Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080032	A. BUILDING: _____ B. WING _____	R-C 10/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHAMY RETIREMENT CENTER	909 N SALISBULRY AVENUE SPENCER, NC 28159

(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 000	Initial Comments The Adult Care Licensure Section conducted a follow up survey and complaint investigation from 10/21/25 through 10/24/25.	D 000		
D 067	10A NCAC 13F .0305 (h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) in facilities with at least one resident who is determined by a physician or is otherwise observed by staff to be disoriented or exhibits wandering behavior, a continuously sounding device that is activated when the door is opened shall be located on each exit door that opens to the outside. The sound shall be audible in the facility. If a central system of remote sounding devices is provided, the control panel shall be powered by the facility's electrical system, and be in a location accessible by staff to operate the control panel. Notwithstanding the requirements of Rule .0301, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION. Based on these findings, the previous Type A2 Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to ensure 10 of 10 exit doors had engaged and audible alarms allowing residents, who were disoriented, to exit the facility	D 067		

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without staff's knowledge, including three residents who were intermittently or constantly disoriented (#3, #4, and #5).

The findings are:

Observation of the exit door at the front of the hallway that separated the North Hall from the South Hall on 10/21/25 at 8:30am revealed:
-There was no audible sound when the residents entered or exited the door.
-There were no staff supervising the residents who came in and out the door.

Observation of the exit door at the front of the hallway that separated the North Hall from the South Hall on 10/23/25 at various times between 8:30am and 4:30pm revealed:
-The exit door led to the front parking lot, which was next to the highway.
-There was a 3-inch by 1-inch white alarm box attached to the top of the exit door.
-There was a slide switch on the white alarm box that turned the alarm on and off.
-The slide switch on the white alarm box was in the off position.
-There were visitors, staff, and residents observed entering and exiting the door during the day.
-There were no staff supervising the exit door.
-At 9:15am, the audible alarm was turned on by the surveyor.
-The exit door was opened and the alarm sounded for 30 seconds; the door was closed and no staff came to check to see if anyone left the facility.

Interview with a resident on 10/23/25 at 9:18am revealed:
-Residents would come to the front parking lot

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several times a day.
-She went out the front door to sit on the benches outside.
-She never heard an alarm on the door when she went outside to sit.

Observation of the exit door beside the South Hall dining room on 10/21/25 at 8:35am revealed:
-There was no audible sound when the residents entered or exited the door.
-There were no staff supervising the residents who came in and out the door.

Observation of the exit door beside the South Hall dining room on 10/23/25 at various times between 8:30am and 4:30pm revealed:
-The exit door led to a covered porch with chairs; the area was the designated smoking area.
-There were several residents in the smoking area.
-There was no alarm attached to the exit door.
-There were no staff supervising the residents who came in and out the door.

Interview with a second resident on 10/23/25 at 9:35am revealed:
-Most residents would come to the smoking area several times a day.
-He went to the smoking area 4 to 6 times daily.
-He never heard an alarm on the door when he went outside to smoke.

Observation of the exit door on the back of the South Hall on 10/21/25 at 8:40am revealed:
-There was no audible sound when the residents entered or exited the door.
-There were no staff supervising the residents who came in and out the door.

Observation of the exit door on the back of the

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D 067	Continued From page 3 South Hall on 10/23/25 at various times between 8:30am and 4:30pm revealed: -The exit door led to the back yard. -There was no alarm attached to the exit door. -There were no staff supervising the residents who came in and out the door. Observation of the exit door on the side of the South Hall on 10/21/25 at 9:35am revealed: -There was no audible sound when the residents entered or exited the door. -There were no staff supervising the residents who came in and out the door. Observation of the exit door on the side of the South Hall on 10/23/25 at various times between 8:30am and 4:30pm revealed: -The exit door led to the side yard, which led to the highway. -There was no alarm attached to the exit door. -There were no staff supervising the residents who came in and out the door. Observation of the exit door on the front of the South Hall on 10/21/25 at 9:45am revealed: -There was no audible sound when the residents entered or exited the door. -There were no staff supervising the residents who came in and out the door. Observation of the exit door on the front of the South Hall on 10/23/25 at various times between 8:30am and 4:30pm revealed: -There was a 3-inch by 1-inch white alarm box attached to the top of the exit door. -There was a slide switch on the white alarm box that turned the alarm on and off. -The slide switch on the white alarm box was in the off position. -There was no audible sound when the residents	D 067		

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entered or exited the door.
-There were no staff supervising the residents who came in and out the door.
-At 9:50am, the audible alarm was turned on by the surveyor.
-The exit door was opened and the alarm sounded continuously and faintly due to weak battery supply; the alarm was turned off by the surveyor after 60 seconds and no staff came to check to see if anyone left the facility.

Observation of the exit door at the back of the hallway that separated the North Hall from the South Hall on 10/21/25 at 10:00am revealed:
-There was no audible sound when the residents entered or exited the door.
-There were no staff supervising the residents who came in and out the door.

Observation of the exit door at the back of the hallway that separated the North Hall from the South Hall on 10/23/25 at various times between 8:30am and 4:30pm revealed:
-The exit door led to the backyard.
-There was a 3-inch by 1-inch white alarm box attached to the top of the exit door.
-There was a slide switch on the white alarm box that turned the alarm on and off.
-The slide switch on the white alarm box was in the off position.
-There was no audible sound when the residents entered or exited the door.
-There were no staff supervising the residents who came in and out the door.
-At 9:10am, the audible alarm was turned on by the surveyor.
-The exit door was opened and the alarm sounded for 30 seconds; the door was closed and no staff came to check to see if anyone left the facility.

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D 067	Continued From page 5 Observation of the exit door at the back of the North Hall's shortest hall on 10/21/25 at 10:10am revealed: -There was no audible sound when the residents entered or exited the door. -There were no staff supervising the residents who came in and out the door. Observation of the exit door at the back of the North Hall's shortest hall on 10/23/25 at various times between 8:30am and 4:30pm revealed: -The exit door led to a stoop that had 6 steps leading to the backyard. -There was a 3-inch by 1-inch white alarm box attached to the top of the exit door. -There was a slide switch on the white alarm box that turned the alarm on and off. -The slide switch on the white alarm box was in the off position. -There was no audible sound when the door was opened. -There were no staff supervising the exit door. -No residents were observed exiting this door. -At 8:30am, the audible alarm was turned on by the surveyor. -The exit door was opened and the alarm sounded continuously and faintly due to weak battery supply; the alarm was turned off by the surveyor after 60 seconds and no staff came to check to see if anyone left the facility. Observation of the exit door in the living room on the North Hall on 10/21/25 at 10:20am revealed: -There was no audible sound when the residents entered or exited the door. -There were no staff supervising the residents who came in and out the door. Observation of the exit door in the living room on	D 067		

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the North Hall on 10/23/25 at various times between 8:30am and 4:30pm revealed:
-The 3-inch by 1-inch white alarm box that would activate the alarm was in the off position.
-There was no audible sound when the residents entered or exited the door.
-There were no staff supervising the residents who came in and out the door and residents had the door propped open to view the outside from the living room.
-At 9:30am, the exit door was shut and the audible alarm was turned on by the surveyor.
-The exit door was opened and the alarm sounded for 30 seconds; the door was closed and no staff came to check to see if anyone left the facility.
-At 2:30pm, a resident exited the door, the door alarmed about 30 seconds and no staff came to check to see if anyone left the facility.

Observation of the exit door at the front of the North Hall on 10/21/25 at 10:30am revealed:
-There was no audible sound when the residents entered or exited the door.
-There were no staff supervising the residents who came in and out the door.

Observation of the exit door at the front of the North Hall on 10/23/25 at various times between 8:30am and 4:30pm revealed:
-The exit door led to the front parking lot, which was next to the highway.
-There was no alarm attached to the exit door.
-There were no staff supervising the residents who came in and out the door.

Observation of the exit door at the back of the longest North Hall on 10/21/25 at 10:35am revealed:
-There was no audible sound when the residents

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entered or exited the door.
-There were no staff supervising the residents who came in and out the door.

Observation of the exit door at the back of the longest North Hall on 10/23/25 at various times between 8:30am and 4:30pm revealed:
-The exit door led to a stoop that had 8 steps leading to the backyard.
-There was a 3-inch by 1-inch white alarm box attached to the top of the exit door.
-There was a slide switch on the white alarm box that turned the alarm on and off.
-The slide switch on the white alarm box was in the off position.
-There was no audible sound when the residents entered or exited the door.
-There were no staff supervising the residents who came in and out the door.
-At 9:20am, the exit door was shut and the audible alarm was turned on by the surveyor.
-The exit door was opened and the alarm sounded for 30 seconds; the door was closed and no staff came to check to see if anyone left the facility.
-At 9:35am, a resident exited the door, the door alarmed about 30 seconds and no staff came to check to see if anyone left the facility.

Interview with a third resident on 10/23/25 at 9:25am revealed:
-He went outside to smoke during the day and night.
-He would go out the exit door at the back of the longest North Hall; this door was the closest to his room.
-He would cut the alarm off by sliding the black button on the alarm box to off but no staff had told him he could not turn off the alarm.
-There was no audible alarm when he went

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D 067	Continued From page 8 outside. -He did not remember a time the exit door alarmed. Interview with a housekeeper on 10/24/25 at 8:38am revealed: -He was a housekeeper for both the North and the South Hall. -Some residents and staff would turn the alarms off; the residents and staff had been told not to turn the alarms off. -Staff were responsible for responding to exit door alarms when the alarms sound but some staff ignore the alarms. -He had not seen any maintenance workers in the facility fixing or replacing door alarms. -He was not aware of any plans to fix the door alarms but he had reported the situation of where doors were missing door alarm boxes to the Administrator. Interview with a personal care aide (PCA) on 10/23/25 at 10:30am revealed: -She worked first shift and at times third shift. -Most of the exit doors had an alarm attached to them; she thought there were two exit doors that did not have alarms. -The alarms should be turned on each night before she came to work. -She did not remember hearing an alarm sound when she entered the building for third shift. -She knew some residents would turn the alarms off and go outside. -Some residents knew how to turn the exit door alarms off. -She had found some residents who had gone outside during the night to smoke. Interview with another PCA on 10/24/25 at 9:45am revealed:	D 067	Facility installed alarms on all exit doors , to assure that the safety and well being of All Residents and Staff. Facility's Maintenance Department will monitor to assure on a day to day basis that ALL alarms sound to alert All staff that residents, staff and visitors are entering the facility . Staff was re-oriented by Facility's Admin ,how to response to door alarms and assure that all Staff are alert and aware where all residents whereabouts in the facility. **11/05/25 - Amended per telephone call with Adminstrator on 12/05/25. SA**	11/20

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-The exit doors were not alarmed during the day.
-The residents would go in and out of the facility during the day as they wanted.
-Some residents would go outside to smoke, and others would go outside to sit and visit with other residents.
-She had not heard of any residents wandering away from the facility.
-There were a few residents who were confused at times, but they did not try to leave the facility.

Interview with a third PCA on 10/24/25 at 10:16am revealed:
-The last time the PCA heard a door alarm inside the facility was on 10/20/25 at the end of the South Hall.
-Second shift staff turned the door alarms on at 10:00pm nightly and third shift turned them off at 5:00am daily.

Interview with a medication aide (MA) on 10/22/25 at 4:12pm revealed:
-She did not know if the exit doors had an alarm on them; she had not heard a door alarm.
-She had never heard door alarms in the facility until surveyors were checking them on 10/22/25.
-The residents would go in and out of the facility during the day as they wanted.
-The facility did not have any residents who wandered.

Interview with another MA on 10/23/25 at 3:16pm revealed:
-When she entered the facility in the mornings, the doors were unlocked and not alarmed.
-She knew some residents would turn the alarms off and go outside.
-There were no residents who wandered in the facility and there were no intermittently or constantly confused residents in the facility.

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-There were a few residents with dementia, but they did not try to leave the facility.

Interview with a third MA on 10/24/25 at 10:48am revealed she had never heard exit door alarms in the facility until the surveyors were checking them on 10/23/25.

Interview with the Resident Care Coordinator (RCC) on 10/24/25 at 10:15am revealed:
-She was not aware of any issues with exit door alarms.
-She had not heard an exit door alarm in the area of the North Hall around her office since she started last month.

Interview with the Administrator on 10/24/25 at 11:25am revealed:
-She thought there were two doors that did not have alarms on them.
-The alarms were turned on and off at each door with a slide switch.
-Some residents would turn the alarms off; the residents had been told not to turn the alarms off.
-She was not aware staff had turned the alarms off and no staff should have silenced the alarms to the exit doors.
-The exit doors that were not alarmed should be locked and monitored by the staff to ensure residents did not exit those doors.
-The facility had about 4 residents who were intermittently or constantly disoriented on their FL2.
-The staff would have to follow the sound of the alarming exit door to know which exit door was alarming.
-Once the door was closed the alarm would stop and the staff would not know which exit door alarmed.
-She did not know there were 6 doors that did not

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have an alarm or a working alarm.
-All exit doors should be locked, and the doors with alarms should be turned on at all times.
-She did realize since she had residents who were disoriented and she expected that the alarms be on at all times and staff to supervise the residents while they were outside.
-She was not aware staff had found some residents who had gone outside near the road in the evening.
-The staff should check all the exit doors when an alarm sounded to see if a resident had exited the facility.
-She had received no correspondence from the Owner on the door alarms until the new alarm systems were delivered on 10/23/25 and only 2 alarms units were delivered yesterday.

Interview with the Owner on 10/24/25 at 12:15pm revealed:
-He was not aware the door alarms were turned off by residents and staff and this was unacceptable.
-He was not aware that some of the exit doors were missing alarms or did not have working alarms.
-He had ordered a new red alarm system recently and the system was delivered yesterday (10/23/25) but he was unable to recall the date he placed the order for the new alarm system.
-This new alarm system would have a unit on every door.

1. Review of Resident #5's current FL2 dated 09/12/25 revealed:
-Diagnoses included infectious disease, hypertension with chronic kidney disease (HTN w/ CKD), chronic obstructive pulmonary disease (COPD), neurocognitive disorder, seizure, neuropathy and history of cerebrovascular

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accident (CVA).
-There was no information listed under the orientation section.

Review of Resident #5's care plan dated 01/17/25 revealed:
-She was sometimes disoriented and forgetful and needed reminders.
-She required a wheelchair for locomotion.

