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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on November 4, 2025 through November 6, 2025.	D 000	Upon identification of an acute change in condition or a medical emergency, the facility will notify the PCP. When it is determined by PCP a specialist referral is needed the facility will require the PCP office schedule the referral and contact the facility with appointment date. This will be documented in the resident's record, including date, time, location, purpose, and referring physician. The facility will request the PCP office forward any test or lab results to facility. This will be monitored on a daily basis by facility manager and RCC. All staff must immediately report significant behavioral changes, medication refusals, and weight changes to the manager or RCC. The manager or RCC is responsible for ensuring the PCP is notified, and all communication is documented. This will be monitored on a daily basis by facility manager and RCC.	11/7/25
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: FOLLOW UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews the facility failed to ensure referral and follow-up to meet the acute health care needs of 2 of 5 sampled residents (#1, #3) related to following up with a resident's primary care provider (PCP) regarding behaviors and medication refusals (#1), and failure to report weight gain of a resident (#3) to the PCP. The findings are: 1. Review of a policy dated 10/29/04 titled Management of Physical Aggression or Assault by a Resident revealed: -Residents were expected to adhere to the facility's policies and respect the rights of others. Harassment, physical or verbal abuse of other residents or staff was considered to be inappropriate and unacceptable. -Residents engaging in inappropriate behavior may be subject to behavior intervention	D 273		

Reviewed and Acknowledged 12/05/25 KC

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techniques as deemed necessary by the facility and the resident's physician.
-Depending on the severity of the behavior and based on the circumstances that facility would: Ask all staff to be alert to inappropriate behaviors. Report immediately to the supervisor any maladaptive behaviors. De-escalate the situation as needed. Report dangerous behaviors to the resident's physicians and/or area mental health authority and implement physician's orders. Report dangerous behavior to the resident's family/responsible persons per HIPAA standards and seek intervention.

Review of an undated policy titled Resident's Abusive Language Policy revealed:
-Using obscene or abusive language would not be permitted.
-Frequent continued use of such language would be taken to mean the resident was unable to adjust to the home's rules regarding respect for the rights of others.
-The facility reserved the right to request the resident, family, responsible person or agency to arrange other placement immediately according to the facilities discharge policies

Review of Resident #1's current FL-2 dated 04/30/25 revealed:
-Diagnoses included multiple sclerosis (MS), coronary artery disease (CAD), hypertension, benign prostatic hyperplasia (BPH), atrial fibrillation with rapid ventricular response (A-fib with RVR), and gastroesophageal reflux disorder (GERD).
-The resident was ambulatory.
-The resident required no assistive devices.
-The resident was continent of bowel and bladder.

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Review of Resident #1's Resident Register revealed he was admitted to the facility on 04/16/25.

Observations of Resident #1 11/04/25 between 9:00am and 4:00pm revealed:
-Resident #1 ambulated independently with no assistance.
-Resident #1 required no assistance with bathing, toileting, grooming, dressing, and transfers.

Review of a note from a local mental health provider dated 11/04/25 revealed:
-Resident #1 had an appointment scheduled for 09/19/25.
-Resident #1 refused to participate after being informed that the appointment was for psychiatric services.

Review of a facility progress notes dated 09/29/25 revealed:
-Resident #1 requested an appointment with a mental health provider.
-Resident #1 had an appointment scheduled for an assessment with a mental health provider.
-Resident #1 refused to attend the mental health appointment.
-Resident #1 became confrontational with staff after being asked to wait until later that day to get his laundry done.

Review of a faxed document dated 09/29/25 revealed:
-A note was sent to Resident #1's primary care provider (PCP) asking the PCP to discuss behaviors with Resident #1.
-Attached to the note were progress notes regarding Resident #1's behavior on 09/29/25.

Review of a facility progress note dated 10/04/25

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revealed Resident #1 made a gesture at staff using his middle finger all day.

Review of a facility progress note dated 10/05/25 revealed:
-Resident #1 called a staff member an [expletive] while the staff member was interacting with another resident.
-Resident #1 wrote a letter to the facility Manager stating the staff member was bothering him.

Review of an Accident/Incident Report dated 09/12/25 revealed Resident #1 refused his medication at 7:30am and walked away.

Review of undated handwritten notes, some unsigned and some with Resident #1's signature, revealed Resident #1 wrote numerous letters to the facility Manager.

Review of an undated letter given to the facility Manager by Resident #1 on 11/06/25 revealed there was list of side effects for Lisinopril.

Review of Resident #1's physician's order sheet dated 07/24/25 revealed there was no order for Lisinopril.

Observation of Resident #1's medication on hand on 11/06/25 at 9:00am revealed:
-The medications were on individual dose packages on a roll.
-The pack that contained Metoprolol listed the medication and described the pill as white and round.
-The white round pill in the pack labeled with Metoprolol had "R25" on it.
-There was no packaging with Lisinopril listed.

Interview with Resident #1 on 11/04/25 at 9:40am

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revealed:
-He had been at the facility since the end of April 2025.
-He did not enjoy being at the facility because none of his friends were there.
-Staff gave him his medication but he did not need help with anything.
-He was totally cognizant and should not have been at the facility.
-The facility Manager took him grocery shopping.
-He did his own grocery shopping.
-He did not want or need the facility staff's help.

Second interview with Resident #1 on 11/05/25 at 2:19pm revealed:
-He requested a mental health appointment with the same provider he previously walked out on.
-He did not go to the mental health appointment because a family member told him not to trust the mental health provider.
-If he got back to his hometown, he could afford an apartment.
-He managed his own finances.
-He did not need help from facility staff.

