Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Heritage Care Home Dial's #2
Address: 1698 Canal Road Pembroke, NC 28372
County: Robeson
License Number: HAL-078-038

II. Dates of Visits: 7/28/25, 9/4/25 and 9/22/25
Purpose of Visits: Complaint Investigation
Exit / Report Date: 9/26/25

Instructions to the Provider *(please read carefully)*:

In column **III (b),** please provide a plan of correction to address *each of the rules*, which were violated and cited in column **III (a),** The plan must describe the steps the facility will take to achieve and maintain compliance. In column **III (c),** indicate a specific completion date for the plan of correction.

*If this CAR includes a **Type B violation**, failure to meet compliance after the date of correction provided by the facility could result in a civil penalty in an amount up to $400.00 for each day that the facility remains out of compliance.

*If this CAR includes a **Type A1 or an Unabated B violation**, this agency *will* plan to submit an Administrative Penalty Recommendation for the violation(s). If this CAR includes a **Type A2 violation**, this agency *may* submit an Administrative Penalty Recommendation for the violation(s). The facility has an opportunity to schedule an Informal Dispute Resolution (IDR) meeting within **15 working days** from the mailing or delivery of this Corrective Action Plan. If on follow-up survey the **Type A1 or Type A2** violations are not corrected, a civil penalty of up to $1000.00 for each day that the facility remains out of compliance may be assessed. If on follow-up survey the **Unabated B** violations are not corrected, a civil penalty of up to $400.00 for each day that the facility remains out of compliance may also be assessed.

III (a). Non-Compliance Identified *For each citation/violation cited, document the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Rule/Statutory Reference (text of the rule/statute cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Unabated Type B, Citation)* • *Findings of non-compliance*	**III (b). Facility plans to correct/prevent:** *(Each Corrective Action should be cross-referenced to the appropriate citation/violation)*	**III (c). Date plan to be completed**
Rule/Statute Number: 10A NCAC 13G .1004 Medication Administration	☐ POC Accepted _____ *DSS Initials*	
Rule/Statutory Reference: (a) A family care home shall assure that the preparation and administration of medications, prescription and nonprescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record;		
Level of Non-Compliance: Type A1 Violation		
This rule is not met as evidenced by: **Based on observations, interviews, and record reviews, the facility failed to ensure medication was administered as ordered for 2 of 3 residents sampled (Resident #1 and Resident #2) related to mental health injections resulting in both residents having an increase in mental health symptoms and having to visit the local hospital due to those symptoms.** The findings are:		

1. Review of Resident #1's current FL-2 dated 08/12/25 revealed: -Diagnoses included: type 2 diabetes mellitus, hyperlipidemia, insomnia, chronic kidney disease, foot callus, hallucination, fatigue, and schizophrenia. -He was ambulatory and continent of bowel and bladder. -Included an order for Uzedy 250mg/0.7mL inject 250mg every 2 months (Uzedy is a long-acting injection, a form of Risperdal, and is given under the skin and used to treat schizophrenia). Review of Resident #1's previous FL-2 dated 03/17/25 revealed: -Diagnoses included: schizoaffective disorder bipolar type and tobacco dependence. -He was ambulatory and continent of bowel and bladder. -Included an order for Uzedy 250mg/0.7mL Inject 0.7mL subcutaneously every 30 days. Review of Resident #1's Resident Register revealed he was admitted to the facility on 03/24/25. Review of Resident #1's care plan dated 03/24/25 revealed: -He was receiving medications for mental illness / behavior. -He was receiving mental health services. -He required supervision with eating, toileting, ambulation, and transferring. -He was totally dependent in the area of medication administration. -The facility primary care physician (PCP) signed the care plan on 04/08/25. Review of Resident #1's physician orders signed by the facility PCP on 05/13/25 revealed there was no change to the order for Uzedy 250mg/0.7mL inject 0.7mL every 30 days. Review of Resident #1's May 2025 medication administration record (MAR) revealed:		

-There was an entry for Uzedy 250mg/0.7mL inject 0.7mL under the skin every 30 days. -Administrator documented that Resident #1 refused the injection on 05/23/25. Review of Resident #1's June 2025 MAR revealed: -There was an entry for Uzedy 250mg/0.7mL inject 0.7mL under the skin every 30 days. -Administrator documented that Resident #1 was administered the injection on 06/22/25. Review of Resident #1's July 2025 MAR revealed: -There was an entry for Uzedy 250mg/0.7mL inject 0.7mL under the skin every 30 days. -Administrator documented that Resident #1 was administered the injection on 07/22/25. Review of Resident #1's August 2025 MAR revealed: -There was an entry for Uzedy 250mg/0.7mL inject 0.7mL under the skin every 2 months. -Administrator documented that Resident #1 refused the injection on 08/6/25, and also noted that "his dr gave this shot last week". Review of Resident #1's progress note dated 03/31/25 written by the mental health provider revealed: -He was seen for routine follow up. -He was healthy appearing, in no acute distress, and ambulated without assistance. -He had good judgement, normal mood, and was alert to person, place, and time, and both recent and remote memory were normal. -The Uzedy 250mg/0.7mL was prescribed for 250mg every 2 months. -He was administered the Uzedy 250mg/0.7mL injection during this visit. -He was scheduled to follow up on 07/02/25. Review of Resident #1's progress note dated 05/13/25 written by the facility PCP revealed: -He was seen for a routine chronic care visit with the clinician. -He appeared stable with no new concerns reported.		

-He remained on Farxiga (used to treat diabetes), trazodone (antidepressant), Zyprexa (antipsychotic medication), Depakote (used for treatment of bipolar disorder) and monthly risperidone injection.

Review of Resident #1's progress note dated 06/10/25 written by the facility PCP revealed:
-He was seen for a routine chronic care visit.
-He was stable and no new concerns were reported.

