| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| NORTH POINTE OF MAYODAN | 6970 NC HWY 135 MAYODAN, NC 27027 |

| (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 |
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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted an annual survey and follow-up survey on 10/21/25 to 10/23/25. | D 000 | | |
| D 067 | 10A NCAC 13F .0305 (h)(4) Physical Environment<br><br>10A NCAC 13F .0305 Physical Environment<br><br>(h) The requirements for outside entrances and exits are:<br>(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.<br><br>This Rule is not met as evidenced by:<br>TYPE A2 VIOLATION<br><br>Based on observations, interviews, and record reviews, the facility failed to ensure 3 of 8 exit doors had engaged audible alarms that were accessible to four residents who were intermittently disoriented (#1, #3, #4 and #6) including a resident (#6) who left the facility without staff knowledge and was returned by local | D 067 | SCUC/Director will keep list of known disoriented or wanderers and it will be available to staff.<br><br>Director/Administrator re-trained staff on Door Alarm Policy (staff will go to alarmed door to see who went out).<br><br>Director/SIC will ensure each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened.<br><br>Director/Designee will check door alarms per the manufacturers recommendations at least monthly to assure they are working properly. If found that alarms are not working, vendor will be contacted immediately to repair. | 11/22/2025 |



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mandi Powell, ED

TITLE: Administrator

(X6) DATE: 12/5/25



Reviewed and acknowledged. PD 12/15/25

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| D 067 | Continued From page 1<br>law enforcement.<br><br>The findings are:<br><br>Observations of the Assisted Living (AL) side of the facility from 10/21/25 to 10/23/25 at various times between 8:00am and 6:15pm revealed:<br>-On 10/21/25, the main front door to the facility led to a parking lot that was next to a main road for the area.<br>-The main front door to the facility was not alarmed.<br>-Visitors, residents and staff entered and exited the front doors.<br>-Residents were observed sitting on the front porch alone.<br>-There was a back door that opened to an area with a porch for residents to smoke that was not alarmed.<br>-There was sidewalk and a parking lot backed by a wooded area off the back porch where the smoking area was.<br>-Residents and staff were observed entering and exiting the back door.<br>-Residents were observed sitting in the smoking area without staff supervision.<br>-There was a door in the employee break room that opened to the back porch and smoking area.<br>-There was a keypad at the employee break room door, and staff were entering and exiting the break room door without entering a code on the keypad.<br>-On 10/22/25, the main front door to the facility was not alarmed.<br>-Visitors, residents and staff entered and exited the front doors and were observed sitting on the front porch.<br>-The door in the employee breakroom was not locked and not alarmed.<br>-The back door to the smoking area and back | D 067 | | |

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porch was not alarmed; staff and residents went in and out during the day.
-On 10/23/25, the main front door, the back door to the smoking area and the employee breakroom door were not alarmed.
-Residents were observed going in and out of the three doors, including the employee breakroom door, without staff supervision.

1. Review of Resident #6's current FL2 dated 08/03/25 revealed:
-Diagnoses included hypertension, osteopenia and Alzheimer's disease.
-She was intermittently disoriented.

Telephone interview with Resident #6's power of attorney (POA) on 10/23/25 at 11:50am revealed:
-The entry doors to the facility were not alarmed during the day.
-He had not heard the alarm when he visited during the day.
-It was his understanding the doors were only alarmed at night.
-He asked the Executive Director (ED) how the door alarms worked, and he was told there was an alarm panel that was activated when a resident went out of an alarmed door.
-The staff were supposed to respond to see who went out of the alarmed door.
-Resident #6 walked away from the facility on 10/12/25 and was returned to the facility by the local police.
-Resident #6 walked out of a door that was not alarmed because staff had turned the alarm off.

Confidential telephone interview with a staff member revealed:
-Resident #6 walked all the way to a local fast-food restaurant a "couple of weeks" ago.
-Two policeman showed up at the facility with the

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resident.
-The alarms had not been set, and the doors had not been locked.
-It was dark and raining on the evening Resident #6 left the facility.