Third interview with Resident #1 on 11/06/25 at 8:54am revealed:
-The tiny white pill in his medication was Lisinopril, and it was making him sick.
-Lisinopril had "Y11" on it.
-Staff told him the tiny white pill was Metoprolol.
-He went through the pharmaceutical guide and the guide said there was no tiny white pill with the number 11 on it identified as Metoprolol.
-He was taken off Lisinopril in 2018 and put on Metoprolol.
-Both Lisinopril and Metoprolol are blood pressure medications.
-Either the pharmaceutical company made a mistake, or the pharmacy substituted the

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medication.
-The facility was not at fault; it was the dispensing company's fault.
-He had not looked at the number on Metoprolol.
-He took the small white pill out of the medication cup yesterday, took it in the bathroom and held it up to the light to see the "Y11".

Telephone interview with the Pharmacy Technician and Pharmacist at the facility's contracted pharmacy on 11/06/25 at 9:47am revealed:
-Resident #1 had been using their pharmacy since 04/16/25.
-Resident #1 had no order for Lisinopril since being with their pharmacy.
-Resident #1 took Famotidine.
-Famotidine was a small round white pill with the number 11 on it.

Interview with a personal care aide (PCA) on 11/05/25 at 12:00pm revealed Resident #1 became agitated when he did not get his way and said they were neglecting him.

Telephone interview with the medication aide (MA) on 11/05/25 at 12:35pm revealed:
-Resident #1 became upset if staff did not stop what they were doing immediately to do what he wanted them to do.
-She was on good terms with Resident #1 until the local pharmacy forgot to send one of his medications.
-On 10/05/25, Resident #1 became upset when she had to exchange another resident's dirty coffee cup (at his table) for a clean cup; he made the statement "oh great now I have to get my coffee last" and called her a [expletive].
-She reported the 10/05/25 incident to the Resident Care Coordinator (RCC) but Resident

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#1 had already called the local Department of Social Services (DSS)before she could report to the RCC.
-Resident #1 asked her to schedule an appointment for a mental health assessment but refused to attend on the day of the appointment; she did not recall the dates.
-Resident #1 told her his goal was to get the facility shut down.
-The PCP was supposed to be contacted when a resident had behavior.
-She sent a fax to Resident #1's PCP regarding his behavior but she did not recall the date.
-She did not think Resident #1's PCP had been notified of his behavior prior to her notification.
-She documented anytime she had an interaction with Resident #1 but was unsure what other staff members did when they had interactions with him.
-She was unsure if there was a policy regarding documentation of behavior and reporting behavior to management and the PCP.

Second interview with the MA on 11/06/25 at 8:23am revealed:
-Resident #1 refused his medication this morning (11/06/25) in the dining room.
-Resident #1 told her he was not going to take the medication until the Lisinopril was taken out.
-She took the medication cup back to the cart and put it in Resident #1's tray and went to the next resident.
-Resident #1 asked if she was going to give him any medication.
-She informed Resident #1 she would give him medication when there was someone else present to witness her administering the medication.
-Resident #1 told her he was going to tell the surveyors that she was withholding his

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medication and that he was not refusing his medication.
-The facility Manager witnessed her picking the medication up, but she was not sure if she heard the conversation as she was walking through the dining room.
-Resident #1 took his medication for the facility manager after taking the Metoprolol and Senna out of the cup.
-She was unsure if anyone followed up with Resident #1's PCP after she sent notification of his behavior and medication refusal on 09/29/25 but he had an appointment with the PCP after 09/29/25.
-Resident wrote a letter to the facility Manager and put it on her desk today (11/06/25).
-The RCC was responsible for following up with the PCP.

Interview with a housekeeper on 11/04/25 at 9:24am revealed:
-Resident #1 was trying to get the facility shut down.
-Resident #1 had frequent complaints.

Interview with the RCC on 11/05/25 at 8:37am revealed:
-Resident #1's refusal of medication, documented in a progress note and Accident/Incident report on 09/12/25, had not been reported to the PCP.
-Resident #1's refusal to attend a mental health assessment, documented in a progress note on 09/29/25, had not been reported to the PCP.
-Resident #1 making gestures at staff with his finger on 09/04/25 and calling staff an expletive on 10/05/25, documented in progress notes, had not been reported to the PCP.
-When a resident refused medication, the PCP was supposed to be contacted but she was unsure how many times the resident had to

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refuse before the PCP was notified.
-The MAs were responsible for notifying the PCP of medication refusals.
-She had not dealt with a resident with behaviors but was understanding that she was supposed to contact Resident #1's PCP about his behaviors.
-Resident #1 did not have behaviors daily but he did have behavioral issues.
-Resident #1 walked and mumbled things all the time.
-Resident #1 had frequent complaints.
-Resident #1 wanted things done immediately.
-The facility Manager was aware of Resident #1's behavior because she was at the facility all the time.
-The facility Manager determined when to notify the Administrator of a resident's behaviors.

Second interview with the RCC on 11/06/25 at 11:54am revealed:
-She was responsible for notifying the PCP and following up with the PCP regarding residents.
-She did not know the MA sent notification to Resident #1's PCP regarding his behavior until 11/05/25.
-Resident #1 went out of the facility to see the PCP.
-Resident #1 did not allow them to go into appointments with him.
-The PCP sent a summary back with the resident after appointments.
-Resident #1 had an appointment with the PCP on 10/01/25.
-The summaries only show if there were new orders, but no details of the visit were provided.
-She did not follow up with the PCP regarding Resident #1's behavior because she did not know his behavior had been reported to the PCP.