Review of Resident #5's charting note dated 10/11/25 at 10:55pm revealed the resident was "hanging out at the curb supposedly to meet the men she has been chatting with on the dating chat line."

Observation on 10/22/25 at 4:12pm revealed:
-A male resident yelled, "She's up at the road again."
-Resident #5 was observed rolling her wheelchair across the front parking lot of the facility in close proximity to the highway.
-Facility staff did not respond and Resident #5 returned to the facility on her own.

Based on observations, interviews, and record reviews, Resident #5 was not available for interview due to being hospitalized on 10/23/25.

Telephone interview with Resident #5's guardian on 10/24/25 at 9:03am revealed:
-Resident #5 was adjudicated incompetent on 04/19/16 and she was her guardian.
-She felt the resident's long-term memory was intact but her short- term memory was not, and she was unable to make safe decisions on her own.
-Facility staff had not reported to her that Resident #5 had gone into the facility's front parking lot or to the highway unsupervised.

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-She expected facility staff to "have eyes on" Resident #5 and do a much better job of monitoring her physical location.
-There should be some type of "buzzer" to alert staff whenever exit doors were opened.

Telephone interview with Resident #5's primary care provider (PCP) on 10/24/25 at 4:26pm revealed:
-Resident #5 had behavior issues but could usually answer questions appropriately.
-She had observed Resident #5 in the front parking lot but never at the highway and felt she would be in danger of being injured or taken if she got to the highway.

Telephone interview with Resident #5's psychiatric provider on 10/23/25 at 2:46pm revealed:
-Resident #5's cognition "waxed and waned" but she recognized the provider and could recall details of previous conversations.
-Resident #5 could make simple decisions like attending activities, deciding on meal choices, bedtimes, etc.
-He did not think it was safe for Resident #5 to leave the facility unattended and was concerned about her safety unless a staff member was with her at all times.

Interview with a personal care aide (PCA) on 10/24/25 at 10:16am revealed:
-She had observed Resident #5 going outside and in the front parking lot unsupervised on multiple occasions.
-She had observed Resident #5 at the highway next to the facility on one occasion when she came to work and Resident #5 reported she had been waiting on the PCA to arrive at the facility.

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Interview with a medication aide (MA) on 10/24/25 at 10:48am revealed she had observed Resident #5 going outside into the parking lot on multiple occasions on first shift.

Interview with the Administrator on 10/24/25 at 2:48pm revealed:
-She had no knowledge of Resident #5 going to the highway.
-She observed Resident #5 in the parking lot without staff from the window in her office on multiple occasions and would ask her to come back inside each time.

2. Review of Resident #3's current FL2 dated 07/17/25 revealed:
-Diagnoses included prediabetes, vitamin D deficiency, vitamin B12 deficiency, hypertension, hyperlipidemia, anxiety, and bipolar affect.
-She was intermittently disoriented.

Observation of Resident #3 on 10/23/25 at revealed:
-She was sitting in her wheelchair inside her room.
-She was dozing off while talking.

Interview with Resident #3 on 10/23/25 at 10:00am revealed:
-She did not recall any alarms ever being on the door over the last year that she had lived at the facility.
-She never had to unlock a door to go outside but she remained in her room most of the time.

Interview with Resident #3's guardian on 10/23/25 at 11:26am revealed:
-She was not aware the exit door alarms were not working at times.
-She would have concerns related to falling if

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Resident #3 was not supervised by staff when she went outside to smoke.
-She would not be concerned Resident #3 would leave the facility.

3. Review of Resident #4's FL2 dated 09/12/25 revealed:
-Diagnoses included schizoaffective disorder, bipolar manic, major neurocognitive disorder, Alzheimer's disease with behaviors, prediabetes, hypothyroidism, hyperlipidemia, and history of brain tumor.
-She was intermittently disoriented.

Observation of Resident #4 on 10/23/25 at 9:50am revealed:
-She was walking around the facility and went out the exit door at the South Hall dining room several times.
-No alarm sounded when she went out the exit door to the smoking area.
-There was no staff supervising her.

Interview with Resident #4 on 10/23/25 at 9:55am revealed:
-She did not recall any alarms ever being on the door over the last several years that she had lived at the facility.
-She had not gone out the front doors a lot and walked around the facility mostly when she was not smoking.
-She never had to unlock a door to go outside and she went outside to smoke several times a day.

_____

The facility failed to ensure 10 of 10 exit doors were alarmed with an audible sounding device when the door was opened allowing residents who were intermittently or constantly disoriented to go outside the facility without staff's knowledge.

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D 067	Continued From page 16 One resident (#5), who was intermittently disoriented went outside on several occasions in the evenings to the main road at the front of the building. The facility's failure resulted in a substantial risk for serious physical harm to the residents and constitutes an Unabated Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/24/25.	D 067		
D 079	10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; 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: FOLLOW UP TO TYPE A1 VIOLATION The Type A1 Violation was abated. Non-compliance continues. THIS IS A TYPE A2 VIOLATION.	D 079		

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D 079	Continued From page 17 Based on observations and interviews, the facility failed to maintain an environment that was clean and free from hazards, as evidenced by an active infestation of bedbugs. The findings are: Review of the environmental inspection report from the local county health department dated 08/29/25 revealed the facility received 10 demerits. Review of information about bed bugs from the Centers for Disease Control (CDC) dated 04/26/24 revealed: -Bed bug infestations usually happened around where people slept. -Bed bugs hid during the day in the seams of mattresses, box springs, bed frames, headboards, dressers, in cracks, in crevices, and behind wallpaper. -Bed bugs could travel over 100 feet at night but tended to live within eight feet of where people slept. -Signs of infestations included bites on the face, neck, arms, and other parts of the body, exoskeletons and live bed bugs in the folds of mattresses and sheets, rusty colored blood spots on mattresses, sheets, and nearby furniture, and a sweet musty odor. -Professional pest control companies should be contacted to treat bed bug infestations. Review of the Facility Maintenance Room Audit Log for August 2025 through October 2025 revealed: -Room audits were documented from 10/03/25 through 10/13/25 on the North Hall and the South Hall. -There was no documentation that the mattresses	D 079	Facility contracted a Pest Control Agency to assure that the home will maintain a bug free environment . ALL inspections will be monthly services and ongoing. Housekeeping will assure that the facility is maintained and cleaned daily, Housekeeping and designee personal will be responsible for monitoring facility DAILY. **11/05/25 - Amended per telephone call with Adminstrator on 12/05/25. SA**	11/28

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or the box springs were inspected for any of the residents' rooms.
-There was no documentation of room audits from 08/14/25 through 10/02/25 and from 10/14/25 through 10/20/25.

Review of the Facility's Pest Control and Bedbug Policy and Procedures (undated) revealed the facility's purpose was to maintain a safe, clean, and comfortable living environment for residents, staff, and visitors by effectively managing pest control and preventing, identifying, and addressing bedbug infestations in a timely and humane manner.

Review of the Pest Control Company's Preparation Form revealed:
-The preparation instructions were sent by electronic email correspondence to the Owner on 08/11/25 and the Owner forwarded the instructions by electronic email correspondence to the Administrator on 08/12/25.
-All the sheets and the bedding material should have been stripped off the beds and bagged.
-All the mattresses and the box springs should have been completely bare.
-There should not have been any plastic or protective covers on the mattresses or the box springs when the pest control company arrived for treatment.
-All the mattresses and the box springs should be placed upright against the walls.
-The pest control company would void the warranty if the facility failed to follow the preparation instructions.

Observations of resident room #4 on the South Hall on 10/23/25 at 12:05pm revealed there were at least ten live bedbugs crawling around between the corner of the mattress and the box

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springs.

Interview with the resident who resided in resident room #4 on 10/24/25 at 9:00am revealed:
-She noticed the bed bugs in her room and the bed bugs were an ongoing issue.
-She felt the bed bugs crawling on her in the middle of the night while she attempted to sleep and had seen bed bugs crawling across the floor.
-She knew the facility had been treated by a pest control company back in August 2025, but the problem had not been resolved in her room.
-She had reported the bed bugs to the personal care aides (PCAs) and the medication aides (MAs) but nothing had been done about the bed bugs in her room.

Telephone interview with the primary care provider (PCP) for the residents at the facility on 10/22/25 at 2:30pm revealed:
-Bed bugs in the facility put the residents at risk for skin irritation and bed bug bites that were left untreated could become infected.
-She was aware there were bed bugs at the facility in the past and she had told the staff to treat the residents' beds/rooms for bed bugs; but she was not aware of any current bed bug situation in the facility.

Telephone interview with the pest control technician from the facility's current contracted pest control company on 10/23/25 at 4:09pm revealed:
-The pest control company had treated the facility for bed bugs for the North Hall on 08/27/25 and for the South Hall on 08/28/25.
-He had given tasks to do at the facility between treatments and advised the Owner the treatment would only be effective if the suggested steps were followed by the staff.

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-He told the facility staff to wash and dry the residents' bedsheets on high heat between treatments but felt this was not done properly because there were bedsheets that the pest control company had to remove before treatment.
-He told the facility staff to place box springs and mattresses along the walls of residents' rooms between treatments but felt this was not done properly because the box springs and mattresses in several rooms on the South Hall were still in a normal position during the treatments.
-He told the Owner the mattresses and box springs needed to be replaced if possible.
-He had seen bed bugs all over the facility, but they were the worst in the residents' rooms at the back of the South Hall.
-If the facility was not taking the preventative preparation steps needed before the treatments, the bed bug infestation would never be resolved and pest control company would not guarantee an effective treatment.
-He had received no communication from the facility staff or Owner about live bed bugs since the bed bug treatment on 08/27/25 and 08/28/25.

Interview with a housekeeper on 10/24/25 at 8:38am revealed:
-The pest control company sprayed at the facility two days at the end of August 2025.
-He felt the facility staff followed the preparation instructions but the Administrator only provided certain instructions related to the preparation.
-He could not recall a requirement to stand the mattresses and box springs in an upright position against the walls and he knew this step had not been completed by the facility staff.
-He and the other housekeeper were responsible for daily room audits and for checking the mattresses and box springs in resident's rooms.
-He was not aware of bed bugs in any resident's

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D 079	Continued From page 21 room until it was discovered yesterday (10/23/25). -The pest control company had treated the facility previously in August 2025 for bed bugs and she thought treatment had resolved the bed bug issue. Interview with another housekeeper on 10/24/25 at 10:00am revealed: -She could not recall a requirement to stand the mattresses and box springs in an upright position against the walls and she could not recall if this step was completed by the facility staff. -She and the other housekeeper were responsible for daily room audits and for checking the mattresses and box springs in residents' rooms. -She was not aware that any residents were having issues with bed bugs until this morning (10/24/25) when a PCA told her. Interview with a PCA on 10/24/25 at 9:45am revealed: -She worked on both the North Hall and the South Hall. -She had not seen bed bugs in the residents' rooms on the South Hall. -The housekeeping staff was responsible for inspecting residents' mattresses and box springs with daily room audits. -The Administrator provided generic preparation instructions 3 days before the pest control company's bed bug treatment of the residents' room which primarily consisted of stripping bedsheets and removing the residents' clothes from their rooms. -She was not aware the staff should have placed the box springs and mattresses along the walls of residents' rooms because those details were not on the preparation instructions the Administrator provided to her.	D 079	Housekeepers in the facility will be in- serviced by Administrator On how conduct an aduit while cleaning the residents rooms and overall space of the facility. Administrator and Maintenance will assure that ALL residents room is Free from bed bugs and maintain safe and clean . An audit will take be conducted on a daily basis by Housekeepers on duty.	11/20/25

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D 079	Continued From page 22 -She was not aware that any residents were having issues with bed bugs until this morning (10/24/25) when another PCA told her. Telephone interview with a MA on 10/23/25 at 3:16pm revealed: -She worked on both the North Hall and the South Hall. -She had not seen bed bugs in the residents' rooms on the South Hall. -The housekeeping staff was responsible for inspecting residents' mattresses and box springs with daily room audits. -The Administrator provided generic preparation instructions 3 days before the pest control company's bed bug treatment of the residents' rooms which consisted of removing the residents' clothes from their rooms. -She was not aware the staff should have placed the box springs and mattresses along the walls of residents' rooms because those details were not on the preparation instructions the Administrator provided to her. -She was not aware that any residents were having issues with bed bugs and no residents or staff had told her of any bed bug issues within the last couple of weeks. Interview with another MA on 10/24/25 at 11:45am revealed: -She worked on both the North Hall and the South Hall. -She was not involved in the preparation related to the pest control company's treatment on 08/27/28 and 08/28/25 because she had started a month ago. -She had not seen bed bugs in the residents' rooms on the South Hall but she was not responsible to check between the residents' mattresses and box springs.	D 079		

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-The housekeeping staff was responsible for inspecting residents' mattresses and box springs with daily room audits.
-She was not aware that any residents were having issues with bed bugs until yesterday (10/23/25).

Interview with the Business Office Manager (BOM) on 10/23/25 at 4:00pm revealed:
-She was not involved in the preparation related to the pest control company's treatment on 08/27/28 and 08/28/25.
-She thought the bed bug situation had been resolved until more bed bugs were discovered today (10/23/25).
-No staff had made her aware of bed bug activity in residents' rooms within the last several weeks.

Interview with the Resident Care Coordinator (RCC) on 10/24/25 at 10:15am revealed:
-She was not involved in the preparation related to the pest control company's treatment on 08/27/28 and 08/28/25 because she had started a month ago.
-No staff had made her aware of bed bug activity in residents' rooms or on residents within the last several weeks.
-She was not aware of who was responsible for completing room audits in the residents' rooms.
-She was not aware of any meetings management was to have related to compliance concerns and issues such as the bed bugs in residents' rooms.

Interview with the Administrator on 10/24/25 at 3:30pm revealed:
-She was not aware of the current bed bug situation on the South Hall until yesterday (10/23/25).
-She was aware of the pest control technicians'

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instructions for the staff to place box springs and mattresses along the walls of residents' rooms between treatments for the bed bug treatment to be resolved.
-She was not aware the staff had not placed box springs and mattresses along the walls of residents' rooms in the South Hall.
-She expected the facility staff to follow the preparations from the pest control company and expected the housekeeping staff to inspect residents' mattresses and box springs daily.