Review of facility progress notes dated 04/05/25 – 07/26/25 for Resident #1 documented by the Administrator revealed:
-On 04/05/25 at 5:00pm he had a physical altercation with another resident and law enforcement was called.
-On 04/09/25 he was threatening other residents, Administrator spoke to him and got him to calm down.
-On 04/25/25 he was smoking in his room, Administrator told him he could not do this.
-On 05/12/25 staff had to intervene due to him trying to hit another resident.
-On 05/20/25 he was standing over another resident while they were sleeping staring at a female resident and scaring her.
-On 06/01/25 staff had to intervene during a verbal altercation with this resident and another resident.
-On 06/15/25 he was threatening to kill residents and staff; staff finally got him to calm down and go to his room.
-On 06/30/25 he hit another resident, but caused no harm.
-On 07/02/25 he was walking around the facility screaming and hollering that he was going to kill everyone.
-On 07/02/25 he requested to be sent to the hospital due to hearing voices telling him to kill people.
-On 07/16/25 he pushed another resident down and punched him once, the Administrator intervened and discussed the residents behavior could not continue this way.
-On 07/23/25 he was given a 30 day notice due to non payment, he cursed at the Administrator.
-On 07/24/25 he was smoking in the building and there

was a lit cigarette in the trashcan and he said he was going to burn everyone up. -On 07/24/25 Administrator completed IVC due to Resident #1 was threatening to kill people. -On 07/25/25 local law enforcement did not come to pick Resident #1 up. -On 07/25/25 he started another fire in the trashcan and was trying to burn the building down. Another IVC was done and he was given an immediate discharge notice due to the safety of all residents being in danger. -On 07/26/25 the local hospital contacted Administrator about why the IVC was done and Administrator explained he tried to set fire in the building and was threatening to kill other residents. The hospital returned Resident #1 to the facility and dropped him off without contacting staff. Review of Resident #1's hospital medical records dated 07/02/25 revealed. -He presented to the emergency department from the facility due to an outburst. -He reported "people are trying to kill me, I believe they are trying to put spells on me". -Hospital staff made contact with facility Administrator and Administrator reported patient will say "crazy things" like he killed the president and he will occasionally threaten other residents. -Administrator also reported patient had gotten physical with one other resident who resided in a different building and she told the two men to stay away from one another and they had. -Administrator reported her main concern was he had been talking "crazy stuff" and he asked to go to the emergency department. -Resident #1 had past psychiatric history at two inpatient psychiatric hospitals. -Resident #1 reported to hospital staff that he had a problem with a guy from one of the other houses who would slip in at night and "cast spells" on him. -Resident #1 reported the spells are only cast when he is at the facility, when he leaves they go away, so that was why he asked to go to the hospital. -He reported he was only mentally ill while at the		

facility, when he leaves he was no longer mentally ill and he thought if he got his medications adjusted it would help him. -His Depakote was increased and he was discharged back to the facility. Review of Resident #1's hospital medical records dated 07/26/25 revealed: -He was admitted on 07/25/25 and discharged on 07/26/25. -He presented to the emergency department as an IVC for reported homicidal ideation toward others at his assisted living facility. -It was reported he was starting fires in trash cans using cigarettes and threatening to kill other residents. -He denied this and also denies suicidal ideation or hallucinations. -He reported being brought in against his wishes and described a conflict with a woman who "kicked him out" for "sitting on the couch" which he felt was an excuse. -He endorsed hearing voices, describing them as "just regular things" and clarifying that the voices were not his own, but "somebody else". -His thought process was linear and he was not delusional. -Hospital social worker contacted facility Administrator for Resident #1's medication list and was informed the Uzedy was given on 07/22/25. -Administrator reported Resident #1 was compliant with taking his medications as prescribed. -He was oriented, alert and cooperative. -He was discharged and instructed to follow up with mental health provider in three days. Review of Resident #1's progress note dated 07/30/25 written by the mental health provider revealed: -He was seen for Medicare Annual Wellness visit. -Uzedy 250mg/0.7mL was prescribed for 250mg every 2 months. -He had good judgement, his mental status was active and alert, he had normal mood, he was oriented to person, place and time, and his recent and remote memory were both normal.		

-He was seen in the local hospital emergency department recently due to involuntary commitment (IVC) by the facility.
-There was confusion when the last Uzedy injection was administered.
-Per hospital note the injection was given by a named provider at the hospital on 07/22/25, however Resident #1 denies and facility denies injection being given.
-He reported he was harassed at facility by the Administrator, and police had been called on him several times.
-The last time was Saturday (07/26/25).
-Administrator reported to police Resident #1 was smoking in facility and walking to the end of the driveway.

Review of a discharge notice dated 07/25/25 revealed:
-Resident #1 was issued an immediate discharge notice on 07/25/25 due to the safety of other residents was in danger due to he was smoking in the room and starting fires and standing over people while they slept and threatening to kill them.
-The planned discharge location was the local hospital.
-The discharge notice was signed by the Administrator.

Telephone interview with the Office Manager at the facility pharmacy on 09/24/25 at 12:55pm revealed:
-The order for Uzedy every 2 months for Resident #1 was received on 07/30/25.
-That was the only time an order for Uzedy was received from facility.
-Prior authorization was needed, so the medication was not filled until 08/07/25.

Interview with Resident #1 on 07/28/25 at 12:45pm revealed:
-The Administrator was harassing him.
-He was sent to the hospital for no reason, and she wanted him to stay there "for life".
-She said he was sleeping on the couch and smoking in the building, "but there was no evidence of that".
-Three months ago he had pushed another resident down, but it was because that resident had hit him with

his cane.
-He was supposed to get his mental health injection every 2 months, but he had not had it since he had been at this facility.
-He was not aware of who was responsible for administering the injection to him.

Second interview with Resident #1 on 09/04/25 at 12:20pm revealed:
-It had been four months or more since he had an injection.
-He was supposed to get his injection every two months.
-He had never refused his injection, he did not refuse any medication because he knew it helped him.

Interview with the supervisor in charge (SIC) on 07/28/25 at 11:35am revealed.
-Law enforcement was called several times concerning Resident #1's behaviors.
-He had been smoking in the building and set a trash can on fire.
-He would stay up all night in the living room listening to loud music.
-She had heard the Administrator say he missed his injection, but she did not know any other details or dates.

Telephone interview with the Program Director of Resident Services for Resident #1's mental health provider on 07/28/25 at 2:50pm revealed:
-She had been working with Resident #1 since December 2024.
-She assisted with obtaining placement for him at the current facility.
-Resident #1 had previously received mental health services from the assertive community treatment (ACT) team but had recently been transitioned to the community support team (CST).
-When he was on the ACT team the nurse with the ACT team would administer the Uzedy injection.
-Since he was transitioned to CST there was no longer a nurse available to give the injection.