Interview with the facility Manager on 11/05/25 at

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D 273	Continued From page 9 10:12am and 2:55pm revealed: -Staff reported any issues they had with a resident to the RCC. -The RCC reported any issues staff had with residents to her, but the RCC was responsible for handling the issues. -If the RCC could not handle the issue, she intervened. -Resident behaviors were normally reported to her after 2 incidents. -Resident #1 had frequent complaints. -Resident #1 walked around mumbling, making remarks about staff as he walked past them. -Resident #1's behavior was not always documented because that was normal for him. -Resident #1 had no physical behavior. -She heard the RCC and MA talking about notifying Resident #1's PCP about his behavior, but she was not sure when this was done or if it was done. -Resident #1's behaviors from 09/12/25 to 10/05/25 should have been reported to the PCP. -Resident #1 used expletives when speaking with providers and the local DSS. -The RCC was responsible for notifying Resident #1's PCP of his behavior. -The Administrator was aware of Resident #1's behavior. -She spoke with the Administrator daily and the Administrator visited the facility for a day twice a month. -The facility did not have a policy that addressed resident behavior. Second interview with the facility Manager on 11/06/25 at 8:38am revealed: -Resident #1 looked up the side effects of Lisinopril yesterday (11/05/25). -Resident #1 was not prescribed Lisinopril. -Resident #1 refused his medication this morning	D 273		

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when the MA attempted to administer his medications.
-She showed Resident #1 all of his medication as well as the corresponding pictures of the medications on the computer screen from the electronic medication administration record (eMAR).
-Resident #1 kept saying the Lisinopril was a little round pill with the number 11 on it.
-Once Resident #1 realized he was taking Metoprolol, he looked up what the side effects of Metoprolol were and stated it was the same as Lisinopril.
-Resident #1 refused to take the Metoprolol and asked who prescribed the medication.
-She showed Resident #1 the FL2 dated 04/30/25 as well as the prescription dated 04/16/25.
-Resident #1 was taking Metoprolol when he was admitted to the facility.
-Resident #1 wrote a letter to her this morning (11/06/25).
-This was Resident #1's normal behavior.
-She did not know if anyone followed up with Resident #1's PCP after the MA faxed the notes regarding his behavior and medication refusal on 09/29/25.
-The MA and RCC were responsible for PCP follow up.

Interview with the Administrator on 11/05/25 at 3:20pm revealed:
-Resident #1 had behaviors but it got to the point where they did not know if it was behavior or personality.
-Resident #1 had outbursts and told exaggerated stories but was not aggressive.
-When Resident #1 had behaviors, staff talked to him to calm him down.
-There was no policy on how to handle Resident #1's behavior.

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D 273	Continued From page 11 -Resident #1 refused psychiatric services. -Staff did not report Resident #1's behavior to her because it was not alarming to them and it was just his personality. -Staff did not have to report Resident #1 to the Manager every time he had a behavior. -The staff that were with Resident #1 24 hours a day, 7 days a week knew that this was his personality. -Resident #1 had done nothing for her to discharge him. -Staff had been told to walk away from Resident #1 and not to respond or engage. -She and the facility Manager talked almost daily. -The Manager reported to her when she felt she could not handle a situation or if she needed advice or direction. -She expected the Manager to call her if a resident hit staff or another resident. -Resident #1's behavior was not a big deal to the PCP because they knew he did not want psychiatric services. -The residents' PCPs did not respond most of the time. -She did not know if anyone called the PCP back to follow up on the notification sent from the facility regarding Resident #1's behavior. -She expected staff to document but they did not have to document in the progress notes. Second interview with the Administrator on 11/06/25 at 11:19am revealed staff were not required to follow up with the PCP after notification of Resident #1's behavior. Telephone interview with the licensed practical nurse (LPN) at Resident #1's PCP office on 11/05/25 at 9:02am and 9:29am revealed: -Resident #1's PCP was not available today, 11/05/25.	D 273		

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-Resident #1 was seen in their office 4 times. (Dates were not provided.)
-Resident #1 was last seen for a hospital follow up. (The date was not provided.)
-There were no concerns with Resident #1's behavior.
-Facility staff had no reported behavior concerns, refusal of medication or refusal of mental health services for Resident #1.

Second attempted telephone interview with Resident #1's PCP by phone on 11/06/25 at 10:03am was unsuccessful.

2. Review of Resident #3's current FL-2 dated 04/17/25 revealed diagnoses included hypertension, diabetes mellitus, chronic leg swelling, depression, and stent 12/2023.

Review of Resident #3's signed physician orders dated 07/24/25 revealed there was an order to check weight daily and report weight gain of two pounds in one day or five pounds in one week.

Review of Resident #3's September 2025 electronic medication administration record (eMAR) revealed:
-There was an entry to check weight daily and report weight gain of two pounds in one day or five pounds in one week and scheduled for 7:00am-3:00pm shift daily.
-There was documentation of weights recorded for Resident #3 of 214 pounds on 09/02/25 and 225 pounds on 09/03/25, an 11-pound weight gain in one day.
-There was documentation of weights recorded for Resident #3 of 214.3 pounds on 09/08/25 and 226 pounds on 09/09/25, an 11.7-pound weight gain in one day.
-There was documentation of weights recorded

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D 273	Continued From page 13 for Resident #3 of 214 pounds on 09/16/25 and 227 pounds on 09/17/25, a 13-pound weight gain in one day. -There was documentation of weights recorded for Resident #3 of 214 pounds on 09/22/25 and 228 pounds on 09/23/25, a 14-pound weight gain in one day. -There was documentation of weights recorded for Resident #3 of 214 pounds on 09/29/25 and 226 pounds on 09/17/25, a 12-pound weight gain in one day. -There was no documentation of reporting the weight gain to Resident #3's primary care provider (PCP). Review of Resident #3's October 2025 eMAR revealed: -There was an entry to check weight daily and report weight gain of two pounds in one day or five pounds in one week and scheduled for 7:00am-3:00pm shift daily. -There was documentation of weights recorded for Resident #3 of 214 pounds on 10/06/25 and 220.9 pounds on 10/07/25, a 6.9-pound weight gain in one day. -There was documentation of weights recorded for Resident #3 of 214 pounds on 10/10/25 and 218.8 pounds on 10/11/25, a 4.8-pound weight gain in one day. -There was documentation of weights recorded for Resident #3 of 212 pounds on 10/13/25 and 220.8 pounds on 10/14/25, an 8.8-pound weight gain in one day. -There was documentation of weights recorded for Resident #3 of 218 pounds on 10/21/25 and 220.8 pounds on 10/22/25, a 2.8-pound weight gain in one day. -There was no documentation of reporting the weight gain to Resident #3's PCP.	D 273		