Telephone interview with the Owner on 10/24/25 at 12:15pm revealed:
-He had contacted a pest control company and had the facility treated for bed bugs on 08/27/25 and 08/28/25.
-The current pest control company sent the preparation instructions by email communication to the Owner on 08/11/25 and he emailed the preparation instructions to the Administrator on 08/12/25.
-He felt the bed bug situation was resolved and was not aware of any current bed bug activity in the facility.
-He expected the housekeeping staff to inspect residents' mattresses and box springs daily for any bed bug activity.
-He expected the facility staff to follow the preparations from the pest control company and expected the Administrator to ensure preparations were followed by the facility staff for effective treatment of pest control issues.

_____

The facility failed to ensure that one resident room was clean and free of hazards, as evidenced by an active, ongoing infestation of bedbugs. The facility staff were not following recommendations provided by the pest control technician to eliminate the bedbugs. This failure

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D 079	Continued From page 25 resulted in substantial risk for harm, which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/24/25.	D 079		
D 113	10A NCAC 13F .0311 (d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall supply hot water to the kitchen, bathrooms, laundry, housekeeping closets, and soiled utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F and shall not exceed 116 degrees F. Notwithstanding the requirements of Rule .0301 of this Section, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for 6 of 6 fixtures sampled that were less than 100 degrees and were readily accessible and used by residents. The findings are: Review of the environmental inspection report from the local county health department dated 08/29/25 revealed: -The facility received 10 demerits. -Hot water temperatures ranged from 78-85 degrees F in the North Hall.	D 113	Facility 's Maintenance Department will be responsible for assuring that All Water temps throughout the the facility shall be maintained and documented on a monthly bases, all temp will be recorded and maintained in the business office of the facility. Business Office Manager will be responsible for assuring that the audit is conducted on the monthly basis and recorded moving forward. Administrator will assure that Business Office Manager maintain records .	11/20/25

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D 113	Continued From page 26 -A new pump was placed on the system but was not functioning properly and the Administrator stated they would contact a plumber for repair. Observation of the bathroom in resident room #11 on the North Hall on 10/22/25 at 3:10pm revealed the water temperature in the bathroom shower was 89.0 F and the bathroom sink was 91.0 degrees F. Second observation of the bathroom in resident room #11 on the North Hall on 10/23/25 at 9:05am revealed the water temperature in the bathroom shower was 87.0 F and the bathroom sink was 89.0 degrees F. Interview with a resident who resided in resident room #11 on the North Hall on 10/23/25 at 9:10am revealed: -The water temperature in her shower had been cold for the last several months. -She had let the personal care aides (PCA), the medication aides (MA), the housekeeping staff, and the Administrator know her shower temperatures were cold and they told her to use the shower in the common bathroom shower on the South Hall. -She had not seen a maintenance worker in her room to address or fix the cold water temperatures in her bathroom. -She preferred to use her own shower in her bathroom instead of being told to use the common bathroom shower on the South Hall. Observation of the bathroom in resident room #10 on the North Hall on 10/22/25 at 3:15pm revealed the water temperature in the bathroom shower was 89.0 F and the bathroom sink was 91.0 degrees F.	D 113	Facility Maintenance serviced current Pump, the system is working properly at this time. All water temps located in the showers and bathrooms of the facility, currently have HOT water. Maintenance will assure that all water temps are serviced on a monthly basis and as needed according to Facility's needs. Staff or designee personal will report to Business office Manager, All work orders shall be completed and recorder by Business office manager and maintained in Business office .	11/14/2025

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Observation of the bathroom in resident room #10 on the North Hall on 10/23/25 at 9:55am revealed the water temperature in the bathroom shower was 87.0 F and the bathroom sink was 89.0 degrees F.

Interview with a resident who resided in resident room #10 on the North Hall on 10/23/25 at 10:00am revealed:
-The water temperature in the shower had been cold for the last several months.
-She had let the PCAs, the housekeeping staff, and the Administrator know her shower temperatures were cold and they told her to use the shower in the common bathroom shower on the South Hall.
-She had seen a maintenance worker in her room to address or fix the cold water temperatures in her bathroom but the problem had not been resolved.
-She preferred to use her own shower in her bathroom instead of being told to use the common bathroom shower on the South Hall.

Observation of the bathroom in resident room #9 on the North Hall on 10/22/25 at 3:20pm revealed the water temperature in the bathroom sink was 91.0 degrees F.

Observation of the bathroom in resident room #9 on the North Hall on 10/23/25 at 10:15am revealed the water temperature in the bathroom sink was 89.0 degrees F.

Interview with a resident who resided in resident room #9 on the North Hall on 10/23/25 at 10:20am revealed:
-The water temperature in his sink was either cold or lukewarm for the last several months.
-He had not seen any of the facility staff ever take

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water temperatures while the staff were in his room.
-He washed his hands in cold water because he preferred not to use the common bathroom sink on the South Hall.

Observation of the bathroom in resident room #8 on the North Hall on 10/22/25 at 3:25pm revealed the water temperature in the bathroom sink was 91.0 degrees F.

Observation of the bathroom in resident room #8 on the North Hall on 10/23/25 at 10:05am revealed the water temperature in the bathroom sink was 89.0 degrees F.

Interview with a resident who resided in resident room #8 on the North Hall on 08/11/25 at 10:07am revealed:
-The water temperature in his sink had been cold for the last couple of months.
-He had let the MAs, the housekeeping staff, and the Administrator know his sink water temperatures were cold and they told him to use the sink in the common bathroom sink on the South Hall.
-He had not seen any of the facility staff ever take water temperatures while the staff were in his room.
-He showered in cold water because he preferred not to use the common bathroom shower on the North Hall.

Calibration of the surveyors' thermometers using an ice-water slurry on 10/23/25 at 12:00pm revealed:
-The thermometers read 32 degrees F indicating no adjustment to hot water temperatures were required due to calibration.
-The facility thermometer could not be calibrated

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D 113	Continued From page 29 due to being an infrared thermometer. Review of the Facility Maintenance Room Audit Log for August 2025 through October 2025 revealed: -Water temperatures were documented from 09/30/25 through 10/20/25 from the North Hall with examples of water temperatures as follows: -On 09/30/25, a temperature of 97 degrees F was documented, but a room number was not indicated on the log. -On 10/01/25, a temperature of 86 degrees F was documented, but a room number was not indicated on the log. -On 10/02/25, a temperature of 84 degrees F was documented, but a room number was not indicated on the log. -On 10/06/25, a temperature of 87 degrees F was documented, but a room number was not indicated on the log. -On 10/08/25, a temperature of 87 degrees F was documented, but a room number was not indicated on the log. -On 10/10/25, a temperature of 87 degrees F was documented, but a room number was not indicated on the log. -On 10/13/25, a temperature of 84 degrees F was documented, but a room number was not indicated on the log. -On 10/14/25, a temperature of 87 degrees F was documented, but a room number was not indicated on the log. -On 10/15/25, a temperature of 84 degrees F was documented, but a room number was not indicated on the log. -On 10/16/25, a temperature of 88 degrees F was documented, but a room number was not indicated on the log. -On 10/17/25, a temperature of 84 degrees F was documented, but a room number was not	D 113		

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indicated on the log.
-On 10/20/25, a temperature of 88 degrees F was documented, but a room number was not indicated on the log.
-There was no documentation of water temperature readings from 08/14/25 through 09/29/25.

Interview with a housekeeper on 10/24/25 at 8:38am revealed:
-He was a housekeeper for both the North and the South Hall.
-He was aware of the cold shower and sink temperatures in residents' rooms on the North Hall due to the residents complaining.
-He was responsible for conducting weekly audits for maintenance concerns and for providing the audit logs to the Administrator.
-He had reported the cold water temperatures to the Administrator within the last couple weeks but the water temperatures had not been fixed on the North Hall.
-He had not seen any maintenance workers in the facility fixing the shower and sink water temperatures on the North Hall.
-The Administrator was responsible for providing the results of the weekly audit logs to the Owner for maintenance repairs.

Interview with another housekeeper on 10/24/25 at 10:00am revealed:
-She was a housekeeper for both the North and the South Hall.
-She was aware of the cold shower and sink temperatures in residents' rooms on the North Hall due to the residents complaining.
-She had reported the issues to the Administrator within the last several weeks but she was not aware of any plans to fix the shower and sink water temperatures on the North Hall.

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-She and the housekeeping staff were previously responsible for conducting weekly audits for maintenance concerns but another housekeeper was responsible for conducting the room audits.
-The Administrator was responsible for providing the results of the weekly audit logs to the Owner for maintenance repairs.

Interview with a PCA on 10/24/25 at 9:45am revealed:
-She was aware of the cold shower and sink temperatures in residents' rooms on the North Hall due to the residents complaining.
-She had reported the issues to the Administrator but she was not aware of any plans to fix the shower and sink water temperatures on the North Hall.
-She was told by a MA to have the North Hall residents use the shower in the common bathroom on the South Hall if they experienced cold water in their showers.
-The housekeeping staff were responsible for taking water temperatures in residents' bathrooms.

Interview with a MA on 10/23/25 at 3:13pm revealed:
-She was aware of the cold shower and sink temperatures in residents' rooms on the North Hall due to the residents complaining.
-She had not reported the issues to the Administrator because one of the residents that complained to her had just come from complaining to the Administrator.
-She had not seen any maintenance workers in the facility fixing the shower and sink water temperatures on the North Hall.
-She told residents to use the shower in the common bathroom on the South Hall if they experienced cold water in their showers because

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the Administrator had given that direction.
-She was not aware of who was responsible for measuring water temperatures and she had not seen anyone measuring water temperatures in any of the residents' rooms.

Interview with a second MA on 10/23/25 at 3:30pm revealed:
-She was aware of the cold shower and sink temperatures in residents' rooms on the North Hall due to the residents complaining.
-She reported the issues to the Administrator but she had not seen any maintenance workers in the facility fixing the shower and sink water temperatures on the North Hall.
-She was not aware of who was responsible for measuring water temperatures.

Interview with the Resident Care Coordinator (RCC) on 10/24/25 at 10:15am revealed:
-She was not aware of the cold shower and sink temperatures in residents' rooms on the North Hall.
-No residents or staff had told her residents were complaining about cold water temperatures in their rooms.
-She was not aware of who was responsible for measuring water temperatures in the residents' rooms.
-She was not aware of any meetings management was to have related to compliance concerns and issues such as the cold water temperatures in residents' rooms.

Interview with the Administrator on 10/22/25 at 11:06am revealed:
-She was aware the water temperatures were cold on the North Hall.
-The housekeeping staff were responsible for checking the water temperatures every day.

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-She had communicated with the Owner about the water temperatures being cold and he sent a maintenance worker on 08/18/25 to replace the water pump.
-She informed the Owner recently the cold water temperature issues still existed and was not sure of the next steps to fix the water temperatures in the residents' rooms on the North Hall.
-She expected the maintenance repair projects to be completed in a prompt manner when maintenance issues were addressed from her communication.
-There was supposed to be a compliance team in place to discuss daily concerns but no regularly scheduled meetings had taken place for over a month.

Interview with the Owner on 10/24/25 at 12:15pm revealed:
-He was aware of some of the water temperatures previously being inconsistent in the facility.
-He was not aware some residents from the North Hall were complaining the water temperatures were too cold for their showers and sinks because he thought the issue had been fixed with the previous water pump replacement.
-He expected water temperatures to be at the required levels and for facility staff to report timely issues and complaints for residents not to bathe or shower in cold water temperatures.

Interview with the facility's contracted maintenance worker on 10/24/25 at 3:00pm revealed:
-The maintenance worker replaced a water pump on 08/18/25 at the facility for the Owner.
-He revisited the facility on 10/17/25 related to another work project and to check the progress of the water pump because staff told him the water

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D 113	Continued From page 34 temperatures were still cold and not fixed. -He told the Owner that 1 of the 3 hot water tanks was locked up and needed to be replaced immediately but the Owner told the maintenance worker he would just have it repaired. -Neither the Owner nor the Administrator had communicated with him about the water temperatures since his visit on 10/17/25. Interview with the Administrator on 10/24/25 at 3:30pm revealed: -She was not aware that one of the hot water tanks needed to be replaced and was not aware of the suggestion from the maintenance worker to the Owner. -She had received no communication from the Owner related to the maintenance worker's visit on 10/17/25 but the hot water tank being locked up made sense to her as to why the North Hall would have cold water temperatures.	D 113		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult 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.	D 234		

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D 234	Continued From page 35 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled residents (#3) completed a tuberculosis (TB) skin test prior to admission in compliance with the control measures for the Commission for Health Services. The findings are: Review of Resident #3's current FL2 dated 07/17/25 revealed diagnoses included prediabetes, hypertension, hyperlipidemia, anxiety, and bipolar affect. Review of Resident #3's Resident Register revealed an admission date of 10/10/24. Review of Resident #3's immunization records revealed: -There was documentation a chest x-ray was completed on 04/19/24 to rule out tuberculosis. -There was no documentation for a positive TB test to justify using a chest X-ray instead of a two-step TB test upon admission. -There was no documentation for a single interferon-gamma release (IGRA) assay to detect TB had been administered. -There was no documentation of a first step TB skin test upon admission. Interview with Resident #3 on 10/24/25 at 10:05am revealed she did not remember if she had a two-step TB skin test completed after being admitted to the facility. Telephone interview with Resident #3's guardian on 10/23/25 at 8:30am revealed: -She was not aware Resident #3 did not have a TB test upon her admission to the facility.	D 234	The Resident Care Coordinator will assure that ALL residents upon admission shall have complete a first step TB skin test. In the event if the TB test is unclear , RCC will be responsible for clarifying upon resident's admission . Resident Care Coordinator will be responsible for assuring that all immunizations records are current moving forward. Facility will use an audit form tool to complete during admission.	11/20/205

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D 234	Continued From page 36 -She did not know Resident #3's chest x-ray could not be used for TB testing requirements for admission to the facility. -She had been advised a chest x-ray was acceptable by the physician at Resident #3's previous facility. Interview with the Resident Care Coordinator (RCC) on 10/24/25 at 10:15am revealed: -She was new to the position of RCC in the facility. -She was responsible for auditing residents' admissions, TB requirements, and ensuring all requirements were completed. -She had not reviewed Resident #3's TB testing due to auditing other residents' records over the last month since her arrival. Interview with the Administrator on 10/24/25 at 3:30pm revealed: -Resident #3 had no documentation of a positive TB test to justify using a chest X-ray instead of a two-step TB test upon admission. -She and the RCC were responsible for ensuring residents admitted to the facility had the required screening for TB. -She did not know a chest x-ray could be used to rule out TB only if there was documentation the resident had an allergy to the TB antigen. -She did not know Resident #3's chest x-ray could not be used for TB testing requirements for admission to the facility.	D 234		
D 253	10A NCAC 13F .0801 (a) (b) Resident Assessment 10A NCAC 13F .0801 Resident Assessment (a) The facility shall complete an assessment of	D 253		