-The facility should have coordinated and taken him into the office to get his injection. -The Administrator had not communicated any concerns regarding Resident #1's behavior or his injection. -She was not aware that he was not receiving his mental health injection as scheduled. -She would make contact with the clinical director over the ACT team today to see if was possible to assist with getting the injection administered for Resident #1. -She last saw Resident #1 on 07/15/25 when she visited the facility to drop off his check to the Administrator. Interview with the Administrator on 07/28/25 at 10:50am revealed: -Resident #1 was given a 30 day notice of discharge on 07/23/25 due to facility not receiving full payment. -Resident #1 became upset and threatening so she completed the IVC on 07/24/25. -The IVC expired after 24 hours and law enforcement had not picked Resident #1 up. -He continued to threaten other residents and was smoking in the building and set fire to the trash can on 07/25/25. -She went back on 07/25/25 and did another IVC and also issued an immediate discharge notice. -Law enforcement picked Resident #1 up on the evening of 07/25/25 and took him to the hospital. -The hospital called the following day and she told them she could not take him back, but about two hours later the hospital dropped him off at facility. -Resident #1 was admitted to the facility on 03/24/25. -He had a mental health provider who was working with him and his qualified professional (QP) was at facility on during this interview. -She thought behavior was the result of him not having his mental health injection. -He had not had the injection because she was not able to get information from his mental health provider. -She sent a text message to the supervisor with the mental health provider on 05/06/25 asking for mental health provider notes and documentation about when		

the injection was last given. -The supervisor responded by providing the contact number to the mental health physician. -She had tried getting information and documentation from the mental health physician, but they reported it was confidential. -The QP was responsible for taking him to his mental health appointments; she did not know why the injection was not given at his appointment. -Resident #1 reported to Administrator in May 2025 that he had missed his injection. -No other efforts were made to get the Uzedy injection for Resident #1. Second interview with the Administrator on 09/04/25 at 4:30pm revealed: -Resident #1 would be discharged on 09/05/25 to another facility. -Resident #1 had his injection in August 2025, but she did not have any documentation. Telephone interview with the facility PCP on 09/26/25 at 2:29pm revealed: -She visited the facility monthly to see Resident #1 and other residents. -Resident #1 had an order for Uzedy injection monthly. -She was not aware he had not been receiving his injection as ordered. -She expected the facility to get home health or the mental health provider to administer the injection. -If Resident #1's Uzedy was not administered as ordered it could cause increased agitation, hallucinations or other symptoms. Telephone interview with Resident #1's mental health provider on 09/26/25 at 12:15pm revealed: -The Uzedy 250mg/0.7mL inject 0.7mL under the skin every 2 months was originally prescribed to Resident #1 in November 2024. -There was no record of it being changed to monthly in her notes. -It was expected that he be given the injection every 2 months as prescribed.		

-If he did not get the Uzedy injection as prescribed it may not affect his physical health, but there could be mental health concerns like outburst, hallucinations, delusions, and disorganized thinking. -The Uzedy injection was administered to Resident #1 during an office visit on 03/31/25. -He was seen in the office on 05/22/25, but the injection was not administered during that visit. Interview with Resident #1's QP on 07/28/25 at 11:05am revealed: -Resident #1 was previously in a private living situation and she had been working with him since March 2025. -He needed help with money management and medication administration so the supervisor worked on obtaining this placement. -She just recently became aware that Resident #1 was not receiving his mental health injection as prescribed. -When the Administrator reported to her the concerns about Resident #1's behavior and him setting a trashcan on fire she asked the Administrator if he was taking all his oral medication and his injection.		
-The Administrator responded by saying he was taking his oral medication, but she did not know anything about an injection. -She was not sure of details of why the injection was missed, but the facility was responsible for administering medication. -He called her in early July 2025 to report he was at the hospital due to hearing voices. -Facility had issued a discharge notice, but mental health provider had worked hard on obtaining this placement and had no other placement options at this time. -She agreed to contact her supervisor to see how they could assist with getting the injection as soon as possible for Resident #1. 2. Review of Resident #2's current FL-2 dated 08/12/25 revealed: -Diagnoses included: schizoaffective disorder, hypokalemia, developmental delay, mixed		

dyslipidemia, hypertention, metabolic syndrome, hyperammonemia, and iron deficiency anemia.
-She was ambulatory.
-She was verbally abusive.
-She was incontinent of bladder and continent of bowel.
-Included an order for Haloperidol Deaconate 100mg inject 1ML into the muscle every 4 weeks (Haloperidol is an antipsychotic medication used primarily for treating schizophrenia administered intramuscularly for patients requiring prolonged parenteral antipsychotic therapy).

Review of Resident #2's previous FL-2 dated 07/23/25 revealed:
-Diagnoses included: schizoaffective disorder bipolar type, nicotine dependence, and developmental delay.
-Included an order for Haldol Deaconate 100mg/2mL IM every 4 weeks – next due 07/30/25.

Review of the Resident Register revealed Resident #2 had an admission date of 07/24/25.

Review of Resident #2's record revealed that Resident #2 was appointed a guardian of the person on 09/14/20.

Review of Resident #2's care plan dated 07/30/25 revealed:
-She was receiving medications for mental illness.
-She was sometimes disoriented, and forgetful.
-She required supervision for eating and ambulation.
-She required limited assistance with toileting and dressing.
-She required total assistance with medication administration.
-The care plan was signed by the PCP on 08/12/25.

Review of Resident #2's licensed health professional support (LHPS) review dated 09/03/25 revealed:
-Female resident was new to the facility.
-She was alert and oriented.
-She did not know her boundaries and "visited" nurse several times while in the office.

-She had a LHPS task for medication administration through injection.
-Haloperidol Dec 100Mg/ml vial 1ml every 4 weeks was prescribed.
-Recommendation made was to continue current plan of care.
-LHPS review was signed by the registered nurse (RN).

Review of Resident #2's July 2025 medication administration records (MAR) revealed:
-There was an entry for Haloperidol Dec 100 Mg/ml vial inject 1 ML into the muscle every 4 weeks.
-Haloperidol Dec 100 Mg/ml Vial was not documented as administered in July 2025.