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D 273	Continued From page 14 Review of Resident #3's record revealed there was no documentation that Resident #3's PCP had been contacted regarding the Resident #3's weight gain. Interview with Resident #3 on 11/04/25 at 2:15pm revealed: -Her weight on today (11/04/25) was 224 pounds. -She was not weighed on 11/03/25. -She was weighed "about every other day" by the medication aide (MA). -Sometimes she did not go to get weighed. -The MAs did what they needed to do and would wait on her to come to the office to get weighed. Second interview with Resident #3 on 11/06/25 at 9:05am revealed: -She had only been to the hospital once since admission to the facility about one year ago. -She had not had any shortness of breath, pain, or discomfort but had been coughing a little. Interview with the MA on 11/04/25 at 4:38pm revealed: -When she worked she weighed Resident #3 every day. -Whichever MA that was working was supposed to check Resident #3's weight. -She did not have any idea what the process was for calling the PCP. -She usually reported to the RCC but had not notified the RCC or PCP .of any weights for Resident #3. Interview with the Resident Care Coordinator (RCC) on 11/04/25 at 3:58pm revealed: -Either she or the MA documented in the resident record if the PCP was notified about a resident. -She documented on progress notes when she contacted the PCP.	D 273		

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D 273	Continued From page 15 -She was aware of the PCP order for Resident #3's weight gain of two pounds in one day or five pounds in one week to be reported. -She had not reported any weight gains to Resident #3's PCP. -The MA would have contacted the PCP if contact had been made regarding Resident #3's weight gains. Second interview with the RCC on 11/05/25 at 4:05pm revealed she called the MA and the MA said she had not made any telephone calls to Resident #3's PCP. Interview with the facility Manager on 11/05/25 at 10:15am revealed: -The RCC always handled calling the PCP. -She intervened when the RCC needed assistance in handling an issue such as behaviors with residents and calling the PCP. Second interview with the facility Manager on 11/06/25 at 8:25am revealed: -The MAs obtained resident weights. -She expected the MAs and RCC to stay on top of faxing and calling the PCP's regarding weights and any other issues regarding the residents such as behaviors and medications. -The MAs were able to review weights by looking at the eMAR or vital report records. -She expected the MAs to review resident weights to determine if there were discrepancies. -The RCC reviewed the MA worksheet and should know if there were weight discrepancies that needed to be reported. Interview with the Administrator on 11/06/25 at 10:47am revealed: -Resident #3 had a physician order for weights with parameters.	D 273		

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D 273	Continued From page 16 -The weights should have been reported to the PCP. -She did not know if the RCC was reporting the weights to the PCP or delegating that duty. -She expected the weights for Resident #3 to be done according to the PCP order. Telephone interview with the Nurse Practitioner for Resident #3 on 11/05/25 at 2:22pm revealed: -Resident #3 was a new resident to her and had not seen the resident yet. -The last visit for Resident #3 was a televised visit on 04/17/25 by the previous PCP. -There was a current order dated 07/24/25 for Resident #3 to be weighed daily and report a two-pound weight gain in one day or five-pound weight gain in one week. -In March 2025, there was a provider note that Resident #3 was retaining fluid and gaining weight. -There was no notation in Resident #3's notes of reported weight gains called from the facility. -Fluid overload could result in heart issues for the resident which could be exhibited by coughing, shortness of breath, chest pain, and swelling in the legs.	D 273		
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages shall be offered in accordance with each residents' prescribed diet or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks.	D 298		

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D 298	Continued From page 17 This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure snacks were offered to all residents between meals. The findings are: Observation of the facility on 11/04/25 and on 11/05/25 from 9:00am to 5:00pm revealed: -After the meal service, no food of any type was offered or served. -No one at the facility offered or made the residents aware they could have snacks between meals. -There were two residents on the 200 hall that were bedbound and unable to get up without assistance to go and get snacks. Review of the facility's menu week 2 revealed: -On 10/04/25, the snack was graham crackers and chilled water. -On 10/05/25, the snack was vanilla wafers and chilled water. -There were no scheduled times for snacks to be served. Review of the facility's kitchen on 11/05/25 at 4:45pm revealed: -There were a variety of single served potato chip bags sitting in a large size container under a serving table. -There were a variety of single served cookies and pies sitting in a medium size container on the serving table.	D 298	The facility shall assure there are three scheduled snacks daily Morning Snack will be offered after Breakfast and before Lunch Afternoon Snack will be offered after Lunch and before Dinner Evening/Bedtime Snack will be offered after Dinner and before bedtime Snacks will consist of nourishing foods and beverages appropriate for the resident population as planned by US Food's registered dietician. Snacks will be prepared by kitchen staff to meet these guidelines. The nursing staff is responsible for the proper distribution of snacks, ensuring that each resident receives appropriate snack. This will be monitored on a daily basis by nursing staff, manager and RCC	11-7-25