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D 253	Continued From page 37 each resident within 30 days following admission and annually thereafter. (b) The facility shall use the assessment instrument and instructional manual established by the Department or an instrument developed by the facility that contains at least the same information as required on the instrument established by the Department. The assessment shall be completed by an individual who has met the requirements of Rule .0508 of this Subchapter. If the facility develops its own assessment instrument, the facility shall ensure that the individual responsible for completing the resident assessment has completed training on how to conduct the assessment using the facility's assessment instrument. The assessment shall be a functional assessment to determine the resident's level of functioning to include psychosocial well-being, cognitive status, and physical functioning in activities of daily living. The assessment instrument established by the Department shall include the following: (1) resident identification and demographic information; (2) current diagnoses; (3) current medications; (4) the resident's ability to self-administer medications; (5) the resident's ability to perform activities of daily living, including bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting, and eating; (6) mental health history; (7) social history, to include family structure, previous employment and education, lifestyle habits and activities, interests related to community involvement, hobbies, religious practices, and cultural background; (8) mood and behaviors;	D 253	Resident Care Coordinator will be Responsible for auditing residents medical charts and assuring that All assessments are conducted within 30 days upon resident's admission, facility will use an audit tool . In the event if there's a significant change in resident condition, care plan will be revised and signed by resident's MD and filed in medical chart. All audits shall be maintained, stored and recored.	11/20/25

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D 253	Continued From page 38 (9) nutritional status, including specialized diet or dietary needs; (10)skin integrity; (11)memory, orientation and cognition; (12)vision and hearing; (13)speech and communication; (14)assistive devices needed; and (15)a list of and contact information for health care providers or services used by the resident. The assessment instrument established by the Department is available on the Division of Health Service Regulation website at https://policies.ncdhhs.gov/divisional/health-benefits-nc-medicaid/forms/dma-3050r-adult-care-home-personal-care-physician/@@display-file/form_file/dma-3050R.pdf at no cost. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to complete an annual care plan for 1 of 3 sampled residents (#2). The findings are: 1. Review of Resident #2's current FL2 dated 01/12/25 revealed: -Diagnoses included type 2 diabetes, hypertension, edema, lymphedema, morbidly obese, and septic shock. -She was semi-ambulatory and required a	D 253		

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wheelchair.
-She was incontinent of bladder and bowel.
-There was no information under orientation.

Review of Resident #2's care plan dated 07/22/24 revealed:
-She required supervision from staff with eating, toileting, dressing, and personal hygiene.
-She required limited assistance from staff with ambulating, bathing, and transferring.
-The care plan was signed by Resident #4's Primary Care Provider (PCP) on 07/22/24.
-There was no updated care plan for review.

Interview with Resident #2 on 10/23/25 at 9:01am revealed:
-She had lived at the facility for almost two years and she was her own responsible party.
-She was unaware of the nature of a care plan.
-She had never been offered the opportunity to participate in the development of her care plan.
-The personal care aides (PCA) had not assisted her with any activities of daily living and the medication aides (MA) only administered her medications daily.

Telephone interview with Resident #2's primary care provider (PCP) on 10/24/25 at 4:24pm revealed:
-She recalled receiving and signing an updated care plan for Resident #2 on 10/21/25 but was unaware that the assessment was overdue.
-This signed care plan was provided to surveyor on 10/22/25.
-She expected staff to provide assistance to Resident #2 for transfers, bathing, toileting and ambulation.

Interview with the Resident Care Coordinator (RCC) on 10/22/25 at 11:19am revealed:

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D 253	Continued From page 40 -She had been employed at the facility for one month. -She was responsible for completing resident care plans. -She was aware that Resident #2's care plan was overdue and faxed an updated care plan to Resident #2's PCP on 10/21/25. -She had completed an audit of all current resident records and created folders for the PCP to sign overdue documents. Interview with the Administrator on 10/22/25 at 2:46pm revealed: -She was unaware that Resident #2's care plan was overdue. -It was the RCC's responsibility to complete and update all residents' care plan-She expected the RCC to complete record audits at least once per quarter.	D 253		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record	D 270		

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D 270	Continued From page 41 reviews, the facility failed to provide supervision for 1 of 7 sampled residents (#5) who was wandering outside the facility unsupervised into the front parking lot and to the highway that ran parallel to the facility. The findings are: Review of Resident #5's current FL2 dated 09/12/25 revealed: -Diagnoses included an infectious disease , hypertension with chronic kidney disease (HTN w/ CKD), chronic obstructive pulmonary disease (COPD), neurocognitive disorder, seizure, neuropathy and history of cerebrovascular accident (CVA). -There was no information listed under the orientation section. -She required assistance from staff with bathing and dressing. -She was incontinent of bowel and bladder. Review of Resident #5's care plan dated 01/17/25 revealed: -She was sometimes disoriented and forgetful and needed reminders. -She required a wheelchair for locomotion. Review of Resident #5's record on 10/23/25 at 9:40am revealed she had been adjudicated incompetent on 4/19/16 and had been assigned a legal guardian. Review of Resident #5's charting notes from 08/01/25 through 10/23/25 revealed: -A medication aide (MA) noted on 10/11/25 at 10:55pm that Resident #5 was "hanging out at the curb supposedly to meet the men she has been chatting with on the dating chat line." -There were no other charting notes available for	D 270	Administrator will educate ALL staff on how to provide continuous supervision and monitoring to all residents in the home, to ensure that the safety and the well-being of ALL residents. Admin Revised assignment tasks sheets for All Caregiver in the facility to assure that the perimeters of the home is being monitored and the staff know the whereabouts of residents at all times . The Resident Care Coordinator and Supervisors In charge will be responsible for monitoring tasks logs and the whereabouts of the residents. **11/05/25 - Amended per telephone call with Adminstrator on 12/05/25. SA**	12/1/2025

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review.

Review of Resident #5's incident and accident reports from August 2025 through October 2025 revealed there were no reports available for review.

Observation on 10/22/25 at 4:12pm revealed:
-A male resident yelled, "She's up at the road again."
-Resident #5 was observed rolling her wheelchair across the front parking lot of the facility in close proximity to the four-lane highway with continuous moving traffic that runs parallel to the facility.
-Facility staff did not respond, and Resident #5 returned to the facility on her own.

Interview with a personal care aide (PCA) on 10/24/25 at 10:16am revealed:
-She provided assistance to Resident #5 on the days she worked.
-She assisted Resident #5 with dressing, toileting and grooming, denture care and assisted her to and from the dining room for meals.
-She had observed Resident #5 going outside and in the front parking lot unsupervised on multiple occasions.
-She had observed Resident #5 at the highway next to the facility on one occasion when she came to work and Resident #5 reported she had been waiting on the PCA to arrive at the facility.
-She did not report the incident to anyone because Resident #5 came back into the building upon the PCA's arrival to the facility.
-She was not told to monitor Resident #5 for wandering behaviors.

Interview with a MA on 10/24/25 at 10:48am revealed:
-She had observed Resident #5 going outside

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into the parking lot on multiple occasions on first shift and Resident #5 returned to the facility on her own each time.
-She was not told to monitor Resident #5 because of her going near the road.
-She was unaware of Resident #5 having a legal guardian.

Telephone interview with Resident #5's guardian on 10/24/25 at 9:03am revealed:
-Resident #5 was adjudicated incompetent on 04/19/16 and she was now her guardian.
-She felt the resident's long-term memory was intact but her short- term memory was not, and she was unable to make safe decisions on her own.
-Facility staff had not reported to her that Resident #5 had gone into the facility's front parking lot or to the highway unsupervised.
-The facility's previous Administrator had stopped all residents from sitting in front of the building unless accompanied by staff.
-She expected facility staff to "have eyes on" Resident #5 and do a much better job of monitoring her physical location.
-There should be some type of "buzzer" to alert staff whenever exit doors were opened.

Telephone interview with Resident #5's primary care provider (PCP) on 10/24/25 at 4:26pm revealed:
-She was unaware that Resident #5 had been adjudicated incompetent and had a guardian.
-Facility staff should assist Resident #5 with bathing, transfers and other activities of daily living as needed.
-Resident #5 had behavior issues but could usually answer questions appropriately.
-She had observed Resident #5 in the front parking lot but never at the highway and felt she

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would be in danger of being injured or taken if she got to the highway.
-Facility staff had not informed her of any instances of Resident #5 going out unsupervised and to the highway.

Telephone interview with Resident #5's psychiatric provider on 10/23/25 at 2:46pm revealed:
-He visited Resident #5 at least once monthly.
-Resident #5's cognition "waxed and waned" but she recognized the provider and could recall details of previous conversations.
-Resident #5 could make simple decisions like attending activities, deciding on meal choices, bedtimes, etc.
-He did not think it was safe for Resident #5 to leave the facility unattended and was concerned about her safety unless a staff member was with her at all times.
-It would be fine for Resident #5 to maneuver around in a contained area such as an enclosed patio.

Interview with the Resident Care Coordinator (RCC) on 10/24/25 at 11:05am revealed:
-She had been employed at the facility for one month.
-She barely knew Resident #5 and was unaware that she was going outside and into the road unsupervised.
-She was unaware Resident #5 had a legal guardian.

Interview with the Administrator on 10/24/25 at 2:48pm revealed:
-She had no knowledge of Resident #5 going to the highway.
-She observed Resident #5 in the parking lot without staff from the window in her office on

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multiple occasions and would ask her to come back inside each time.
-She felt that Resident #5 had the right to go outside unsupervised and she could not keep her from doing so.
-She expected facility staff to supervise all residents at all times.
-She expected staff to report all incidents to her and the RCC and to document each incident.
-She expected the MAs to notify the PCP of an incident as soon as it happened.
-She was aware Resident #5 had a guardian and spoke to the guardian often about the resident's condition and behaviors, including her wandering outside the facility into the parking lot.

Based on interviews, Resident #5 was not available for interview due to being hospitalized on 10/23/25.

_____
The facility failed to provide supervision for a resident who went outside the facility unsupervised to the front parking lot and to the highway that ran parallel to the facility. This failure resulted in the resident leaving the facility unsupervised on multiple occasions without staff knowledge, which resulted in substantial risk for harm or injury, and constitutes a Type A2 Violation.

_____
The facility provided a Plan of Protection in accordance with G.S. 131D-24 on 10/24/25 for this violation.

CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 23, 2025.

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D 276	Continued From page 46	D 276		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure an order was implemented to check blood pressure (BP) and heart rate (HR) for 1 of 3 sampled residents (#1). The findings are: Review of Resident #1's current FL2 dated 01/11/25 revealed diagnoses included diabetes mellitus and hypertension. Review of Resident #1's signed physician's order dated 08/23/25 revealed there was an order to check BP and HR daily and record, report systolic blood pressure (SBP) less than 100 or greater than 150 to the primary care provider (PCP). Review of Resident #1's August 2025, September 2025, and October 2025 from 10/01/25 to 10/24/25 electronic medication administration record (eMAR) revealed there was no documentation of recorded BP or HR values. Telephone interview with Resident #1's PCP on 10/24/25 at 4:30pm revealed: -She did not know staff had not checked Resident	D 276	The Resident Care Coordinator or designee MA will ensure referral and follow up of routine and acute Health Care needs of the residents/ Medication Aides will be retrained on resident care policy notifying physical or health care provider of any changes using notification of condition communication form . The RCD will review correspondence with providers to ensure a response is received in a timely manner and new orders and referrals are completed. The RCC will be responsible for training new med aides that comes onboard moving forward .	12/1/2025

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#1's HR and BP daily as ordered.
-When she visited the facility, staff normally had HR and BP results for Resident #1 or results were obtained while she was at the facility.
-She wrote the order to obtain and record Resident #1's BP and HR daily after some of Resident #1's BP medications were discontinued following a hospital visit in August 2025.
-She would have expected the staff to implement the order to obtain Resident #1's BP and HR daily as she wrote it.

Interview with Resident #1 on 10/24/25 at 4:59pm revealed:
-Staff did not check his BP daily.
-Staff checked his BP and HR sometimes.

Interview with a medication aide (MA) on 10/24/25 at 5:27pm revealed:
-She did not know there was an order to check BP and HR daily from August 2025 for Resident #1.
-She followed the orders in the eMAR system for checking vital signs.
-She normally documented BP and HR values in the eMAR system under vital signs.

Interview with the Resident Care Coordinator (RCC) on 10/24/25 at 5:15pm revealed:
-There was no documentation of Resident #1's BP or HR values for the past few months.
-She did not know Resident #1 had an order from August 2025 for staff to check his BP and HR daily and record.
-The MAs would have been responsible to implement Resident #1's daily BP and HR order.

Interview with the Administrator on 10/24/25 at 5:45pm revealed:
-She did not know Resident #1 had an order from

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D 276	Continued From page 48 August 2025 for staff to check his BP and HR daily and record. -The MAs were responsible to implement orders for the residents.	D 276		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions set forth in 15A NCAC 18A .1300 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION. Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to ensure the kitchen was clean and free of contamination related to	D 283		

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D 283	Continued From page 49 the reach-in ice machine being clean and held together with duct tape and a dishwasher that was not maintained in an operating condition. The findings are: Review of the environmental inspection report from the local county health department dated 08/29/25 revealed: -The facility received six and a half demerits. -The exterior of the ice machine near the lid and hinges was worn and need to be sealed and repaired. -Dish machine was not functional since June 2025. -Because of the volume of reusable cups, plates, utensils, this would need to be addressed as soon as possible. 1. Observation of the reach-in ice machine located in the kitchen on 10/22/25 at 8:40am revealed: -There was duct tape applied to several areas from the top to the bottom left side of the ice machine. -There was duct tape applied to the door opening of the ice machine. -The air filters were covered in heavy dust and build-up. Interview with the dining aide on 10/22/25 at 3:35pm revealed: -The ice machine had not been serviced for maintenance when he worked at the facility last year and upon his return within the last week. -The duct tape on the sides of the ice machine and around the door opening had been there since he started last week. -He and the Dietary Manager (DM) had reported the condition of the ice machine to the	D 283	Facility Maintenance serviced ice machine and repaired , dishwasher has been ordered and will be replaced . Dietary manager will be responsible for cleaning ice machine monthly to ensure that it's free from dust and conmination The cleaning will be maintained and recored monthly.	12/1/2025

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Administrator over the last week as a concern.
-He was not aware if there were any plans to fix the ice machine and the ice machine filters had looked the same as when he had worked at the facility last year.