Confidential interview with a second staff revealed:
-Resident #6 walked out of the facility without staff knowledge because the doors were not alarmed.
-The doors were not alarmed in the evening prior to Resident #6 leaving the facility.
-The doors were not alarmed or locked on second shift; third shift staff locked and alarmed the doors after all the staff arrived for their shifts.
-The ED told the facility staff to start locking and alarming the doors the evenings on second shift after the incident on 10/12/25, where Resident #6 was returned to the facility by the police.

Interview with a housekeeper on 10/23/25 at 2:35pm revealed:
-About two to three months ago she saw Resident #6 outside of the facility alone.
-Resident #6 was on the sidewalk next to the parking lot.
-She knew Resident #6 should not be outside by herself, so she went out to get her.
-She went outside and brought Resident #6 inside; the resident had no problem following her back inside.
-She did not think Resident #6 should be outside alone because it was a safety issue.
-There was a busy road in front of the facility and Resident #6 should not be on or near the busy road.
-She let the ED know she found Resident #6 outside and brought her back into the facility.

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Interview with a medication aide (MA) on 10/23/25 at 1:40pm revealed:
-She worked second shift and was working from 2:30pm to 11:00pm on 10/12/25, when Resident #6 was brought back to the facility by the local police.
-She and the other MA did not know Resident #6 was out of the facility until the police officers brought her back.
-She asked Resident #6 where she was going when the police officers found her; Resident #6 was confused, she said she was going home and gave her previous house address.
-There was no telling when the facility staff would have realized Resident #6 was missing if the police officers had not brought her back.
-The front doors, employee entrance and smoking area door were not alarmed until after third shift staff arrived and the second shift left for the day.
-Third shift MAs and staff began showing up around 10:00pm and the last staff came in around 11:00pm.
-The third shift staff set the alarms for the evening; she had never set the door alarms on second shift.

Interview with the Special Care Unit Coordinator (SCC) on 10/23/25 at 1:40pm revealed:
-Resident #6 would sit outside on the front porch and not try to walk away.
-One day in June 2025 a housekeeper found Resident #6 outside at the edge of the parking lot but not in the parking lot.
-She had not noticed any increased confusion in Resident #6.
-The staff should constantly be walking around and always be aware of where the residents were.
-If Resident #6 had increased confusion, then the

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staff should have increased their monitoring of her.
-She was not aware of Resident #6 leaving the facility at night before the incident on 10/12/25.

Interviews with the ED on 10/23/25 at 8:15am and 12:25pm revealed:
-About a week ago, 10/12/25, Resident #6 walked out of the facility to a local restaurant.
-The police brought her back to the facility before 11:00pm after she told them her name and her address.
-The facility staff did not know Resident #6 had left the facility and the property until the police brought her back.
-Resident #6 must have gone outside during the time the staff had turned off the door alarm for the front door during shift change or when two personal care aides (PCAs) placed a pumpkin on the front porch and did not reset the alarm.
-Resident #6 was usually quiet and would walk around the facility with her sweater and her purse; she would say she was going home.
-Resident #6 lived at the facility for over three years and had tried to walk out of the facility before.
-When Resident #6 walked outside in the past, the staff would see her and go get her; Resident #6 would tell the staff she was going home when they asked why she was outside.
-The farthest the resident had walked was to the parking lot when she went to a white car she thought was hers and said she was going to drive it home; that was about a year ago.
-The staff realized they needed to watch Resident #6 after she was found in the parking lot beside someone else's car.
-The staff were required to go outside with Resident #6 after she was found in the parking lot.