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D 298	Continued From page 18 Interview with a resident on the 300 hall on 11/04/25 at 11:10am revealed: -Staff did not provide snacks three times a day. -The staff would give out snacks a couple of days then they would stop, -She could not recall the last time staff brought her a snack. -If residents wanted a snack, they must walk to the kitchen to ask for a snack. -She did not want to walk to the kitchen to ask for a snack. -She would like to be offered snacks daily. Interview with a second resident on the 200 hall on 11/05/25 at 9:45am revealed: -She was lying in bed. -The resident did respond verbally when addressed but was unable to articulate words. Interview with a third resident on the 200 hall on 11/05/25 at 9:50am revealed: -That staff brought snacks sometimes, but he could not remember the last time he was given a snack. -He knew that he could go to the kitchen and ask for a snack, but he never asked for a snack. -He enjoyed eating snacks when he got them. Interview with a fourth resident on the 200 hall on 11/05/25 at 9:53am revealed: -He was given a snack at night between 7:30pm and 8:00pm. -He did not get a snack during the day at 10:00am and 2:00pm. -Sometimes he would go to the kitchen and ask for a snack. -He asked for a snack yesterday and got potato chips, but he did not remember the time when he asked for the snacks.	D 298		

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D 298	Continued From page 19 -He would like it if staff brought him the snack. Interview with a fifth resident on the 200 hall on 11/05/25 at 10:00am revealed: -He was given a snack at nighttime around 9:00pm, but never during the day. -He would like to get snacks between meals. -He knew he could go to the kitchen and ask for a snack, but he never went because he did not want to bother anyone. Interview with a sixth resident on the 200 hall on 11/05/25 at 10:00am revealed: -He was non-ambulatory and unable to get out of bed without assistance. -He was given a snack at nighttime but never during the day. -He would like to get snacks during the day. Interview with a seventh resident on the 100 hall on 11/05/25 at 10:18am revealed: -He went to the kitchen and asked for a snack. -He always went to the kitchen various times throughout the day to get a snack because no staff comes to him with snacks. Interview with an eighth resident on the 100 hall on 11/05/25 at 10:28am revealed: -She was given a snack at 10:00am, 2:00pm, and at 7:00pm daily. -She was not given her 10:00am snack today because "guess they are busy". Interview with a ninth resident on the 300 hall on 11/05/25 at 10:45am revealed: -The staff very seldom came around with a snack. -He did not know he could go to the kitchen to ask for a snack. -He could not walk to the kitchen by himself	D 298		

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because he was blind.
-He would like to get a snack between meals.

Interview with a tenth resident on the 300 hall on 11/05/25 at 10:51am revealed:
-The resident was sitting in her recliner.
-When spoken to, she asked, "where am I? Am I alright".
-The resident then asked, "Have we ate yet and will you come and get me to eat?".
-The resident was unable to answer when she was asked if she received snacks.

Interview with the Dietary Manager on 11/05/25 at 4:55pm revealed:
-She was not aware snacks were not offered or served to the residents.
-She ensured there were snacks in the kitchen to hand out to residents.
-She did not give out the snacks but the personal care aide (PCA) working on the halls was responsible for handing out snacks.
-Snacks were to be handed out to residents daily around 10:00am, 2:00m, and 8:00pm.
-The PCAs were to take the snacks to the floors and hand them out to their residents.
-Residents could come to the kitchen to ask for a snack.
-Two to three residents came to the door and asked for snacks, and she gave them a snack.
-She did not know if residents who were bedbound were getting their snacks.
-All PCAs on their hall were responsible to hand out snacks.

Interview with a personal care aide (PCA) on 11/06/25 at 8:25am revealed:
-She was not aware that residents were not getting their three snacks a day.
-Residents did come to the kitchen to ask for a

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snack.
-She worked yesterday, 11/05/25 and she was assigned to two halls, and she was busy and did not give out snacks.
-The PCAs did get busy, and it would slip their minds to hand out snacks.
-All PCAs were responsible to hand out snacks.

Interview with a second PCA on 11/06/25 at 8:35am revealed:
-She had been working as a PCA at the facility for one month.
-She did not know who was responsible for handing out snacks to the residents.
-When a resident asked for a snack, she would give them one.
-She remembered during her training that snacks were given at 10:00am and 2:00pm, but she did not know that she was responsible to hand out the snacks.

Interview with the facility Manager on 11/06/25 at 9:35am revealed:
-She was not aware that snacks were not being offered during the day.
-Snacks were offered at 10:00am, 2:00m, and 8:00pm.
-Dayshift PCAs should go room to room and ask each resident if they want a snack.
-Nightshift PCAs passed out ice, water, or milk with each snack.
-The PCAs knew which residents could not get out of bed and they were to make sure those residents got a snack three times a day.
-The PCAs were expected to train the new PCAs on how and when to offer snacks.
-The lead medication aide (MA) was to ensure snacks were being offered.
-She was responsible to ensure snacks were being offered to each resident three times a day.

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D 298	Continued From page 22 Interview with the Administrator on 11/06/25 at 10:55am revealed: -She was not aware that snacks were not being offered during the day. -The snacks should be offered at 10:00am, 2:00m, and 8:00pm. -The cook was responsible for preparing the snacks, but she was not sure if the PCAs or the cook handed them out to the residents. -The snacks should be offered to each resident including those who were bedbound. -The facility manager was responsible for overseeing that snacks were offered three times a day.	D 298		
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 B VIOLATION Based on these findings, the previous Type B Violation was abated. Non-compliance continues. Based on interviews, the facility failed to ensure a resident (#1) was free from exploitation related to staff requiring the resident to buy them groceries in exchange for taking him to the store. The findings are: Review of Resident #1's current FL-2 dated	D 338		