Interview with the DM on 10/24/25 at 10:40am revealed:
-She was not aware if the ice machine was serviced for maintenance because she just started last week.
-The duct tape on the sides of the ice machine and around the door opening had been there since she started last week.
-The ice machine was in rough condition when she worked at the facility last year but it did not have duct tape on the sides then.
-She and the dining aide had reported the condition of the ice machine to the Administrator over the last week as a concern.
-She was not aware if there were any plans to fix the ice machine and was not aware of the last time any staff had changed the ice machine filters.

Telephone interview with the facility's contracted maintenance staff for the ice machine on 10/24/25 at 3:00pm revealed:
-The first time he had assessed the ice machine for the facility was on 10/23/25.
-He advised the Administrator and the Owner the ice machine needed replaced due to outdated parts.

Interview with the Administrator on 10/22/25 at 10:30am revealed:
-She was aware the ice machine had duct tape all around the sides and around the door opening along with dirty air filters.
-She was aware the condition of the ice machine

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was a sanitation issue for the residents.
-She had contacted a maintenance company to service the ice machine and the maintenance worker advised her the ice machine needed replaced due to being obsolete.
-The Administrator addressed the maintenance repair issues for the ice machine with the Owner on 08/13/25 and the Owner said he was working on it.

Interview with the Owner on 10/24/25 at 12:15pm revealed:
-He was aware the condition of the ice machine was a sanitation issue for the residents.
-He expected the Administrator to take the ice machine out of order and he was in the process of replacing the machine.

Refer to the interview with the Administrator on 10/22/25 at 10:30am.

Refer to the interview with the Owner on 10/24/25 at 12:15pm.

2. Observation of the dishwasher located in the kitchen on 10/22/25 at 8:40am revealed:
-The dishwasher was not running and had an "out-of-order" sign on it.
-The kitchen staff used disposable silverware and Styrofoam cups.
-The kitchen staff washed the limited amount of non-disposable plates and cups in the 3-compartment sink with diluted bleach and with a common dishwashing detergent.

Interview with the dining aide on 10/22/25 at 3:35pm revealed:
-The dishwasher had not been serviced for maintenance since he had started within the last week.

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-The ice machine went down in June 2024 when he worked at the facility last year and was still down when he returned last week.
-The kitchen staff washed dishes and silverware in the sink with diluted bleach and with a common dishwashing detergent but this was a long process to clean the dishes.
-He and the Dietary Manager (DM) had reported the condition of the dishwasher to the Administrator within the week out of concern.
-He was not aware if there were any plans to fix the dishwasher.

Interview with the DM on 10/24/25 at 10:40am revealed:
-She was not aware if the dishwasher was serviced for maintenance since she just started last week.
-The ice machine went down in June 2024 when she worked at the facility last year and was still down when she returned last week.
-She and the dining aide had reported the condition of the dishwasher to the Administrator over the last week as a concern.
-She was not aware if there were any plans to fix the dishwasher.
-The kitchen staff washed dishes and silverware in the sink with diluted bleach and with a common dishwashing detergent.
-She thought there were no plans to fix the dishwasher due to the dishwater and the parts were obsolete.

Observation of the facility's kitchen on 10/24/25 at 10:50am revealed a maintenance technician from the facility's current contracted maintenance company was assessing the dishwasher in the kitchen.

Interview with the maintenance worker on

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10/24/25 at 10:55am revealed:
-He had been contacted on 10/23/25 by the Owner to assess the dishwasher in the kitchen for repairs.
-He advised the Administrator on 10/24/25 the dishwasher needed a total replacement due to being obsolete.
-The average life expectancy of a dishwasher was 20-25 years if maintained properly; but the facility's current dishwasher had not been properly maintained as suggested according to his assessment.

Interview with an inspector from the local county health department on 10/23/25 at 3:47pm revealed:
-He visited the facility on 08/29/25 and assessed the dishwasher in the kitchen.
-He told the previous DM and the Administrator the dishwasher needed to be replaced as soon as possible due to its condition and according to the volume of residents in the facility.
-He suggested the kitchen staff use diluted bleach to wash dishes in the 3-compartment sink only as a temporary solution until the facility replaced the dishwasher.
-He expected the dishwasher to be replaced already and the facility staff should have stopped washing dishes in diluted bleach.

Interview with the Administrator on 10/22/25 at 10:30am revealed:
-She was aware the dishwasher was not working in the kitchen and had advised the Owner.
-The Owner arranged for a contracted maintenance staff to repair the dishwasher but the contracted maintenance staff advised the Administrator the dishwasher needed to be replaced due to being obsolete.
-The contracted maintenance staff communicated

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D 283	Continued From page 54 the details of his findings about the dishwasher with the Owner. -The Owner had not communicated any further plans about the kitchen dishwasher with the Administrator until 10/22/25. Interview with the Owner on 10/24/25 at 12:15pm revealed: -He was aware the dishwasher unit in the kitchen was not working but previous maintenance projects were not completed satisfactorily due to the former contracted maintenance staff being unreliable. -The previous Owner used the dishwasher beyond its average life expectancy and he knew the dishwasher unit "was on its last leg." -He contacted a maintenance worker who assessed the dishwasher today (10/24/25) and the dishwasher would be replaced within the next week. Refer to the interview with the Administrator on 10/22/25 at 10:30am. Refer to the interview with the Owner on 10/24/25 at 12:15pm. _____ Interview with the Administrator on 10/22/25 at 10:30am revealed: -The Owner was responsible for arranging for the contracted maintenance staff to complete repairs. -Completing maintenance projects were difficult due to the history of unpaid repair projects by the Owner. -She expected the maintenance repair projects to be completed in a prompt manner when maintenance issues were addressed from her communication. -There was supposed to be a compliance team in place to discuss daily concerns but no regularly	D 283		

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D 283	Continued From page 55 scheduled meetings had taken place for over a month. Interview with the Owner on 10/24/25 at 12:15pm revealed: -There were no issues with funding that should have delayed the completion of the maintenance repair projects. -There was a team in place for the facility to meet and discuss daily compliance concerns for the building. _____ The facility failed to ensure the kitchen and food preparation areas were maintained under sanitary conditions. The ice machine was held together with duct tape and the filters had not been cleaned or serviced. The dishwasher was not being used as it had not been serviced or replaced, resulting in dietary staff using disposable silverware and beverage cups to reduce the amount of dishes to be washed. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes an Unabated Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/24/25 for this violation.	D 283		
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes: (1) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers.	D 286	Facility	

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This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure residents were provided with non-disposable place settings, including plates, forks, knives, spoons, and cups during meal service.

The findings are:

Observation of the North Hall dining room during the lunch meal service on 10/21/25 at 12:03pm revealed:
-There were 15 residents in the dining room.
-The place setting consisted of a plastic utensils, a non-disposable plate, and a Styrofoam bowl for every resident.
-Residents were served fruit punch in a non-disposable cup.

Observation of the South Hall dining room during the lunch meal service on 10/21/25 at 12:30pm revealed:
-There were 13 residents in the dining room and the place setting consisted of plastic utensils, a Styrofoam plate and a Styrofoam bowl for every resident.
-Residents were served fruit punch in a non-disposable cup and water in a Styrofoam cup.

Observation of the North Hall dining room during the breakfast meal service on 10/22/25 at 8:30am

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D 286	Continued From page 57 revealed: -There were 10 residents in the dining room and the place setting consisted of a plastic fork and a Styrofoam plate for every resident. -Residents were served milk and coffee in Styrofoam cups. Observation of the South Hall during the breakfast meal service on 10/22/25 at 8:45am revealed: -There were 9 residents in the dining room and the place setting consisted of a plastic fork and a Styrofoam plate for every resident. -Residents were served milk and coffee in Styrofoam cups. Interview with a resident on 10/22/25 at 10:33am revealed: -She ate all three meals in the facility dining room daily. -Residents were served on Styrofoam plates and bowls daily and were given plastic silverware daily. -She would "love to eat her meals on real plates and in real bowls and drink out of real cups while using real silverware." Interview with a second resident on 10/22/25 at 10:45am revealed: -She ate all three meals in the facility dining room daily. -The tables were pre-set with Styrofoam dishes and plastic silverware daily before residents arrived in the dining room. -She felt residents were served on real plates during the lunch meal on 10/21/25 only because state surveyors were present. -She said " I would love to eat off real dishes and have real silverware."	D 286		

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Interview with a dietary aide on 10/22/25 at 9:46am revealed:
-He was not aware that residents were supposed to be served on non-disposable dishes with real silverware.
-It was his responsibility to set the tables in the dining room, and he used whatever he was given by the Dietary Manager (DM), which was usually Styrofoam dishes and plastic silverware.
-Real dishes and silverware were not used because residents took them from the tables to keep them in their rooms.

Interview with a personal care aide (PCA) on 10/22/25 at 10:41am revealed:
-Residents usually had plastic spoons and forks with paper plates and cups at every meal.
-She could not recall the last time real plates and silverware were used during meals other than the lunch meal on 10/21/25.
-The dietary staff set the table before the meal service.

Interview with the DM on 10/22/25 at 10:01am revealed:
-She had been employed at the facility for one week but had worked at the facility before.
-She was aware the residents were using disposable dishes and silverware during meals.
-She was aware residents were supposed to be provided with non-disposable dishes and silverware, which included a spoon, fork and knife and non-disposable cups.
-She thought it was acceptable to use disposable plates during the breakfast meal on 10/22/25 because she only served pancakes and sausage.
-There had been an issue with residents taking dishes and silverware with them to their rooms.
-She purchased new silverware, including spoons, forks and knives from a local store on

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D 286	Continued From page 59 10/22/25. Interview with the Administrator on 10/22/25 at 10:08am revealed: -She was aware residents were using disposable dishes and plastic forks and spoons during mealtimes. -She expected every resident to be provided with a non-disposable fork, knife, spoon, plate and cups during meals. -She found a stack of plates in a female resident's room the previous week and felt this was an ongoing issue with supplies being low. -She was responsible for placing supply orders for the kitchen and the facility Owner would review the orders before submission. -Each time she ordered dishes or silverware, the items were removed before the order was submitted. -She planned to order more dishes and silverware on a continuous basis.	D 286	Facility Purchased dinner ware for the home, Dietary Manager will be responsible for ensuring that All meals are served on non-disposal dinner war. Dinner ware shall be cleaned and have a quantity enough to serve the residents in the community. Dietary will notify Admin/ office Manager if the dinner ware is low in stock. This will be an ongoing observation.	12/1/2025
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 provide at least 14 hours per week of planned group activities for the residents residing at the facility.	D 317	Facility has a new Activity Director and assistant who will exercise the daily activities in the home. Admin will ensure that 14 hours of activities are being exercised and residents have the right to attend. The activity assistant will be responsible for recording and coordinating activities in the home Activity Calendar will be posted monthlyand visible for All residents .	11/20/2025

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D 317	Continued From page 60 The findings are: Observations during the facility tour on 10/21/25 at 9:00am revealed there was no October 2025 activity calendar posted in the facility. Observation of the facility from 10/21/25 to 10/24/25 at various times revealed: -No activities were offered for residents on 10/21/25. -Six residents were taken to a local dollar store to shop on 10/22/25. -No activities were offered for residents on 10/23/25 -BINGO was played on 10/24/25 and the activity was announced on the facility's intercom system. -A personal care aide (PCA) conducted the BINGO game and 8 residents attended. Interview with a resident on 10/22/25 at 2:34pm revealed: -He had resided at the facility for over two years. -The last activity calendar he received was in May 2025. -He had two BINGO coupons hanging on his refrigerator that were dated in August, and he was unable to cash them in for prizes because neither BINGO nor any other activity had been offered since. -A TV screen within the facility was supposed to advertise activities but it had not been working for several months. -He wished the facility had activities daily. Interview with a second resident on 10/22/25 at 3:11pm revealed: -She had resided at the facility for one year. -The only field trip the staff took the residents on was a weekly trip to the local dollar store on Wednesdays.	D 317		

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-She thought an activities calendar was posted three months ago.
-She could not recall the last activity that occurred within the facility, but a PCA would occasionally pass out coloring or word search sheets.
-A PCA was acting as the Activity Director, but she did not do her job and spent most of her time sitting in the office of the transportation aide.
-She would participate if more activities were offered.

Interview with a third resident on 10/22/25 at 3:26pm revealed:
-She had resided at the facility for 2 years.
-She could not recall the last time an activity calendar was posted within the facility.
-She recalled hearing one of the staff announce the activity for the day over the facility's intercom system about three weeks ago.
-She was never informed about activities that were available.

Telephone interview with a resident's guardian on 10/24/25 at 9:03 am revealed she felt the facility needed an activity director because the residents were bored.

Interview with a PCA on 10/22/25 at 2:55pm revealed:
-She had witnessed BINGO, arts and crafts and nail care over the last several months.
-The last time BINGO was offered was on 10/14/25.
-A PCA was currently serving as the Activity Director.
-She had not seen an activity calendar posted within the facility in several months.

Interview with a second PCA on 10/22/25 at 2:59pm revealed:

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-She had been serving as the facility's Activity Director for a few months while also working as a PCA, Monday through Friday.
-She showed a movie on 10/20/25 and took residents shopping on 10/22/25.
-The Administrator posted the activity schedule on the facility TV screen between the South & North hallways.
-She was not a certified Activity Director and could not afford to take the certification classes.

Interview with a medication aide (MA) on 10/24/25 at 10:48am revealed:
-She had been employed at the facility for one month.
-The activity calendar had never been posted on the television or on the facility's bulletin board since her start date.
-She felt the residents were bored and needed several activities daily.
-She felt activities were occurring this week because surveyors were present in the facility.
-She and several other staff members planned to purchase pumpkins for the residents to carve and paint before Halloween.