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-There was an incident with Resident #6 one night in the early spring of 2025 between 9:00pm and 10:00pm.
-The staff had disarmed the front door for her to leave, and Resident #6 went outside undetected while the door was not alarmed.
-Resident #6 went outside to the parking lot alone; she saw the resident walking out ahead of her.
-She called the facility from the parking lot and told the MA Resident #6 "walked right out past you".
-When the staff brought Resident #6 back inside the facility the resident told the staff she was going home and told them her former address.
-Resident #6 was admitted to the facility with a dementia diagnosis so she knew she would have to move Resident #6 to the SCU at some point.

Attempted telephone interview with Resident #6's primary care provider (PCP) on 10/23/25 at 1:10pm was unsuccessful.

Based on observations, interviews and record reviews it was determined Resident #6 was not interviewable.

Refer to the interview with the facility's contracted mental health provider (MHP) on 10/22/25 at 9:50am.

Refer to the interview with the facility's contracted primary care provider (PCP) on 10/22/25 at 4:35pm.

Refer to the interview with three residents in the AL on 10/22/25 at 10:10am.

Refer to the interview with a fourth resident in the AL on 10/23/25 at 12:16pm.

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| D 067 | Continued From page 7<br><br>Refer to the interview with a PCA on 10/22/25 at 10:30am.<br><br>Refer to the interview with a second PCA on 10/22/25 at 10:35am.<br><br>Telephone interview with a third PCA on 10/22/25 at 10:02pm.<br><br>Refer to the interview with a MA on 10/22/25 at 10:45am.<br><br>Refer to the interview with a second MA on 10/23/25 at 2:00pm.<br><br>Refer to interview with the SCC on 10/22/25 at 2:40pm.<br><br>Refer to interview with the ED on 10/22/25 at 2:19pm and 4:55pm.<br><br>Refer to the interview with the ED on 10/23/25 at 12:25pm.<br><br>Refer to the telephone interview with the Administrator on 10/22/25 at 12:20pm.<br><br>2. Review of Resident #1's current FL2 dated 02/04/25 revealed:<br>-Diagnoses included dementia.<br>-Resident #1 was intermittently disoriented.<br><br>Interview with Resident #1 on 10/23/25 at 3:30pm revealed:<br>-He did not go out of the facility unless he had someone with him.<br>-He went out to see his primary care provider (PCP) but went with someone from the facility. | D 067 | | |

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Interview with a personal care aide (PCA) on 10/22/25 at 10:28am revealed:
-Resident #1 did not wander.
-He was confused sometimes; sometimes he would forget to put on a pull-up or refuse care.

Telephone interview with Resident #1's PCP on 10/22/25 at 2:00pm revealed:
-Resident #1 was usually cognitively intact.
-Resident #1 had long-term memory loss.
-He did not have concerns that Resident #1 would wander away from the facility.
-He thought it was a good idea to have alarms on the entrance and exit doors for other residents that were confused.

Refer to the interview with the facility's contracted mental health provider (MHP) on 10/22/25 at 9:50am.

Refer to the interview with the facility's contracted PCP on 10/22/25 at 4:35pm.

Refer to the interview with three residents in the AL on 10/22/25 at 10:10am.

Refer to the interview with a fourth resident in the AL on 10/23/25 at 12:16pm.

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

Refer to the interview with a second PCA on 10/22/25 at 10:35am.

Telephone interview with a third PCA on 10/22/25 at 10:02pm.

Refer to the interview with a medication aide (MA) on 10/22/25 at 10:45am.

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Refer to the interview with a second MA on 10/23/25 at 2:00pm.

Refer to interview with the Special Care Unit Coordinator (SCC) on 10/22/25 at 2:40pm.

Refer to interview with the Executive Director (ED) on 10/22/25 at 2:19pm and 4:55pm.

Refer to the interview with the ED on 10/23/25 at 12:25pm.

Refer to the telephone interview with the Administrator on 10/22/25 at 12:20pm.

3. Review of Resident #3's current FL-2 dated 07/23/25 revealed:
-Diagnoses included cerebral palsy, paranoid schizophrenia and hallucinations.
-He resided in the assisted living (AL).
-Resident #3 was intermittently disoriented.