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D 338	Continued From page 23 04/30/25 revealed: -Diagnoses included multiple sclerosis (MS), coronary artery disease (CAD), hypertension, benign prostatic hyperplasia (BPH), atrial fibrillation with rapid ventricular response (A-fib with RVR), and gastroesophageal reflux disorder (GERD). -The resident was ambulatory. -The resident required no assistive devices. -The resident was continent of bowel and bladder. Observation of Resident #1 on 11/04/25 between 9:00am and 4:00pm revealed: -Resident #1 ambulated independently with no assistance. -Resident #1 required no assistance with bathing, toileting, grooming, dressing, and transfers. Interview with Resident #1 on 11/05/25 at 2:19pm revealed: -The facility Manager took him to the store so he could buy his own groceries on Monday and Friday. -The Resident Care Coordinator (RCC) took him to the grocery store a few times. -Before the facility Manager started taking him to the store twice a week, he made arrangements with a personal care aide (PCA) to go to the grocery store on Saturday. -The arrangements he made with the PCA was that he would buy her something if she took him to the grocery store on Saturday. -The PCA expected him to buy her groceries in exchange for taking him to the grocery store. -The PCA started out getting a few items such as bottled water and blueberry muffins. -At the time, he received $235 per month from the Supplemental Nutrition Assistance Program (SNAP) and $352 per month from his insurance	D 338	Personnel are strictly prohibited from soliciting, suggesting, or accepting any gift, money, loan, favor, or personal purchase from a resident in exchange for services . Staff may not require a resident to purchase groceries, personal items, or fuel for them in return for providing transportation or assistance with errands.. If a staff member is required to use their personal vehicle for a facility-provided service (e.g., resident transport), they will be reimbursed by the facility, not the resident. Any staff member who witnesses, suspects, or receives an allegation of resident exploitation or financial coercion must immediately report the concern to the manager or RCC. All reports of exploitation or financial coercion will be investigated immediately by facility manager. A report of the alleged allegation will be sent to the HCPR as required. Any violation of this policy will result in immediate disciplinary action, up to and including termination of employment and notification to the health care personnel care registry and law enforcement. Failure by a staff member to report a witnessed or suspected incident of exploitation, as required by this policy, is also grounds for disciplinary action.	11-7-25

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company's wellness program.
-By the time the PCA stopped taking him to the store, she was buying approximately $75 worth of groceries to include meat using his SNAP benefits.
-After a while, the PCA started buying more groceries than he was buying.
-He made arrangements with the PCA around May 2025.
-On 2 occasions, the PCA's family member was waiting outside of the grocery store in his car to take the groceries from the PCA.
-When at the grocery store, he had a shopping cart and the PCA had a shopping cart.
-Once the facility Manager found out "what was going on", she stopped the PCA from taking him to the store.
-The facility Manager found out that the PCA was taking him to the store on her own.

Second interview with Resident #1 on 11/06/25 at 12:20pm revealed:
-A second employee who was a medication aide (MA) expected him to bring her peanut butter crackers, soda and bottled water back from the store.
-He offered to bring the MA something back from the store and she asked for peanut butter crackers, soda and bottled water.
-The MA accepted steaks and cases of yoohoo drinks from him.
-The MA did not ask for the steaks; he had them in his small refrigerator freezer and had no way to cook them so he gave them to her.
-He did not recall when he bought the items for the MA from the store or when he gave the MA the steaks and yoohoo drinks.

Interview with the PCA on 11/05/25 at 12:00pm revealed:

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D 338	Continued From page 25 -She used to take Resident #1 to the store in May 2025 and June 2025. -The things Resident #1 wanted to purchase and bring into the facility (hot plates and coffee pots) were not allowed so the facility Manager stopped her from taking him to the store. -She never charged Resident #1 for taking him to the store because that was her job. -Resident #1 offered to buy her food items using his SNAP card but she declined. -Resident #1 bought her a bottled water and she accepted it because she was thirsty -Resident #1 purchased the bottled water using his SNAP card. Second interview with the PCA on 11/06/25 at 11:00am revealed: -When she took Resident #1 to the grocery store, she had a tote, and he had a cart. -She added some things to her tote for her family member and paid for the items herself. -Her family member met her at the grocery store because she had his SNAP card to purchase the items Interview with the Medication Aide (MA) on 11/05/25 at 12:35pm revealed: -Resident #1 would ask staff if they wanted anything from the store when he was first admitted. -She allowed the PCA to take Resident #1 to the store on a Saturday and he brought her back a bulk pack of peanut butter crackers and a 6 pack of soda. -She accepted the items from Resident #1 but did not ask for the items. -Resident #1 bought her family member 2 steaks and they took the steaks home. -She was unsure what agreement Resident #1 and the PCA had.	D 338		

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D 338	Continued From page 26 -She did not know if the facility had a policy regarding accepting things from residents. Interview with the RCC on 11/05/25 at 9:29pm revealed: -The facility Manager took Resident #1 to the store on Monday and Friday. -She took Resident #1 to the store when the facility Manager could not. -Neither she nor the facility Manager required Resident #1 to buy them anything in exchange for taking him to the store. -Staff did not take anything from the residents. -One PCA took Resident #1 to the store in the past. -Resident #1 walked into her office one day and said he was going to call and report that he was being exploited for his food stamps. -Resident #1 was referring to the PCA that took him to the store on the weekend when he spoke with being exploited. -Resident #1 walked and mumbled things like this all the time. -The PCA had not taken Resident #1 to the store in 4 or 5 months. -Resident #1 brought the incident up in October 2025 and states that the PCA used his food stamps. -No Accident/Incident report was done because Resident #1 was just venting. -No one spoke with the PCA about the allegations because she had not taken Resident #1 to the store in 4 or 5 months. -Falls and hospital visits were documented in Accident/Incident reports. -Anything a resident did or said out of the norm for that resident was documented in a progress note. -Resident #1 venting was normal for him. -Resident #1 always walked in her office, vented	D 338		

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D 338	Continued From page 27	D 338		

and walked back out.
-Resident #1 did not come in her office and say the PCA used his food stamp card.
-The Manager was aware of Resident #1's statements because she was at the facility all the time.
-The Manager determined when to notify the Administrator of incidents.