Interview with the Administrator on 10/23/25 at 11:32am revealed:
-The facility did not have a current Activity Director.
-An Activity Director was hired and was scheduled to start on 10/13/25 but called and declined the position one week prior.
-A PCA was currently serving as the Activity Director.
-She was unaware of the 14 hour per week requirement for activities.
-She was responsible for posting the activities calendar on the television within the facility, but she had not posted the calendar for the month of

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D 317	Continued From page 63 October 2025. -She planned to discuss covering the costs for the PCA to become a certified Activity Director with the Owner of the facility.	D 317		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: FOLLOW UP TO TYPE A1 VIOLATION Based on these findings, the previous Type A1 Violation was not abated. Based on observations and interviews, the facility failed to ensure residents were treated with respect and dignity as evidenced by residents who were yelled at by a staff (Staff C) when residents asked about medications and residents were provided with non-disposable place settings, including plates, plastic utensils, and cups during meal service. The findings are: 1. Review of the Facility's Resident Agreement revealed: -Each resident had the right to express complaints or suggestions without fear of reprisal, interference, coercion or discrimination. -Each resident had the right to suggest, recommend and be heard per the facility's grievance policy.	D 338	Facility Administrator scheduled an in service on Resident's Rights on December 9th 2025 conducted by the Local Residents Rights Ombudsman long term care agency. The CEU will ensure that All staff is educated and exercises the importance of resident rights in the home. This In-service will be annually moving forward. **11/05/25 - Amended per telephone call with Adminstrator on 12/05/25. SA**	12/9/2025

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-Every resident had the following rights: to be treated with respect, consideration, dignity, and full recognition and to be free of mental and physical abuse, neglect, and exploitation.

Review of Staff C's, medication aide (MA), personnel record revealed:
-Staff C was hired on 05/08/25.
-There was no documentation of Resident Rights training.
-There was documentation of a Criminal Background check dated 08/12/25.
-There was documentation of a Health Care Personnel Registry (HCPR) check dated 05/08/25.

Interview with a resident on 10/21/25 at 9:45am revealed:
-There was a 3rd shift MA (Staff C) who treated the residents like they were prisoners and ordered them around.
-Staff C yelled a lot when Staff C was mad or upset with the residents.
-Staff C had a horrible attitude towards the residents and would yell at residents if they asked questions about medications or came "too close" to the medication cart.
-He had reported Staff C to the Administrator within the last couple of months but stopped because nothing had been done.

Interview a second resident on 10/21/25 at 10:04am revealed:
-Staff C was "mean" to the residents.
-Staff C brought things to residents she liked.
-Staff C did not like her anymore.

Interview with a third resident on 10/24/25 at 9:25am revealed:
-Staff C would make her the last to receive her

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medications on the medication pass when she upset Staff C and asked questions about her medications.
-Staff C yelled at her when the resident asked questions about her medications or if the resident came "too close" to the medication cart.
-She had reported Staff C's behavior to the MAs within the last month but stopped because nothing had been done.
-She had not reported Staff C's behavior to the Administrator because she felt the Administrator allowed Staff C to continue her actions due to her working 3rd shift.

Interview with a fourth resident on 10/24/25 at 9:35am revealed:
-Staff C had a horrible attitude towards the residents and yelled at residents if they asked questions about medications or came "too close" to the medication cart.
-He had witnessed Staff C withhold another resident's medication when Staff C was upset with the resident.
-He used to report Staff C's behavior to the Administrator but stopped because nothing had been done.

Interview with a fifth resident on 10/24/25 at 10:10am revealed:
-Staff C had become angry and refused to give the resident's medications when the resident asked Staff C questions about her medications.
-She had reported Staff C to the Administrator within the last several weeks and the Administrator told the resident she would work on it, but Staff C continued with her "horrible" behavior.

Interview with sixth resident on 10/24/25 at 12:58pm revealed:

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-Staff C worked third shift at the facility and was in the building every night whether she was scheduled to work or not.
-Staff C made residents feel like they had to "walk on eggshells" because she spoke to the residents "like they are nothing",
-Staff C screamed and yelled at two other residents often because they came to her cart requesting medications.
-Staff C withheld medications from two residents on several occasions because the residents would come to the medication cart.
-Staff C came into this resident's room one night at 1:00am, turned on the light and blocked the resident's door so she could not exit.
-Staff C told the resident that she "needed to watch herself because I run the show around here and I can make your life much harder."
-Staff C came into the bathroom when the resident's roommate was taking a shower and pulled her bonnet off, squeezed shampoo onto her hair and forcibly washed her hair.
-Most residents feared for their safety whenever Staff C was working.

Interview with a personal care aide (PCA) on 10/23/25 at 10:30am revealed:
-She had witnessed Staff C yelling at the residents because the residents had asked questions related to their medications.
-She had reported Staff C to the Administrator but nothing had been done to Staff C because Staff C had continued her rude behavior.

Interview with a MA on 10/24/25 at 9:15am revealed:
-Staff C treated the residents like they were prisoners and yelled at them.
-She had witnessed Staff C yelling at the residents because the residents had asked

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questions related to their medications.
-She had reported Staff C to the Administrator within the last couple of months but nothing had been done to Staff C because Staff C had continued her rude behavior.

Telephone interview with another MA on 10/24/25 at 11:45am revealed:
-Staff C yelled and was mean to residents often because they came to the medication cart requesting medication.
-Staff C would bring snacks and food to certain residents and leave out the residents who had upset her.
-Staff C talked to the residents with any "ugly" attitude and had said "I'll give your medicine when I want to" when residents asked for their medications.
-She had reported Staff C to the Administrator within the last month.
-"You have to be careful what you say" to Staff C because Staff C would retaliate.

Interview with the Resident Care Coordinator (RCC) on 10/24/25 at 10:15am revealed:
-She was not aware of Staff C yelling at the residents because the residents had asked Staff C questions related to their medications.
-She expected staff or residents to report any instance of verbal abuse to her and for residents to be unafraid to ask staff questions.
-She expected staff to treat all the residents with dignity and respect and residents to express their concerns without retaliation.

Interview with the Administrator on 10/24/25 at 3:30pm revealed:
-She was not aware of Staff C yelling at the residents because the residents had asked Staff C questions related to their medications.

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-There was not an HCPR report completed because she was not aware of the verbal abuse by Staff C.
-The staff had not been provided with Resident Rights training since her start in April 2025 and she had not found training for staff on Resident Rights.
-She expected staff or residents to report any instance of verbal abuse to her and for residents to be unafraid to ask staff questions.
-She expected staff to treat all the residents with dignity and respect and residents to express their concerns without retaliation.

Attempted telephone interviews with Staff C on 10/24/25 at 10:00am and at 4:22pm were unsuccessful.

2. Observation of the North Hall dining room during the lunch meal service on 10/21/25 at 12:03pm revealed:
-There were 15 residents in the dining room.
-The place setting consisted of a plastic fork or a plastic spoon, a non-disposable plate, and a Styrofoam bowl for every resident.
-Residents were served fruit punch in a non-disposable cup.

Observation of the South Hall dining room during the lunch meal service on 10/21/25 at 12:30pm revealed:
-There were 13 residents in the dining room and the place setting consisted of a plastic fork or a plastic spoon, a Styrofoam plate and a Styrofoam bowl for every resident.
-Residents were served fruit punch in a non-disposable cup and water in a Styrofoam cup.

Observation of the North Hall dining room during

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D 338	Continued From page 69 the breakfast meal service on 10/22/25 at 8:30am revealed: -There were 10 residents in the dining room and the place setting consisted of a plastic fork, and a Styrofoam plate for every resident. -Residents were served milk and coffee in Styrofoam cups. Observation of the South Hall during the breakfast meal service on 10/22/25 at 8:45am revealed: -There were 9 residents in the dining room and the place setting consisted of a plastic fork and a Styrofoam plate for every resident. -Residents were served milk and coffee in Styrofoam cups. Interview with a resident on 10/22/25 at 10:33am revealed: -She ate all three meals in the facility dining room daily. -Residents were served on Styrofoam plates and bowls daily and were given plastic silverware daily. -She would "love to eat her meals on real plates and in real bowls and drink out of real cups while using real silverware." Interview with a second resident on 10/22/25 at 10:45am revealed: -She ate all three meals in the facility dining room daily. -The tables were pre-set with Styrofoam dishes and plastic silverware daily before residents arrived in the dining room. -She felt residents were served on real plates during the lunch meal on 10/21/25 only because state surveyors were present. -She said " I would love to eat off real dishes and have real silverware."	D 338		

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D 338	Continued From page 70 Interview with a dietary aide on 10/22/25 at 9:46am revealed: -He was not aware that residents were supposed to be served on non-disposable dishes with real silverware. -It was his responsibility to set the tables in the dining room, and he used whatever he was given by the dietary manager, which was usually Styrofoam dishes and plastic silverware. Interview with a personal care aide (PCA) on 10/22/25 at 10:41am revealed: -Residents usually had plastic spoons and forks with paper plates and cups at every meal. -She could not recall the last time real plates and silverware were used during meals other than the lunch meal on 10/21/25. -The dietary staff set the table before the meal service. Interview with the Dietary Manager (DM) on 10/22/25 at 10:01am revealed: -She had been employed at the facility for one week but had worked at the facility before. -She was aware the residents were using disposable dishes and silverware during meals. -She was aware residents were supposed to be provided with non-disposable dishes and silverware, which included a spoon, fork and knife and non-disposable cups. -She thought it was acceptable to use disposable plates during the breakfast meal on 10/22/25 because she only served pancakes and sausage. Interview with the Administrator on 10/22/25 at 10:08am revealed: -She was aware residents were using disposable dishes and plastic forks and spoons during mealtimes.	D 338		

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D 338	Continued From page 71 -She expected every resident to be provided with a non-disposable fork, knife, spoon, plate and cups during meals. _____ The facility failed to ensure the residents were treated with dignity and respect related to multiple residents being yelled at by Staff C causing the residents to be frightened and afraid to report Staff C's behavior. Several residents had reported Staff C's behavior to the Administrator, but stopped because nothing was being done. This failure resulted in verbal abuse of the residents and constitutes an Unabated Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/24/25.	D 338		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION. The Type A2 Violation was abated. Non-compliance continues. THIS IS A TYPE B VIOLATION Based on observations, interviews, and record	D 358	All medication Aides in the facility completed an in- service and re-educated on medication administration by a RN from a local Pharmacy. This in-service will be scheduled annually by Resident Care Coordinator to ensure that All staff is knowledgeable on how to administer medication in a timely manner and only according to DR's orders. New medication aides oncoming will be trained by the Resident Care Coordinator and Facility RN upon administering resident's medications. **11/06/25 - Amended per telephone call with Adminstrator on 12/05/25. SA**	

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reviews, the facility failed to ensure medications were administered as ordered for 2 of 3 residents related to errors with sliding scale insulin (#1); and errors with holding a blood thinner prior to a scheduled colonoscopy, errors with a medication for cholesterol, and not discontinuing a medication for insomnia (#3).

The findings are:

1. Review of Resident #1's current FL2 dated 01/11/25 revealed diagnoses included diabetes mellitus and hypertension.

Review of Resident #1's signed physician order dated 08/23/25 revealed there was an order for insulin aspart (a medication used to treat diabetes mellitus) 100 unit/mL pen (3mL) check FSBS (finger stick blood sugar) before meals and inject based on sliding scale: 0-150 = 0 units, 151-190 = 1 unit, 191-230 = 2 units, 231-270 = 3 units, 271-310 = 4 units, 311-350 = 5 units, 351-399 = 6 units, 400 or greater = notify provider.

Review of Resident #1's hospital after visit summary (AVS) dated 10/03/25 revealed:
-Resident #1 was seen by a provider in the emergency room (ER) for "elevated blood sugar with no symptoms."
-The only abnormality was that Resident #1's blood sugar was "very high".

Review of Resident #1's September 2025 electronic medication administration record (eMAR) from 09/12/25 to 09/30/25 revealed:
-There was an entry for insulin aspart flexpen 100 units/ml, check FSBS before each meal and inject per sliding scale insulin: 0-150 = 0 units, 151-190 = 1 unit, 191-230 = 2 units, 231-270 = 3 units, 271-310 = 4 units, 311-350 = 5 units,

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351-399 = 6 units, 400 or greater = notify provider.
-There was documentation 0 units of insulin aspart were administered instead of 1 unit for a FSBS value of 141 on 09/17/25 at 7:30am.
-There was documentation 3 units of insulin aspart were administered instead of 5 units for a FSBS value of 333 on 09/18/25 at 11:30am.
-The eMAR was blank when 4 units of insulin aspart should have been administered for a FSBS value of 294 on 09/19/25 at 7:30am.
-There was documentation 2 units of insulin aspart were administered instead of 4 units for a FSBS value of 302 on 09/20/25 at 7:30am.
-There was documentation 2 units of insulin aspart were administered instead of 5 units for a FSBS value of 326 on 09/20/25 at 11:30am.
-There was documentation 6 units of insulin aspart was administered instead of 5 units for a FSBS value of 340 on 09/22/25 at 4:00pm.
-There was documentation 1 unit of insulin aspart was administered instead of 0 units for a FSBS value of 139 on 09/25/25 at 7:30am.

Review of Resident #1's October 2025 eMAR from 10/01/25 to 10/21/25 revealed:
-There was an entry for insulin aspart flexpen 100 units/ml, check FSBS before each meal and inject per sliding scale insulin: 0-150 = 0 units, 151-190 = 1 unit, 191-230 = 2 units, 231-270 = 3 units, 271-310 = 4 units, 311-350 = 5 units, 351-399 = 6 units, 400 or greater = notify provider.
-There was documentation 3 units of insulin aspart were administered instead of 5 units for a FSBS value of 335 on 10/02/25 at 7:30am.
-There was documentation 5 units of insulin aspart were administered instead of 6 units for a FSBS value of 389 on 10/05/25 at 11:30am.
-There was documentation 4 units of insulin

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aspart were administered instead of 6 units for a FSBS value of 371 on 10/06/25 at 4:00pm.
-There was documentation 3 units of insulin aspart were administered instead of 5 units for a FSBS value of 356 on 10/07/25 at 11:30am.
-There was documentation 5 units of insulin aspart were administered instead of 3 units for a FSBS value of 239 on 10/08/25 at 7:30am.
-There was incorrect documentation that 396 units of insulin were administered instead of 6 units for a FSBS value of 396 on 10/11/25 at 7:30am.
-There was documentation 4 units of insulin aspart were administered instead of 5 units for a FSBS value of 314 on 10/15/25 at 4:00pm.
-There was documentation 6 units of insulin aspart were administered instead of 4 units for a FSBS value of 298 on 10/16/25 at 4:00pm.
-There was documentation 5 units of insulin aspart were administered instead of 6 units for a FSBS value of 352 on 10/19/25 at 7:30am.
-There was documentation 5 units of insulin aspart were administered instead of 6 units for a FSBS value of 399 on 10/19/25 at 11:30am.
-There was documentation 5 units of insulin aspart were administered instead of 6 units for a FSBS value of 380 on 10/19/25 at 4:00pm.