Review of Resident #2's August 2025 MAR revealed:
-There was an entry for Haloperidol Dec 100 Mg/ml vial inject 1 ML into the muscle every 4 weeks.
-Medication Aide documented that Resident #2 was administered the injection on 08/02/25.
-Administrator documented that Resident #2 refused the injection on 08/30/25.

Review of Resident #2 September 2025 MAR revealed:
-There was an entry for Haloperidol Dec 100 Mg/ml Vial inject 1 ml into the muscle every 4 weeks.
-Haloperidol Dec 100 Mg/ml had not been administered as of 09/03/25.

Review of a progress note dated 08/12/25 completed by the facility PCP revealed:
-Resident #2 was seen on 08/12/25 for a new admission appointment.
-Medical history included schizoaffective disorder, diabetes, hypertension, and hyperlipidemia.
-She was in stable condition and adjusting well in the facility.

Review of a progress note dated 09/02/25 completed by the facility mental health provider revealed:
-Resident #2 was seen for a new patient referral.

-She was referred for schizoaffective disorder bipolar type, depression, anxiety, and psych medication management. -She was overdue for her Haldol injection. -She was ruminating repetitive thought and presented as talkative. -She reported anxiety and mood swings, but declined meds to assist. -Recommendations made were to follow up in 3 months and to have home health services in place for injection by a registered nurse (RN) of haloperidol dec 100Mg/ml IM every 4 weeks. Review of an accident/incident report dated 09/04/25 completed by the Administrator revealed: -At 8:35am staff made the Administrator aware that Resident #2 was nowhere to be found. -Administrator was informed by another resident that Resident #2 called law enforcement to take her to the hospital. -Administrator contacted the local hospital and spoke with several people and was advised Resident #2 was not a patient. -Law Enforcement was contacted and reported that they did receive a call around 10:30pm on 09/03/25 from Resident #2 and EMS picked her up. -Neither the Administrator nor the staff in the building was informed when EMS picked up Resident #2 that she was leaving the building. -Administrator contacted the guardian for Resident #2 and also the local Department of Social Services (DSS). Review of Resident #2's hospital medical records dated 09/03/25 revealed: -She was admitted on 09/03/25 at 11:42pm. -She reported she had been without sleep for 3 days. -She described a severe depression onset three days prior, marked by profound fatigue, minimal sleep (15-30 minutes nightly) and low energy. -She responded inappropriately to questions, her thought content was inappropriate and she reported people had attempted to steal her things and to "mess"		

with her baby. -She also reported having auditory hallucinations that were chronic, episodic and intrusive but not threatening. -She was oriented to all spheres, her impulse control was poor, judgment was poor and insight was poor. -She was placed in seclusion due to behaviors when she was admitted to the psychiatric unit. -She was irate, yelling and screaming at staff. -Contact was made with the facility Administrator. -Administrator was upset due to Resident #2 calling 911 herself and EMS presented to the home and took her to the hospital without informing staff. -Administrator provided name and contact information for the guardian. -Administrator provided diagnoses as schizoaffective bipolar type and Intellectual and Developmental Disability (IDD). -Administrator did not express any other concerns, questions or information. Interview with a resident on 09/04/25 at 12:30pm revealed: -He was sitting on the couch in the living room with Resident #2 when she called 911. -Resident #2 involuntarily committed herself last night by calling the police. -Resident #2 was upset due to not being able to get cigarettes. -Resident #2 had been trying to sell food and drinks for cigarettes. -Resident #2 had refused her medications for several days straight and she then became disruptive. -Resident #2 called the police and they arrived around 11:00pm while the worker was asleep. -The alarms in the building were not working. -The police officer did come into the building when he arrived and Resident #2 walked out with him. Telephone interview with the guardian for Resident #2 on 09/24/25 revealed: -She had just become involved with Resident #2 on 09/01/25, prior to that she had a different guardian.		

-Resident #2 had a history of frequent hospital visits and IVC's. -She was not aware of Resident #2 missing any medication and she had not had any reported concerns from the facility. Based on observations, interviews, and record review it was determined that Resident #2 was a poor historian. Interview with the supervisor in charge (SIC) on 09/04/25 at 11:29am revealed: -The Administrator was responsible for administering all medications. -Resident #2 was supposed to have an injection, but she had not had it since being at facility. -She heard the Administrator say earlier in the week that someone was supposed to give the injection, but it had not been done. -On 09/03/25 Resident #2 was very agitated all day long due to being out of cigarettes. -Resident #2 had snacks and drinks that she was going around trying to sell to everyone so she could get money to buy cigarettes. -At around 10:00pm on 09/03/25 Resident #2 was cussing and fussing and was saying something about "your next death". -This morning around 7:00am she went to Resident #2's room and found she was not in the building. -Another resident reported that Resident #2 had called 911 and left with EMS the evening of 09/03/25. -The alarm had not been working for the past two months, so no alarm was set when she went to bed at night. -The Administrator did put a sensor alarm on the door this morning. -Resident #2 was fine when she first admitted to the facility, but after a couple of days she started harassing other residents for cigarettes. -Resident #2 would go to everyone, even to the residents in the sister facility next door. -Resident #2 would cuss and demand they give her cigarettes. -There had been two incidents when Resident #2 was		

walking to leave the premises and she had to go and get the Administrator to go get resident. -She informed the Administrator of Resident #2's behaviors on 09/03/25 and the Administrator said to tell Resident #2 if she did not calm down she was going to have her IVC'd. Telephone Interview with a registered nurse at the local hospital on 09/04/25 at 10:05am revealed: -Resident #2 arrived to the local hospital via EMS on 09/03/25. -Resident #2 had locked herself in the bathroom at the facility due to her anxiety, and she reported people were stealing her stuff. -Resident #2 arrived at the hospital just before midnight on 09/03/25. Telephone interview with the social worker at the local hospital on 09/05/25 at 9:30am revealed: -Resident #2 was admitted to the psychiatric unit in the local hospital. -Resident #2 was started on oral mental health medications. -Yesterday was a rough day for her, she was very elevated and required seclusion and needed medications that she was initially refusing. -Forced medications were discussed with the guardian who gave consent. -Once the oral medication was in her system she would be given the Haldol injection, possibly within the next week. -There was no discharge date at that time, but the Haldol injection would be administered prior to discharge. Telephone Interview with the Administrator on 09/04/25 at 9:53a.m. revealed: -The Administrator contacted the local DSS and reported that she was unable to locate Resident #2. -Resident #2 had a diagnosis of Schizoaffective Bipolar, and Developmental Delay. -Video camera footage had been reviewed and it showed Resident #2 leaving with EMS the evening of		