Interview with the facility Manager on 11/05/25 at 10:12am revealed:
-She took Resident #1 shopping every Monday and Friday so he could buy what he wanted.
-The PCA used to take Resident #1 to the store, but she changed that because she could not afford to have a staff member leave the facility on the weekend.
-Resident #1 constantly followed the PCA asking if she could take him to the store.
-She did not recall when the PCA last took Resident #1 to the store.
-She did not recall when she started taking Resident #1 to the store twice a week.
-She received a note from Resident #1 regarding being required to buy groceries for someone taking him to the store but did not recall the date she received the note.
-After receiving the note from Resident #1 about him being required to buy groceries for someone taking him to the store, she told him she would take him to the store from then on and no one else was allowed to take him shopping.
-When Resident #1 came back from the store with the PCA, he told staff and other residents that he bought stuff for them.
-The PCA told her Resident #1 offered to buy her something "as a gesture" for her taking him to the store and she accepted it.
-She did not recall what items the PCA accepted from Resident #1.

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D 338	Continued From page 28 -She was unsure if there was a policy regarding accepting things from residents. -She told staff not to accept anything from residents. -The PCA was no longer allowed to take Resident #1 to the store. -The Administrator was not aware the PCA accepted anything from Resident #1 when she took him shopping. Interview with the Administrator on 11/05/25 at 3:20pm revealed: -She was not aware Resident #1 was going to the grocery store. -She was not aware Resident #1 was buying food items for staff members. -She was not aware staff were accepting food items from Resident #1. -Staff were not supposed to accept things from residents. -She was unsure if there was a policy regarding staff accepting things from residents. -She was not aware of any arrangements made between Resident #1 and the PCA for Resident #1 to go to the grocery store on Saturdays. -She and the facility Manager talked almost daily. -The facility Manager reported to her situations she had a hard time handling or needed advice on. -The facility Manager should have investigated the allegations of exploitation. -Any time goods were received in exchange for services, it was considered exploitation.	D 338		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry	D 438		

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D 438	Continued From page 29 The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed report allegations of exploitation to the Health Care Personnel Registry (HCPR) for 1 of 3 staff (Staff A). The findings are: Review of Resident #1's current FL-2 dated 04/30/25 revealed diagnoses included multiple sclerosis (MS), coronary artery disease (CAD), hypertension, benign prostatic hyperplasia (BPH), atrial fibrillation with rapid ventricular response (A-fib with RVR), and gastroesophageal reflux disorder (GERD). Review of Staff A's Personal Record revealed: -She was hired as a PCA on 05/29/23. -The facility completed a criminal background check on Staff A on 05/29/23. -The facility completed a Health Care Personnel Registry (HCPR) check on Staff A on 05/29/23. Interview with Resident #1 on 11/05/25 at 2:19pm revealed: -The facility Manager took him to the store so he could buy his own groceries on Monday and Friday. -The Resident Care Coordinator (RCC) took him to the grocery store a few times. -Before the facility Manager started taking him to the store twice a week, he made an arrangement with a personal care aide (PCA) to get to the grocery store on Saturday. -The arrangement he made with the PCA was	D 438	Any staff member who witnesses, hears of, or suspects an instance of resident abuse, neglect, drug diversion, or fraud must immediately report the allegation verbally to the manager or RCC. The staff member must document the allegation, including the date, time, location, persons involved, and a detailed description of the event, and submit this report to the manager or RCC no later than the end of their shift. Upon receiving the allegation, the manger or RCC must: Ensure the resident(s) involved are immediately protected and safe and Initiate an internal investigation immediately. The manager or RCC is responsible for ensuring that the allegation is reported to the North Carolina Health Care Personnel Registry within twenty-four hours of the allegation being made known to the facility. The report shall be submitted using the DHSR reporting portal or form. Reports must contain all available information regarding the allegation and the identity of the alleged perpetrator, including their job title and any relevant license or certification information. The final results of the facility's investigation, including a determination as to whether the allegation was substantiated, will be submitted to the HCPR with 5 days. All documentation related to the allegation, the internal investigation, and the reporting to the HCPR shall be maintained in facility.	11/7/25

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D 438	Continued From page 30 that he would buy her something if she took him to the grocery store on Saturday. -The PCA expected him to buy her grocery in exchange for taking him to the grocery store. -The PCA started out getting a few items such as bottled water and blueberry muffins. -At the time, he received $235 per month from the Supplemental Nutrition Assistance Program (SNAP) and $352 per month from his insurance company's wellness program. -By the time the PCA stopped taking him to the store, she was using his SNAP benefits to buy approximately $75 worth of groceries to include meat. -After a while, the PCA started buying more groceries than he was buying. -He made the arrangement with the PCA around May 2025. -On 2 occasions, the PCA's family member was waiting outside of the grocery store in his car to take the groceries from the PCA. -When at the grocery store, he had a shopping cart and the PCA had a shopping cart. -Once the facility Manager found out "what was going on", she stopped the PCA from taking him to the store. -The facility Manager found out that the PCA was taking him to the store on her own. Interview with the PCA on 11/05/25 at 12:00pm revealed: -She used to take Resident #1 to the store in May 2025 and June 2025. -The things Resident #1 wanted to purchase and bring into the facility (hot plates and coffee pots) were not allowed so the facility Manager stopped her from taking him to the store. -She never charged Resident #1 for taking him to the store because that was her job. -Resident #1 offered to buy her food items using	D 438	con't. This will be monitored on an as needed basis by manger or RCC	

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D 438	Continued From page 31	D 438		

his SNAP card but she declined.
-Resident #1 bought her a bottled water and she accepted it because she was thirsty
-Resident #1 purchased the bottled water using his SNAP card.