Observation of the medications on hand for Resident #1 on 10/23/25 at 3:53pm revealed there was a 3mL (100 units/mL) insulin aspart pen opened on 10/16/25 available for administration with approximately 250 units remaining available for administration.

Telephone interview with a representative from the facility's contracted pharmacy on 10/24/25 at 4:42pm revealed:
-Resident #1 had an active order for insulin aspart 100 unit/mL pen (3mL) check FSBS before

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meals and inject based on sliding scale: 0-150 = 0 units, 151-190 = 1 unit, 191-230 = 2 units, 231-270 = 3 units, 271-310 = 4 units, 311-350 = 5 units, 351-399 = 6 units, 400 or greater = notify provider.
-Resident #1's insulin aspart was dispensed on 10/05/25, 09/27/25 and 08/23/25 for a quantity of one 3mL insulin aspart flexpen each.

Interview with Resident #1's primary care provider (PCP) on 10/24/25 at 4:30pm revealed:
-She did not know there were seven errors with Resident #1's insulin administration in September 2025 and eleven errors in October 2025.
-She was concerned about hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar) with wrong amounts of insulin being administered to Resident #1.

Interview with Resident #1 on 10/24/25 at 4:59pm revealed:
-Staff checked his FSBS two or three times daily.
-He was administered insulin two or three times daily.
-He did not know when his blood sugar was high.

Interview with a medication aide (MA) on 10/23/25 at 3:35pm revealed:
-She did not know she administered the incorrect amount of insulin aspart to Resident #4 for three errors in September 2025 and five errors in October 2025.
-She administered the wrong amount of insulin aspart to Resident #4 on the days she documented incorrectly.
-She was not aware of any recent medication audits.

Interview with a second MA on 10/24/25 at 5:27pm revealed:

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-She did not know she had four errors with insulin administration to Resident #1 in October 2025.
-She thought she read Resident #1's sliding scale insulin order incorrectly on the eMAR because she was one unit off the correct amount of insulin each time.

Interview with the Resident Care Coordinator (RCC) on 10/24/25 at 5:15pm revealed:
-She did not know there were seven errors with Resident #1's insulin administration in September 2025 and eleven errors in October 2025 because she did not have a computer to use to review the eMARs.
-Resident #1's FSBS trended high.
-The MAs were responsible to administer insulin correctly.

Interview with the Administrator on 10/24/25 at 5:45pm revealed:
-She did not know there were seven errors with Resident #1's insulin administration in September 2025 and eleven errors in October 2025.
-The MAs were responsible to administer insulin correctly according to the physician's orders.

Refer to the interview with a MA on 10/22/25 at 10:00am.

Refer to the interview with a second MA on 10/23/25 at 3:16pm.

Refer to the interview with the RCC on 10/24/25 at 10:15am.

Refer to the interview with the Administrator on 10/24/25 at 3:30pm revealed.
2. Review of Resident #3's current FL2 dated 07/17/25 revealed diagnoses included prediabetes, vitamin D deficiency, vitamin B12

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deficiency, hypertension, hyperlipidemia, anxiety, and bipolar affect.

a. Review of Resident #3's FL2 dated 07/17/25 revealed an order for clopidogrel (a medication used to lower the risk of a stroke) 75mg take 1 tablet once a day.

Review of Resident #3's signed physician order dated 08/12/25 revealed an order to hold clopidogrel 75mg 1 tablet once a day 5 days prior to Resident #3's colonoscopy on 08/28/25.

Review of Resident #3's August 2025 electronic medication administration record (eMAR) from 08/01/25 to 08/31/25 revealed:
-There was an entry for clopidogrel 75mg 1 tablet once daily scheduled at 6:00am.
-Clopidogrel was documented as administered for 31 of 31 opportunities from 08/01/25 to 08/31/25 and was not held from 8/23/25 to 08/28/25.

Observation of Resident #3's medications on hand for administration on 10/22/25 at 9:36am revealed there were 19 tablets remaining of 28 tablets dispensed on 10/08/25 in a bubble pack labeled as clopidogrel one tablet once a day.

Interview with Resident #3 on 10/22/25 at 12:05pm revealed she relied on the medication aides (MA) to give her medications because she was not aware of what medication she was administered every day.

Telephone interview with Resident #3's guardian on 10/22/25 at 1:20pm revealed the Business Office Manager (BOM) had made her aware that Resident #3's clopidogrel was not held for administration on 08/27/25 and the BOM had rescheduled Resident #3's colonoscopy for

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D 358	Continued From page 78 09/25/25. Telephone interview with the pharmacist at the facility's contracted pharmacy on 10/22/25 at 1:35pm revealed: -There was a current order for clopidogrel 75mg take 1 tablet once a day for Resident #3. -Clopidogrel was dispensed on 10/08/25 for a quantity of 28 tablets. -There was no order on file to hold clopidogrel for Resident #3 from 08/12/25. -The pharmacy was responsible for updating the eMAR for the facility; however the facility staff were responsible to enter hold orders into the eMAR. Telephone interview with Resident #3's primary care provider (PCP) on 10/22/25 at 2:30pm revealed: -She did not write the hold order for Resident #3's clopidogrel on 08/12/25; that was managed by Resident #3's gastroenterologist (GI). -She was aware Resident #3's clopidogrel was not held 5 days prior to her colonoscopy on 08/28/25 because she ordered Resident #3's clopidogrel to be held for her rescheduled colonoscopy on 09/25/25 as a reminder to the facility staff. Interview with a MA on 10/22/25 at 10:00am revealed: -She administered Resident #3's medications during the morning shift and had administered Resident #3's clopidogrel. -First shift MAs were responsible to administer Resident #3's clopidogrel since it was ordered as a morning medication. -She was not aware of the physicians' order from 08/12/25 to hold Resident #3's clopidogrel 5 days prior to her colonoscopy on 08/28/25 because	D 358		

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D 358	Continued From page 79 she had only worked for the facility for the last month. Interview with a second MA on 10/23/25 at 3:16pm revealed she was not aware of Resident #3's physicians' order from 08/12/25 to hold clopidogrel for 5 days prior to her colonoscopy on 08/28/25. Interview with the BOM on 10/23/25 at 4:00pm revealed: -She scheduled transportation and medical appointments for residents. -Resident #3 had an appointment for a colonoscopy scheduled for 08/28/25. -She never reviewed a physician's hold order for Resident #3's clopidogrel but she was aware the clopidogrel should be held due to medical knowledge of the procedure for a colonoscopy. -She was aware Resident #3's clopidogrel was not held by the MAs and told the Administrator and Resident #3's guardian on 08/27/25. Interview with the Administrator on 10/24/25 at 3:30pm revealed she was not aware of Resident #3's physician's order from 08/12/25 to hold clopidogrel 5 days prior to Resident #3's colonoscopy on 08/28/25 until the BOM advised her on 08/27/25. Attempted telephone interviews on 10/24/25 at 10:35am and at 12:00pm with the provider who ordered Resident #3's clopidogrel be held was unsuccessful. Refer to the interview with a MA on 10/22/25 at 10:00am. Refer to the interview with a second MA on 10/23/25 at 3:16pm.	D 358		

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D 358	Continued From page 80 Refer to the interview with the Resident Care Coordinator (RCC) on 10/24/25 at 10:15am. Refer to the interview with the Administrator on 10/24/25 at 3:30pm revealed. b. Review of Resident #3's FL2 dated 07/17/25 revealed an order for pravastatin (a medication used to lower cholesterol) 10mg take 1 tablet at bedtime. Review of Resident #3's signed physician order dated 10/04/25 revealed: -There was an order to stop pravastatin 10mg 1 tablet at bedtime. -There was an order to start pravastatin 20mg 1 tablet at bedtime. Review of Resident #3's October 2025 eMAR from 10/01/25 to 10/20/25 revealed: -There was an entry for pravastatin 20mg 1 tablet at bedtime scheduled at 8:00pm. -Pravastatin 20mg was documented at administered for 17 of 17 opportunities from 10/04/25 to 10/20/25. -There was a second entry for pravastatin 10mg 1 tablet at bedtime scheduled at 8:00pm. -Pravastatin 10mg was documented as administered for 20 of 20 opportunities from 10/01/25 to 10/20/25. -Pravastatin 10mg should not have been administered and there were no additional notes for the pravastatin 10mg administered to Resident #3. Observation of Resident #3's medications on hand for administration on 10/22/25 at 9:36am revealed: -There were 19 tablets remaining of 28 tablets	D 358		

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dispensed on 10/08/25 in a bubble pack labeled for pravastatin 10mg one tablet at bedtime.
-There were 17 tablets remaining of 28 tablets dispensed on 10/11/25 in a bubble pack labeled for pravastatin 20mg one tablet at bedtime.

Interview with Resident #3 on 10/22/25 at 12:05pm revealed:
-She relied on the MAs to give her medications because she was not aware of what medication she was administered every day.
-She was not aware of any medication changes by her physician.

Telephone interview with the pharmacist at the facility's contracted pharmacy on 10/22/25 at 1:35pm revealed:
-There was a current order for pravastatin 10mg take 1 tablet at bedtime for Resident #3.
-Pravastatin 10mg was dispensed on 10/08/25 for a quantity of 28 tablets.
-There was no order on file to stop pravastatin 10mg for Resident #3.
-There was a current order for pravastatin 20mg take 1 tablet at bedtime for Resident #3.
-Pravastatin 20mg was dispensed on 10/11/25 for a quantity of 28 tablets.
-The pharmacy was responsible for updating the eMAR for the facility.
-The pharmacy expected the facility staff to provide new orders for the pharmacy to have current orders on file.

Telephone interview with Resident #3's PCP on 10/22/25 at 2:30pm revealed:
-She increased Resident #3's pravastatin to 20mg on 10/02/25 and stopped her pravastatin 10mg.
-She was not aware the facility staff had continued to administer Resident #3's pravastatin

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10mg and pravastatin 20mg at the same time.
-She expected staff to administer or hold Resident #3's medications as ordered.

Interview with a MA on 10/22/25 at 10:00am revealed:
-Second shift MAs were responsible to administer Resident #3's pravastatin since it was ordered as a bedtime medication.
-She was not aware of the physician's order from 10/04/25 to stop pravastatin 10mg and she was not aware pravastatin 10mg and 20mg were administered together.

Interview with a second MA on 10/23/25 at 3:16pm revealed she was not aware of Resident #3's physician's order from 10/04/25 to discontinue pravastatin 10mg and start pravastatin 20mg.

Interview with the RCC on 10/24/25 at 10:15am revealed she was not aware of Resident #3's physician's order from 10/04/25 for medication changes related to her pravastatin.

Interview with the Administrator on 10/24/25 at 3:30pm revealed she was not aware of Resident #3's physician's order from 10/04/25 for medication changes related to her pravastatin.

Refer to the interview with a MA on 10/22/25 at 10:00am.

Refer to the interview with a second MA on 10/23/25 at 3:16pm.

Refer to the interview with the RCC on 10/24/25 at 10:15am.

Refer to the interview with the Administrator on

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D 358	Continued From page 83 10/24/25 at 3:30pm revealed. c. Review of Resident #3's FL2 dated 07/17/25 revealed an order for melatonin (a supplement used to treat insomnia) 3mg take 1 tablet at bedtime. Review of Resident #3's signed physician order dated 10/17/25 revealed an order to stop melatonin 3mg take 1 tablet at bedtime Review of Resident #3's October 2025 eMAR from 10/01/25 to 10/20/25 revealed: -There was an entry for melatonin 3mg 1 tablet at bedtime scheduled at 8:00pm. -Melatonin 3mg was documented as administered for 20 of 20 opportunities from 10/01/25 to 10/20/25. -Melatonin should not have been administered from 10/17/25 through 10/20/25 and there were no additional notes for the melatonin administered to Resident #3. Observation of Resident #3's medications on hand for administration on 10/22/25 at 9:36am revealed there were 177 tablets remaining of 200 tablets dispensed on 09/29/25 cartridge box labeled for melatonin 3mg one tablet at bedtime. Interview with Resident #3 on 10/22/25 at 12:05pm revealed: -She relied on the MAs to give her medications because she was not aware of what medication she was administered every day. -She was not aware of any medication changes by her physician. Telephone interview with the pharmacist at the facility's contracted pharmacy on 10/22/25 at 1:35pm revealed:	D 358		

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-There was a current order for melatonin 3mg take 1 tablet at bedtime for Resident #3.
-Melatonin was dispensed on 09/29/25 for a quantity of 200 tablets.
-There was no order on file to stop melatonin 3mg for Resident #3.

Telephone interview with Resident #3's PCP on 10/22/25 at 2:30pm revealed:
-She did not write the order for Resident #3's melatonin because that was managed by Resident #3's mental health provider.
-She was not aware Resident #3 was administered melatonin from 10/17/25 to 10/20/25 because she had not reviewed his eMAR.

Telephone interview with Resident #3's mental health provider (MHP) on 10/22/25 at 2:45pm revealed:
-He stopped Resident #3's melatonin on 10/17/25 in an effort to reduce the volume of Resident #3's medication regimen.
-He was not aware Resident #3 was administered melatonin from 10/17/25 to 10/20/25.
-He expected staff to discontinue Resident #3's medications as ordered.

Interview with a MA on 10/22/25 at 10:00am revealed:
-Second shift MAs were responsible to administer Resident #3's melatonin since it was ordered as a bedtime medication.
-She was not aware of the physician's order from 10/17/25 to stop melatonin.

Interview with a second MA on 10/23/25 at 3:16pm revealed she was not aware of Resident #3's physician's order from 10/17/25 to discontinue melatonin.