09/03/25. -She was not aware of Resident #2 missing until 8:00am on 09/04/25, when she was notified by the Supervisor in Charge (SIC). -Resident #1 reported that Resident #2 called EMS between 10:30pm – 11:00pm on 09/03/25. -She had contacted dispatch and confirmed with them that Resident #2 contacted the local county 911 at 10:30pm for assistance on 09/03/25 and they arrived at the facility. -Telephone contact had been made with the local hospital and they did not disclose if Resident #2 was present at the hospital. -Resident #2 was approximately 60 years old and she had a guardian. Interview with the Administrator on 09/04/25 at 3:50pm revealed: -Resident #2 was previously at a sister facility in another county, previous facility had to involuntarily commit (IVC) her and at discharge she was admitted to current facility. -Administrator informed the owner that Resident #2 would not be a "good fit" at this facility, but Resident #2 did not get along with the Administrator at sister facility so the owner made the decision to transfer Resident #2 to current facility. -Resident #2 had not had her monthly mental health injection since being admitted to this facility. -She admitted she had overlooked the injection order when Resident #2 was admitted. -It was brought to her attention by the mental health provider when provider asked about the order. -She was responsible for reviewing medication orders at admission, clarifying orders as needed and medication administration. Interview with the facility PCP on 09/26/25 at 2:29pm revealed: -She was not aware of Resident #2 missing her mental health injection. -If Resident #2 was not given her haloperidol properly for her mental health she could have a flare up with		

increased agitation, hallucinations of seeing or hearing thing that were not there.

Interview on with the mental health provider on 09/24/25 revealed:
-Resident #2 was not given her injection of haloperidol while at the facility.
-Her injection was given during the 09/04/25 hospital admission.
-A referral for home health had to be done so the injection could be administered at the facility.

The facility failed to ensure medication was administered as ordered for 2 sampled residents, both of whom had an order for mental health injections, resulting in residents having an increase in behaviors and mental health symptoms and having to visit the local hospital for treatment. This failure resulted in serious neglect of the residents and constitutes a Type A1 Violation.

The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 07/29/25.
CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED October 26, 2025.

Rule/Statute Number: 10A NCAC 13G .0901 Personal Care and Supervision

☐ POC Accepted _____ *DSS Initials*

Rule/Statutory Reference:
(b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.

Level of Non-Compliance: Type A1 Violation

This rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure supervision was provided in accordance with residents assessed needs as evidenced by 1 of 3 residents sampled (Resident #2) having an

increase in behaviors related to her mental health diagnosis and leaving the facility and being gone for approximately 10 hours before staff was aware.

The findings are:

Review of Resident #2's current FL-2 dated 08/12/25 revealed:
-Diagnoses included: schizoaffective disorder, hypokalemia, developmental delay, mixed dyslipidemia, hypertension, metabolic syndrome, hyperammonemia, and iron deficiency anemia.
-She was ambulatory.
-She was verbally abusive.

Review of Resident #2's previous FL-2 dated 07/23/25 revealed diagnoses included: schizoaffective disorder bipolar type, nicotine dependence, and developmental delay.

Review of the Resident Register revealed Resident #2 had an admission date of 07/24/25.

Review or Resident #2's record revealed that Resident #2 was appointed a guardian of the person on 09/14/20.

Review of Resident #2's care plan dated 07/30/25 revealed:
-She was receiving medications for mental illness.
-She was sometimes disoriented, and forgetful.
-She required supervision for eating and ambulation.
-She required limited assistance with toileting and dressing.
-She required total assistance with medication administration.
-The care plan was signed by the PCP on 08/12/25.

Review of Resident #2's licensed health professional support (LHPS) review dated 9/3/25 revealed:
-Female resident was new to the facility.
-She was alert and oriented.
-She did not know her boundaries and "visited" nurse several times while in the office.

-She had a LHPS task for medication administration through injection.
-Haloperidol Dec 100Mg/ml vial 1ml every 4 weeks was prescribed.
-Recommendation made was to continue current plan of care.
-LHPS review was signed by the registered nurse (RN).

Review of a progress note dated 08/12/25 completed by the facility PCP revealed:
-Resident #2 was seen on 08/12/25 for a new admission appointment.
-Medical history included schizoaffective disorder, diabetes, hypertension, and hyperlipidemia.
-She was in stable condition and adjusting well in the facility.

Review of a progress note dated 09/02/25 completed by the facility mental health provider revealed:
-Resident #2 was seen for a new patient referral.
-She was referred for schizoaffective disorder bipolar type, depression, anxiety, and psych medication management.
-She was overdue for her Haldol injection.
-She was ruminating repetitive thought and presented as talkative.
-She reported anxiety and mood swings, but declined meds to assist.
-Recommendations made were to follow up in 3 months and to have home health services in place for injection by a registered nurse (RN) of Haloperidol Dec 100Mg/ml IM every 4 weeks.

Review of an accident/incident report dated 09/04/25 at completed by the Administrator revealed:
-At 8:35am staff made the Administrator aware that Resident #2 was nowhere to be found.
-Administrator was informed by another resident that Resident #2 called law enforcement to take her to the hospital.
-Administrator contacted the local hospital and spoke with several people and was advised Resident #2 was

not a patient.
-Law Enforcement was contacted and reported that they did receive a call around 10:30pm on 09/03/25 from Resident #2 and Emergency Medical Service (EMS) picked her up.
-Neither the Administrator nor the staff in the building was informed when EMS picked up Resident #2 that she was leaving the building.
-Administrator contacted the guardian for Resident #2 and also the local Department of Social Services (DSS).