Second interview with the PCA on 11/06/25 at 11:00am revealed:
-When she took Resident #1 to the grocery store, she had a tote, and he had a cart.
-She added some things to her tote for her family member and paid for the items herself.
-Her family member met her at the grocery store because she had his SNAP card to purchase the items

Interview with the RCC on 11/05/25 at 9:29pm revealed:
-The facility Manager took Resident #1 to the store on Monday and Friday.
-She took Resident #1 to the store when the facility Manager could not.
-Neither she nor the facility Manager required Resident #1 to buy them anything in exchange for taking him to the store.
-Staff did not take anything from the residents.
-One PCA took Resident #1 to the store in the past.
-Resident #1 walked into her office one day and said he was going to call and report that he was being exploited for his food stamps.
-Resident #1 was referring to the PCA that took him to the store on the weekend when he spoke with being exploited.
-Resident #1 made statements like this all the time.
-The PCA had not taken Resident #1 to the store in 4 or 5 months.
-Resident #1 brought the incident up in October 2025 and states that the PCA used his food

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stamps.
-No Accident/Incident report was done because Resident #1 was just venting.
-The Manager was aware of Resident #1's statements because she was at the facility all the time.
-No one spoke with the PCA about the allegations because she had not taken Resident #1 to the store in 4 or 5 months.
-Falls and hospital visits were documented in Accident/Incident reports.
-Anything a resident did that was not normal behavior for that resident was documented in a progress note.
-Resident #1 venting was normal for him.
-Resident #1 always walked in her office, vented and walked back out.
-Resident #1 did not come in her office and say the PCA used his food stamp card.
-The Manager determined when to notify the Administrator of incidents.

Second interview with the RCC on 11/06/25 at 11:54am revealed:
-She was not familiar with HCPR reporting.
-She never had to complete a report to the HCPR.
-She did not recall having HCPR training.
-She did not think to report Resident #1's statements to management or the HCPR.

Interview with the facility Manager on 11/05/25 at 10:12am revealed:
-She took Resident #1 shopping every Monday and Friday so he could buy what he wanted.
-The PCA used to take Resident #1 to the store, but she changed that because she could not afford to have a staff member leave the facility on the weekend.
-Resident #1 constantly followed the PCA asking

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if she could take him to the store.
-She did not recall when the PCA last took Resident #1 to the store.
-She did not recall when she started taking Resident #1 to the store twice a week.
-She received a note from Resident #1 regarding being required to buy groceries for someone taking him to the store but did not recall the date she received the note.
-After receiving the note from Resident #1 about him being required to buy groceries for someone taking him to the store, she told him she would take him to the store from then on and no one else was allowed to take him shopping.
-When Resident #1 came back from the store with the PCA, he told staff and other residents that he bought stuff for them.
-The PCA told her Resident #1 offered to buy her something "as a gesture" for her taking him to the store and she accepted it.
-She did not recall what items the PCA accepted from Resident #1.
-She was unsure if there was a policy regarding accepting things from residents.
-She told staff not to accept anything from residents.
-The PCA was no longer allowed to take Resident #1 to the store.
-The Administrator was not aware the PCA accepted anything from Resident #1 when she took him shopping.

Second interview with the facility Manager on 11/06/25 at 10:23am revealed:
-She was responsible for reporting to the HCPR.
-Abuse, neglect and exploitation were reported to HCPR.
-She considered reporting to HCPR when Resident #1 was buying groceries for Staff A but did not report it because Resident #1 said he

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offered to buy the groceries.
-She did not report to the HCPR because the groceries purchased for Staff A were a gift according to what Resident #1 explained to her.
-Resident #1 told her he offered to buy Staff A groceries if she took him to the store and Staff A accepted the offer.
-She spoke with Staff A and Staff A stated she accepted a drink from Resident #1
-Staff were not supposed to make arrangements with residents in exchange for anything because that was exploitation.
-She found out about the arrangement between Resident #1 and Staff A when Resident #1 wrote her a letter.
-She did not remember the date Resident #1 wrote the letter to her regarding an arrangement between him and Staff A.
-Resident #1 made statements about exploitation to the RCC the same day he wrote the letter.
-The RCC was supposed to notify her of Resident #1's statements but she had already spoken with Resident #1.
-She should have reported the incident to the HCPR but made the decision not to report it.
-The Administrator was not aware of the statements regarding Resident #1 being exploited until 11/05/25.

Interview with the Administrator on 11/05/25 at 3:20pm revealed:
-She was not aware Resident #1 was going to the grocery store.
-She was not aware Resident #1 was buying food items for staff members.
-She was not aware staff were accepting food items from Resident #1.
-Staff were not supposed to accept things from residents.
-She was unsure if there was a policy regarding

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D 438	Continued From page 35 staff accepting things from residents. -She was not aware of any arrangement made between Resident #1 and the PCA for Resident #1 to go to the grocery store on Saturdays. -She and the facility Manager talked almost daily. -The facility Manager reported to her situations she had a hard time handling or needed advice on. Second interview with the Administrator on 11/06/25 at 10:40am revealed: -Abuse, neglect and exploitation were reported to the HCPR. -She did not report the allegations of Resident #1 being exploited by Staff A because she did not know the incident occurred until 11/05/25. -She was not at the facility when Resident #1 made the statements about being exploited and the incident was not reported to her. -The facility Manager was responsible for reporting to the HCPR. -The facility Manager should have investigated the allegations and reported the incident to the HCPR. -Any time goods were received in exchange for services, it was considered exploitation. -The incident between Resident #1 and Staff A needed to be reported to the HCPR.	D 438		