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D 358	Continued From page 85 Interview with the RCC on 10/24/25 at 10:15am revealed she was not aware of Resident #3's physician's order from 10/17/25 to stop Resident #3's melatonin. Interview with the Administrator on 10/24/25 at 3:30pm revealed she was not aware of Resident #3's physician's order from 10/17/25 to stop Resident #3's melatonin. Refer to the interview with a MA on 10/22/25 at 10:00am. Refer to the interview with a second MA on 10/23/25 at 3:16pm. Refer to the interview with the RCC on 10/24/25 at 10:15am. Refer to the interview with the Administrator on 10/24/25 at 3:30pm revealed. _____ Interview with a MA on 10/22/25 at 10:00am revealed: -All MAs were responsible for reviewing physician orders and ensuring discontinued medications were sent to the pharmacy to be removed from the eMAR. -She had not reviewed any of the physicians' orders for the residents because she was not trained and felt uncomfortable with the ordering process. -Another first shift MA was designated primarily to review physician orders even though all the MAs were also responsible for the same task. -She was not sure who was responsible for reviewing the eMAR for accuracy and errors. Interview with a second MA on 10/23/25 at	D 358		

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D 358	Continued From page 86 3:16pm revealed: -All MAs were responsible for reviewing physician orders and ensuring discontinued medication orders were sent to the pharmacy to be removed from the eMAR. -The RCC was responsible for auditing the eMARs for accuracy and for providing any updates to the MAs on medication errors. Interview with the RCC on 10/24/25 at 10:15am revealed: -She had been in the RCC position for a month. -She and the MAs were responsible for reviewing physicians' orders and for ensuring the eMAR was updated either by the pharmacy or by the MAs. -She relied on the Business Office Manager or the Administrator to provide her with copies of the eMAR and the physicians' orders. -She did not have access to the facility's eMAR system because she had not been supplied a laptop and her credentials were pending approval. -She expected the MAs to administer medications as ordered by the provider. Interview with the Administrator on 10/24/25 at 3:30pm revealed: -She expected the MAs to review and forward orders to the pharmacy to ensure the eMAR was updated correctly. -She had designated no other staff to review eMARs other than a first shift MA until the RCC gained full access to the facility's eMAR system. -She expected the MAs to administer or hold medications as ordered by the provider and to follow up with the provider related to any questions related to resident's medications. _____ The facility failed to administer medications as	D 358		

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D 358	Continued From page 87 ordered including a resident (#1) who was a diabetic and was administered incorrect insulin amounts related to SSI which could have resulted in both low and high blood sugar levels. Another resident was administered a held medication which caused the resident, who had a history of cancer, to have a colonoscopy rescheduled for a later appointment (#3). This failure was detrimental to the health and welfare of the residents which constitutes a Type B Violation. This facility provided a plan of protection in accordance with G.S. 131D-34 on 10/24/25. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 8, 2025.	D 358		
D 371	10A NCAC 13F .1004 (n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure infection control measures were implemented during the morning medication pass. The findings are: Observation of the morning medication pass on	D 371		

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D 371	Continued From page 88 10/22/25 at 8:14am revealed: -The medication aide (MA) handed a resident a plastic medication cup with medications. -The resident dropped one oral medication onto the floor as she took her medications. -The MA was wearing gloves and picked up the oral medication from the floor. -The MA stated the resident dropped a medication on the floor and since it was the resident's floor she was going to administer the medication. -The MA stated she did not know which medication was dropped on the floor so she was going to administer the medication. -The MA was holding the oral medication in her gloved hand and the resident took the medication from the MA's gloved hand. -The resident was administered the oral medication that was dropped on the floor. Interview with the MA on 10/22/25 at 2:16pm revealed: -The resident dropped an oral medication onto the floor as she was taking her medications. -She picked up the medication and administered the medication to the resident. -She should have picked up the medication, pulled the resident's medication card from the medication cart, compared the medications and replaced the dropped oral medication. -She knew it was an issue of infection control to administer a medication to the resident after the medication was dropped onto the floor. -She thought the surveyor told her to administer the medication to the resident. Interview with the Administrator on 10/22/25 at 4:03pm revealed: -The MA should have identified the oral medication, taken the new oral medication out of	D 371		

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D 371	Continued From page 89 the medication card and documented what happened. -She expected MAs to properly administer medication as prescribed by physicians to the residents. -The MA administering medications was responsible for implementing and maintaining infection control during the medication pass.	D 371		
D 610	10A NCAC 13F .1801(a) Infection Prevention & Control Policies & Pro 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL POLICIES AND PROCEDURES (a) In accordance with Rule .1211(a)(4) of this Subchapter and G.S. 131D-4.4A(b)(1), the facility shall establish and implement infection prevention and control policies and procedures consistent with the federal Centers for Disease Control and Prevention (CDC) published guidelines on infection prevention and control. The Department shall approve a set of policies and procedures for infection prevention and control consistent with the federal CDC published guidelines on infection prevention and control that shall be made available on the Division of Health Service Regulation, Adult Care Licensure Section website at https://info.ncdhhs.gov/dhsr/acls/acforms.html at no cost. The facility shall either: (1) utilize the set of policies and procedures for infection prevention and control approved by the Department; (2) develop policies and procedures for infection prevention and control that are consistent with the set of Department approved policies and procedures; or (3) develop policies and procedures for	D 610		

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infection prevention and control that are based on nationally recognized standards in infection prevention and control that are consistent with the federal CDC published guidelines on infection prevention and control.

This Rule is not met as evidenced by:
FOLLOW-UP TO TYPE A2 VIOLATION.

Based on these findings, the previous Type A2 Violation was not abated.

Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the Federal Centers for Disease Control and Prevention (CDC) guidelines to ensure proper infection control procedures for the use of glucometers for 3 of 5 sampled residents (#1, #6, and #7) with orders for blood sugar monitoring resulting in the sharing of glucometers between residents.

The findings are:

Review of the CDC guidelines for infection control dated 08/07/24 revealed:
-The CDC recommended blood glucose monitoring devices (glucometers) should not be

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shared between residents.
-If the glucometer was to be used for more than one resident, it should be cleaned and disinfected per the manufacturer's instructions.
-If the manufacturer did not list disinfection information, the glucometer should not be shared between residents.

Observation of the South Hall's medication cart on 10/24/25 at 10:04am revealed:
-There were three glucometers stored in zipper bags in the top drawer of the medication cart.
-The glucometers and zipper bags were labeled with the residents' names.

Observation of the North Hall's medication cart on 10/24/25 at 10:15am revealed:
-There were three glucometers stored in zipper bags in the top drawer of the medication cart.
-The glucometers and zipper bags were labeled with the residents' names.

1. Review of Resident #1's current FL-2 dated 01/11/25 revealed:
-Diagnoses included diabetes mellitus and hypertension.
-There was an order to check blood sugar before each meal and at bedtime.

Observation of Resident #1's glucometer on 10/24/25 at 10:17am revealed:
-The glucometer was labeled with Resident #1's name.
-The current date and time on the glucometer were 07/01/25 and 10:33pm.

Review of Resident #1's October 2025 electronic medication administration record (eMAR), fingerstick blood sugar (FSBS) readings and most recent glucometer entry history revealed:

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	HAL080032	A. BUILDING: _____ B. WING _____	R-C 10/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHAMY RETIREMENT CENTER	909 N SALISBULRY AVENUE SPENCER, NC 28159

(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 610	Continued From page 92 -There was an entry on the eMAR to check FSBS before each meal and at bedtime with scheduled times of 6:00am, 11:30am, 5:30pm and 8:00pm. -On 10/06/25, there was a documented FSBS reading of 371 at 5:27pm. -The FSBS reading of 371 documented on Resident #1's eMAR was in another resident's glucometer history. -On 10/15/25, there was a documented FSBS reading of 330 at 4:10pm; the FSBS reading was not recorded in Resident #1's glucometer history. -The FSBS reading of 330 documented on Resident #1's eMAR was in another resident's glucometer history. -On 10/20/25, there was a documented FSBS reading of 278 at 12:00pm; the FSBS reading was not recorded in Resident #1's glucometer history. -The FSBS reading of 278 documented on Resident #1's eMAR was in another resident's glucometer history. -On 10/21/25, there was a documented FSBS reading of 374 at 1:25pm; the FSBS reading was not recorded in Resident #1's glucometer history. -The FSBS reading of 374 documented on Resident #1's eMAR was in another resident's glucometer history. -On 10/21/25, there was a documented FSBS reading of 357 at 5:23pm; the FSBS reading was not recorded in Resident #1's glucometer history. -The FSBS reading of 357 documented on Resident #1's eMAR was in another resident's glucometer history. Interview with Resident #1 on 10/24/25 at 9:30am revealed: -Staff checked his FSBS two or three times daily. -He did not know if he had his own glucometer that staff used to check his FSBS.	D 610		

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D 610	Continued From page 93	D 610		

Refer to the interview with the medication aide (MA) on 10/24/25 at 5:27pm.

Refer to the telephone interview with the primary care provider (PCP) on 10/24/25 at 4:30pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 10/24/25 at 5:15pm.

Refer to the interview with the Administrator on 10/24/25 at 5:45pm.

2. Review of Resident #6's current FL-2 dated 01/16/25 revealed:
-Diagnoses included asthma, hypertension, hyperlipidemia, traumatic brain injury, and left semi paralysis.
-There was no order for fingerstick blood sugar (FSBS) checks.
-There was a typed statement that read, see attachment.
-There was no order for FSBS checks on the attachment.

Observation of Resident #6's glucometer on 10/24/25 at 10:35am revealed:
-The glucometer was labeled with Resident #6's name.
-The current date and time on the glucometer were 05/17/25 and 3:22am.

Review of Resident #6's FSBS readings from 09/24/25 to 10/24/25 and most recent glucometer entry history revealed:
-Resident #6's FSBS ranged from 103-214 on the FSBS reading administration history from 09/24/25 to 10/24/25.
-Resident #6's FSBS was checked once daily on the FSBS reading administration history.
-There were four FSBS readings in Resident #6's

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D 610	Continued From page 94	D 610		

glucometer history of 330, 479, 540, and 371 that were not documented on Resident #6's FSBS reading administration history.
-The FSBS readings of 371 and 330 were documented on another resident's electronic medication administration record (eMAR).
-There was documentation in the glucometer history that two FSBS readings of 160 and 479 were checked 37 minutes apart on 05/03/25.

Interview with Resident #6 on 10/24/25 at 4:43pm revealed:
-Staff checked her FSBS once daily.
-She did not know if she had her own glucometer that staff used to check her FSBS.

Refer to the interview with the medication aide (MA) on 10/24/25 at 5:27pm.

Refer to the telephone interview with the primary care provider (PCP) on 10/24/25 at 4:30pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 10/24/25 at 5:15pm.

Refer to the interview with the Administrator on 10/24/25 at 5:45pm.

3. Review of Resident #7's current FL-2 dated 04/10/25 revealed:
-There were no diagnoses listed.
-There was a typed statement under diagnoses that read, see attachment, but there was no attachment available for review.
-There was no order for fingerstick blood sugar (FSBS) checks.
-There was a typed statement under medications that read, see attached, but there was no attachment available for review.

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D 610	Continued From page 95 Review of Resident #7's signed physician orders dated 12/16/24 revealed there was a signed order to check FSBS three times daily with meals. Observation of Resident #7's glucometer on 10/24/25 at 10:35am revealed: -The glucometer was labeled with Resident #7's name. -The current date and time on the glucometer were 05/06/25 and 5:53pm. Review of Resident #7's FSBS readings from 09/24/25 to 10/24/25 and most recent glucometer entry history revealed: -Resident #7's FSBS ranged from 69-388 on the FSBS reading administration history from 09/24/25 to 10/24/25. -Resident #7's FSBS was checked three times daily on most days in the FSBS reading administration history. -There were five FSBS readings in Resident #7's glucometer history of 357, 130, 374, 404, and 278 that were not documented on Resident #7's FSBS reading administration history. -The FSBS readings of 357, 374 and 278 were documented on another resident's electronic medication administration record (eMAR). -There was documentation in the glucometer history that two FSBS readings of 357 and 130 were checked four minutes apart on 05/03/25 at 11:59pm and 11:55pm. -There was documentation in the glucometer history that two FSBS readings of 97 and 374 were checked 18 minutes apart on 05/03/25 at 7:02pm and 6:44pm. -There was documentation in the glucometer history that two FSBS readings of 97 and 404 were checked ten minutes apart on 05/02/25 at 11:58pm and 11:48pm. -There was documentation in the glucometer	D 610		

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D 610	Continued From page 96 history that two FSBS readings of 278 and 90 were checked one minute apart on 05/02/25 at 6:59pm and 6:58pm. Interview with Resident #7 on 10/24/25 at 3:45pm revealed: -Staff checked his FSBS three times daily. -He did not know if he had his own glucometer that staff used to check his FSBS. Refer to the interview with the medication aide (MA) on 10/24/25 at 5:27pm. Refer to the telephone interview with the primary care provider (PCP) on 10/24/25 at 4:30pm. Refer to the interview with the Resident Care Coordinator (RCC) on 10/24/25 at 5:15pm. Refer to the interview with the Administrator on 10/24/25 at 5:45pm. _____ Interview with a medication aide (MA) on 10/24/25 at 5:27pm revealed: -Each resident had a glucometer on the medication carts. -She had not shared glucometers when checking residents' FSBS. -She did not know there were at least four instances of glucometer sharing between residents. -She knew there was a risk of spreading bloodborne pathogens from sharing glucometers between residents. Telephone interview with the PCP on 10/24/25 at 4:30pm revealed: -She did not know glucometers were being used to check more than one resident's FSBS. -Glucometers should not be shared because	D 610		

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D 610	Continued From page 97 each resident had their own glucometer. Interview with the Resident Care Coordinator (RCC) on 10/24/25 at 5:15pm revealed: -She did not know there were at least four instances of glucometer sharing between residents. -The MAs should not share glucometers between residents. -She expected glucometers to be labeled with the resident's name. -Different glucometers should be used to check each resident's FSBS. Interview with the Administrator on 10/24/25 at 5:45pm revealed: -She did not know there were at least four instances of glucometer sharing between residents. -She expected the MAs to use the correct glucometer for the correct resident when checking FSBS. -The MAs were responsible for checking residents' FSBS using each resident's individual glucometer. _____ The facility failed to implement infection control procedures consistent with the CDC guidelines resulting in staff sharing glucometers for 3 of 5 sampled residents, placing residents at risk for bloodborne pathogen diseases. This failure resulted in substantial risk for harm, and constitutes an Unabated Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/24/25.	D 610	Facility has a Infection Control 11/20/25 Policy in the home, All staff will be in -serviced on Infection Control and have acces to the policy located in the home nurse's station. In-service will be conducted annually and on -going, all new employees will be in-serviced by facility RN. **10/30/25 - Amended per telephone call with Adminstrator on 12/05/25. SA**	