Review of Resident #2's hospital medical records dated 09/03/25 revealed:
-She was admitted on 09/03/25 at 11:42pm.
-She reported she had been without sleep for 3 days.
-She described a severe depression onset three days prior, marked by profound fatigue, minimal sleep (15-30 minutes nightly) and low energy.
-She responded inappropriately to questions, her thought content was inappropriate and she reported people had attempted to steal her things and to "mess" with her baby.
-She also reported having auditory hallucinations that were chronic, episodic and intrusive but not threatening.
-She was oriented to all spheres, her impulse control was poor, judgment was poor and insight was poor.
-She was placed in seclusion due to behaviors when she was admitted to the psychiatric unit.
-She was irate, yelling and screaming at staff.
-Contact was made with the facility Administrator.
-Administrator was upset due to Resident #2 calling 911 herself and EMS presented to the home and took Resident #2 to the hospital without informing staff.
-Administrator provided name and contact information for the guardian.
-Administrator provided diagnoses as schizoaffective bipolar type and Intellectual and Developmental Disability (IDD).
-Administrator did not express any other concerns, questions or information.

Telephone Interview with the Administrator on 09/04/25 at 9:53a.m. revealed: -The Administrator contacted the local DSS and reported she was unable to locate Resident #2. -Resident #2 had a diagnosis of Schizoaffective Bipolar, and Developmental Delay. -Video camera footage was reviewed this morning and it showed Resident #2 leaving with EMS the evening of 09/03/25. -She was not aware of Resident #2 missing until 8:00am on 09/04/25, when she was notified by the Supervisor in Charge (SIC). -Another resident reported to the SIC this morning that Resident #2 called EMS between 10:30pm – 11:00pm on 09/03/25. -She had contacted dispatch and confirmed with them that Resident #2 contacted the local county 911 at 10:30pm for assistance on 09/03/25 and they arrived at the facility. -Telephone contact was made with the local hospital and they would not disclose if Resident #2 was present at the hospital. -Resident #2 was approximately 60 years old and she had a guardian. Telephone Interview with a registered nurse at the local hospital on 09/04/25 at 10:05am revealed: -Resident #2 arrived to the local hospital via EMS on 09/03/25. -Resident #2 had locked herself in the bathroom at the facility due to her anxiety, and she reported people were stealing her stuff. -Resident #2 arrived at the hospital just before midnight on 09/03/25. Interview with the Administrator on 09/04/25 at 3:50pm revealed: -Resident #2 was previously at a sister facility in another county, previous facility had to involuntarily commit (IVC) her and at discharge she was admitted to current facility. -Administrator informed the owner that Resident #2 would not be a "good fit" at this facility, but Resident		

#2 did not get along with the Administrator at sister facility so the owner made the decision to transfer Resident #2 to current facility. -Resident #2 had not had her monthly mental health injection since being admitted to this facility. Interview with the supervisor in charge (SIC) on 09/04/25 at 11:29am revealed: -On 09/03/25 Resident #2 was very agitated all day long due to being out of cigarettes. -Resident #2 was arguing with another resident about cigarettes and she was "a problem all day, she was flipping on everyone". -She informed the Administrator of Resident #2's behaviors on the afternoon of 09/03/25 and the Administrator said to tell Resident #2 if she did not calm down she was going to have her IVC'd. -No additional interventions were put in place and 15 minute checks were not put in place for Resident #2. -Resident #2 had snacks and drinks that she had purchased with her benefits card, she was going around trying to sell them to everyone so she could get money to buy cigarettes. -At around 10:00pm on 09/03/25 Resident #2 continued cussing and fussing and was saying something about "your next death" and she was going back and forth still arguing with another resident. -At around 10:00pm she was in her room getting her things ready to take a shower. -Resident #2 busted into her room still "flipping out" about a cigarette. -She told Resident #2 she did not have any cigarettes and she watched Resident #2 go to her room. -She took her shower and when she got out she did not hear anything, so she went to bed. -The next morning around 7:00am she went to Resident #2's room and found she was not in the building. -Another resident reported that Resident #2 had called 911 and left with EMS the evening of 09/03/25. -The alarm had not been working for the entire time she had been working at facility, which was the past two months.		

-There was no alarm set when SIC went to bed at night. -The Administrator did put a sensor alarm on the door this morning. -Resident #2 was fine when she first admitted to the facility, but after a couple of days she started harassing other residents for cigarettes. -Resident #2 would go to everyone, even to the residents in the sister facility next door. -Resident #2 would cuss and demand they give her cigarettes. -There had been two incidents when Resident #2 was walking to leave the premises and she had to go and get the Administrator to go get resident. Interview with a resident on 09/04/25 at 12:30pm revealed: -He was sitting on the couch with Resident #2 in the living room when she called 911 -Resident #2 involuntarily committed herself last night by calling the police. -Resident #2 was upset due to not being able to get cigarettes. -Resident #2 had been trying to sell food and drinks for cigarettes all day. -Resident #2 had refused her medications for several days straight and she then became disruptive. -He knew she was not taking her medication because he would hear when the medication aide offered them and she refused. -Resident #2 called the police and they arrived around 11:00pm while the worker was asleep. -He was sitting on the couch when he heard a knock at the door. -He opened the door. -It was a sheriff deputy there for Resident #2. -The deputy did come into the building and Resident #2 walked out with him. -He told the SIC this morning that Resident #2 left with EMS. -The SIC told him that he should have gotten her last night, but he did not think it was his business. -The alarm was not working.		

-He went in and out of the building every night to smoke up until around 1:00am.
-All other residents were in their rooms when this occurred.

Interview with the facility PCP on 09/26/25 revealed:
-She was not aware of Resident #2 missing her mental health injection.
-If Resident #2 was not given her haloperidol properly for her mental health she could have a flare up with increased agitation, hallucinations of seeing or hearing thing that were not there.

Telephone interview with the guardian for Resident #2 on 09/24/25 revealed:
-She had just become involved with Resident #2 on 09/01/25, prior to that she had a different guardian.
-Resident #2 had a history of frequent hospital visits and IVC's.
-She was not aware of Resident #2 missing any medication and she had not had any reported concerns from the facility.

