 14	D 366		

medication, and she had to watch residents take their medications.
-There was a second note written and signed by the Administrator on 10/13/25 at 1:46pm.
-The note referred to a telephone call the Administrator made to the PCA about giving medications to residents.
-The Administrator informed the PCA that only the Supervisor could administer medications because they had to sign off that they administered the medication to the residents and watched them take the medication.
-The Administrator gave the PCA a verbal warning.

Interview with Resident #4 on 11/14/25 at 10:00am revealed:
-He had been administered medication from staff who were not MAs.
-He was not sure of their qualifications.
-This occurred for several months but he was unsure of the exact dates.

Interview with a MA on 11/14/25 at 10:22am revealed:
-She was aware of an incident that occurred in October 2025 when a PCA administered medication who was not a certified MA.
-She reported it to the Administrator and that PCA no longer worked there.
-She had no knowledge of any other incidents.

Interview with the Administrator on 11/14/25 at 11:30am revealed:
-She was not aware of the documented notes in Resident #4's chart.
-She was aware of a PCA passing out medications to residents.
-She started as the interim Administrator in November.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL076027	A. BUILDING: _____ B. WING _____	11/14/2025

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D 366	Continued From page 15 -She expected no one to document or administer medication to residents unless they were certified.	D 366		