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

The facility failed to ensure appropriate supervision was provided in accordance with resident symptoms for Resident #2 who had behaviors related to mental health diagnosis resulting resident being out of the facility for approximately 10 hours without staff being aware. This failure resulted in serious neglect of the residents and constitutes a Type A1 Violation.

The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 07/29/25.
CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED October 26, 2025.

Rule/Statute Number: 10A NCAC 13G .0902 Health Care	☐ POC Accepted _____ *DSS Initials*	
Rule/Statutory Reference: (b)The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.		
Level of Non-Compliance: Type A2 Violation		
This rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up for 1 of 3 residents sampled (Resident #2) who required a home health referral to administer the resident monthly injection used to treat mental health resulting in Resident#2 missing her injection for an extended length of time and having a hospital admission due to mental health symptoms. The findings are: Review of Resident #2's current FL-2 dated 08/12/25 revealed: -Diagnoses included: schizoaffective disorder, hypokalemia, developmental delay, mixed dyslipidemia, hypertension, metabolic syndrome, hyperammonemia, and iron deficiency anemia. -She was ambulatory. -She was verbally abusive. -She was incontinent of bladder and continent of bowel. -Included an order for Haloperidol Deaconate 100 mg inject 1ML into the muscle every 4 weeks (Haloperidol is an antipsychotic medication used primarily for treating schizophrenia administered intramuscularly for patients requiring prolonged parenteral antipsychotic therapy). Review of Resident #2's previous FL-2 dated 07/23/25 revealed: -Diagnoses included: schizoaffective disorder bipolar type, nicotine dependence, and developmental delay. -Included an order for Haldol Deaconate 100mg/2mL IM every 4 weeks – next due 7/30/25.		

Review of the Resident Register revealed Resident #2 had an admission date of 07/24/25.

Review of Resident #2's record revealed that Resident #2 was appointed a guardian of the person on 9/14/20.

Review of Resident #2's care plan dated 07/30/25 revealed:
-She was receiving medications for mental illness.
-She was sometimes disoriented, and forgetful.
-She required supervision for eating and ambulation.
-She required limited assistance with toileting and dressing.
-She required total assistance with medication administration.
-The care plan was signed by the PCP on 08/12/25.

Review of Resident #2's licensed health professional support (LHPS) review dated 09/03/25 revealed:
-Female resident was new to the facility.
-She was alert and oriented.
-She did not know her boundaries and "visited" nurse several times while in the office.
-She had a LHPS task for medication administration through injection.
-Haloperidol Dec 100Mg/ml vial 1ml every 4 weeks was prescribed.
-She was prescribed metformin but no blood sugars were ordered.
-Recommendation made was to continue current plan of care.
-LHPS review was signed by the registered nurse (RN).

Review of Resident #2's July 2025 medication administration records (MAR) revealed:
-There was an entry for Haloperidol Dec 100 Mg/ml vial inject 1 ML into the muscle every 4 weeks.
-Haloperidol Dec 100 Mg/ml Vial was not administered in July.

Review of Resident #2's August 2025 MAR revealed:
-There was an entry for Haloperidol Dec 100 Mg/ml

vial inject 1 ML into the muscle every 4 weeks.
-Medication Aide documented that Resident #2 was administered the injection on 08/02/25.
-Administrator documented that Resident #2 refused the injection on 08/30/25.

Review of Resident #2 September 2025 MAR revealed:
-There was an entry for Haloperidol Dec 100 Mg/ml Vial inject 1 ml into the muscle every 4 weeks.
-Haloperidol Dec 100 Mg/ml had not been administered as of 09/03/25.

Review of a progress note dated 08/12/25 completed by the facility primary care provider (PCP) revealed:
-Resident #2 was seen on 08/12/25 for a new admission appointment.
-Medical history included schizoaffective disorder, diabetes, hypertension, and hyperlipidemia.
-She was in stable condition and adjusting well in the facility.

Review of Resident #2's mental health provider progress note dated 09/02/25 revealed:
-Resident #2 was seen for a new patient referral.
-She was referred for schizoaffective disorder bipolar type, depression, anxiety, and psych medication management.
-She was overdue for her Haldol injection.
-She was ruminating repetitive thought and presented as talkative.
-She reported anxiety and mood swings, but declined meds to assist.
-Recommendations made were to follow up in 3 months and to have home health services in place for injection by a registered nurse (RN) of haloperidol dec 100Mg/ml IM every 4 weeks.

Review of an accident/incident report dated 09/04/25 at completed by the Administrator revealed:
-At 8:35am staff made the Administrator aware that Resident #2 was nowhere to be found.
-Administrator was informed by another resident that

Resident #2 called law enforcement to take her to the hospital. -Administrator contacted the local hospital and spoke with several people and was advised Resident #2 was not a patient. -Law Enforcement was contacted and reported that they did receive a call around 10:30pm on 09/03/25 from Resident #2 and emergency medical services (EMS) picked her up. -Neither the Administrator nor the staff in the building was informed when EMS picked up Resident #2 that she was leaving the building. -Administrator contacted the guardian for Resident #2 and also the local Department Of Social Services (DSS). Review of Resident #2's hospital medical records revealed: -She was admitted on 09/03/25 at 11:42pm. -She reported she had been without sleep for 3 days. -She described a severe depression onset three days prior, marked by profound fatigue, minimal sleep (15-30 minutes nightly) and low energy. -She responded inappropriately to questions, her thought content was inappropriate and she reported people had attempted to steal her things and to "mess" with her baby. -She also reported having auditory hallucinations that were chronic, episodic and intrusive but not threatening. -She was oriented to all spheres, her impulse control was poor, judgment was poor and insight was poor. -She was placed in seclusion due to behaviors when she was admitted to the psychiatric unit. -She was irate, yelling and screaming at staff. -Contact was made with the facility Administrator. -Administrator was upset due to Resident #2 called 911 herself and EMS presented to the home and took her to the hospital without informing staff. -Administrator provided name and contact information for the guardian. -Administrator provided diagnoses as schizoaffective bipolar type and Intellectual and Developmental Delay.		

-Administrator did not express any other concerns, questions or information. Telephone Interview with the Administrator on 09/04/25 at 9:53 a.m. revealed: -The Administrator contacted the local DSS reporting she was unable to locate Resident #2. -Resident #2 had a diagnosis of Schizoaffective Bipolar, and Developmental Delay. -Video camera footage had been reviewed and it showed Resident #2 leaving with EMS the evening of 09/03/25. -She was not aware of Resident #2 missing until 8:00am on 09/04/25, when she was notified by the Supervisor in Charge (SIC). -Another reported that Resident #2 called EMS between 10:30pm – 11:00pm on 09/03/25. -She had contacted dispatch and confirmed with them that Resident #2 contacted the local county 911 at 10:30pm for assistance on 09/03/25 and they arrived at the facility. -Telephone contact had been made with the local hospital and they were not disclosing if Resident #2 was present at the hospital. -Resident #2 was approximately 60 years old and she had a guardian. Telephone Interview with a registered nurse at the local hospital on 09/04/25 at 10:05am revealed: -Resident #2 arrived to the local hospital via EMS on 09/03/25. -Resident #2 had locked herself in the bathroom at the facility due to her anxiety, and she reported people were stealing her stuff. -Resident #2 arrived at the hospital just before midnight on 09/03/25. Interview with the Administrator on 09/04/25 at 3:50 p.m. revealed: -Resident #2 was previously at a sister facility in another county, previous facility had to IVC her and at discharge, she was admitted to current facility. -Administrator informed the owner that Resident #2		

would not be a "good fit" at this facility, but Resident #2 did not get along with the Administrator at sister facility so the owner made the decision to transfer Resident #2 to current facility.
-Resident #2 had not had her monthly mental health injection since being admitted to this facility.
-She admitted she had overlooked the injection order when Resident #2 was admitted.
-It was brought to her attention by the mental health provider when provider asked about the order.
-She was responsible for reviewing medication orders at admission, clarifying orders as needed and medication administration.

Telephone interview on 09/05/25 at 9:30am with the social worker at the local hospital revealed:
-Resident #2 was admitted to the psychiatric unit in the local hospital.
-Resident #2 was started on oral mental health medications.
-Yesterday was a rough day for her, she was very elevated and required seclusion and needed medications that she was initially refusing.
-Forced medications were discussed with the guardian who gave consent.
-Once the oral medication was in her system she would be given the Haldol injection, possibly within the next week.
-There was no discharge date at that time, but the Haldol injection would be administered prior to discharge.

Interview with the supervisor in charge (SIC) on 09/04/25 at 11:29 a.m. revealed:
-The Administrator was responsible for administering all medications.
-Resident #2 was supposed to have an injection, but she had not had it.
-She heard the Administrator earlier in the week that someone was supposed to give the injection, but it had not been done.
-On 09/03/25 Resident #2 was very agitated all day long due to being out of cigarettes.

-Resident #2 had snacks and drinks that she was going around trying to sell to everyone so she could get money to buy cigarettes. -At around 10:00pm on 09/03/25 Resident #2 was cussing and fussing and was saying something about "your next death". -This morning around 7:00am she went to Resident #2's room and found she was not in the building. -Another resident reported that Resdient#2 had called 911 and left with EMS the evening of 09/03/25. -The alarm had not been working for the past two months, so no alarm was set when she went to bed at night. -The Administrator did put a sensor alarm on the door this morning. -Resident #2 was fine when she first admitted to the facility, but after a couple of days she started harassing other residents for cigarettes. -Resident #2 would go to everyone, even to the residents in the sister facility next door. -Resident #2 would cuss and demand they give her cigarettes. -There had been two incidents when Resident #2 was walking to leave the premises and she had to go and get the administrator to go get resident. -She informed the Administrator of Resident #2's behaviors on 09/03/25 and the Administrator said to tell Resident #2 if she did not calm down she was going to have her IVC'd. Interview with a resident on 09/04/25 at 12:30pm revealed: -Resident #2 involuntarily committed herself last night by calling the police. -Resident #2 was upset due to not being able to get cigarettes. -Resident #2 had been trying to sell food and drinks for cigarettes. -Resident #2 had refused her medications for several days straight and she then became disruptive. -Resident #2 called the police and they arrived around 11:00pm while the worker was asleep. -The alarms in the building were not working.		

-The police officer did come into the building when he arrived and Resident #2 walked out with him. Interview on 09/24/25 with the mental health provider revealed: -Resident #2 was not given her injection of haloperidol while at the facility. -Her injection was given during hospital admission. -A referral for home health had to be done so the injection could be administered at the facility. Interview on 09/26/25 with the facility primary care provider revealed: -She was not aware of Resident #2 missing her mental health injection. -If Resident #2 was not given her Haldol medication properly for her mental health it could cause a flare up which could include increased agitation, and hallucinations of seeing or hearing thing that were not there. Based on observations, interviews, and record review it was determined that Resident #2 was not interviewable. Telephone interview with the guardian for Resident #2 on 09/24/25 revealed: -She had just become involved with Resident #2 on 09/01/25, prior to that she had a different guardian. -Resident #2 had a history of frequent hospital visits and IVC's. -She was not aware of Resident #2 missing any medication and she had not had any reported concerns from the facility. --- The facility failed to ensure health care referral and follow up was completed for Resident #2 who had a diagnosis of schizophrenia disorder and required monthly mental health injections. The facility failed to obtain home health services to administer the injection resulting in the resident having to visit the hospital with reported auditory hallucinations and no sleep for 3		

days. The failure resulted in substantial risk for serious physical harm and constitutes a Type A2 Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 07/29/25. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED October 26, 2025.		

IV. Delivered Via:	**CERTIFIED MAIL 7015 1520 0001 1163 7130**	Date: 10/10/25
DSS Signature:	Shachin Williams/SLH	Return to DSS By: 11/3/25

V. CAR Received by:	Administrator/Designee (print name):	
	Signature:	Date:
	Title:	

VI. Plan of Correction Submitted by:	Administrator (print name):	
	Signature:	Date:

VII. Agency's Review of Facility's Plan of Correction (POC)		
☐ ***POC Not Accepted***	By:	Date:
Comments:		
☐ ***POC Accepted***	By:	Date:
Comments:		

VIII. Agency's Follow-Up	By:	Date:
	Facility in Compliance: ☐ Yes ☐ No	Date Sent to ACLS:
Comments:		
**For follow-up to CAR, attach Monitoring Report showing facility in compliance.*		