Interview with Resident #3 on 10/23/25 at 12:15pm revealed he could go outside by himself anytime he wanted to and did not have to tell staff or ask permission.

Interview with a personal care aide (PCA) on 10/21/25 at 8:51am revealed:
-Resident #3 was alert and orient; he would organize bingo games and call bingo numbers.
-He would refuse personal care at times.
-He wanted to do things for himself.
-He did not try to leave the facility.

Interview with a medication aide (MA) on 10/21/25 at 10:45am revealed:
-Resident #3 wanted to be independent and was determined to do as much as he could for

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himself.
-Resident #3 stayed in his room, he would sit in the smoking area, and he would participate in activities.
-Resident #3 would hallucinate but he did not try to leave the facility or go into the parking lot.

Interview with the Special Care Unit Coordinator (SCC) on 10/22/25 at 2:40pm revealed:
-Resident #3 was cognitive; his confusion was due to his hallucinations.
-He would hear things that were not there or see things that were not there.
-He did activities with other residents and sat outside at times, but he did not try to leave the facility.
-She was not concerned about him walking away from the facility.

Attempted telephone interview with Resident #3's PCP on 10/23/25 at 1:10pm was unsuccessful.

Refer to the interview with the facility's contracted mental health provider (MHP) on 10/22/25 at 9:50am.

Refer to the interview with the facility's contracted PCP on 10/22/25 at 4:35pm.

Refer to the interview with three residents in the AL on 10/22/25 at 10:10am.

Refer to the interview with a fourth resident in the AL on 10/23/25 at 12:16pm.

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

Refer to the interview with a second PCA on 10/22/25 at 10:35am.

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| D 067 | Continued From page 11<br><br>Telephone interview with a third PCA on 10/22/25 at 10:02pm.<br><br>Refer to the interview with a MA on 10/22/25 at 10:45am.<br><br>Refer to the interview with a second MA on 10/23/25 at 2:00pm.<br><br>Refer to interview with the SCC on 10/22/25 at 2:40pm.<br><br>Refer to interview with the Executive Director (ED) on 10/22/25 at 2:19pm and 4:55pm.<br><br>Refer to the interview with the ED on 10/23/25 at 12:25pm.<br><br>Refer to the telephone interview with the Administrator on 10/22/25 at 12:20pm.<br><br>4. Review of Resident #4's current FL2 dated 10/09/25 revealed:<br>-Diagnoses included arthritis, insomnia, and right lumbar radiculopathy.<br>-Resident #4 was intermittently disoriented.<br><br>Interview with Resident #4 on 10/24/25 at 9:48am revealed:<br>-She did not leave the facility alone.<br>-She went out to her primary care provider's (PCP) office and went out with her daughter.<br><br>Interview with the Executive Director (ED) on 10/22/25 at 4:55pm revealed:<br>-Resident #4 was high functioning.<br>-Resident #4 went out with her daughter but she did not try to leave the facility.<br>-Resident #4 kept to herself. | D 067 | | |

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| D 067 | Continued From page 12<br><br>Attempted telephone interview with Resident #4's PCP on 10/22/25 at 10:56am was unsuccessful.<br><br>Refer to the interview with the facility's contracted mental health provider (MHP) on 10/22/25 at 9:50am.<br><br>Refer to the interview with the facility's contracted primary care provider (PCP) on 10/22/25 at 4:35pm.<br><br>Refer to the interview with three residents in the AL on 10/22/25 at 10:10am.<br><br>Refer to the interview with a fourth resident in the AL on 10/23/25 at 12:16pm.<br><br>Refer to the interview with a personal care aide (PCA) on 10/22/25 at 10:30am.<br><br>Refer to the interview with a second PCA on 10/22/25 at 10:35am.<br><br>Refer to the interview with a medication aide (MA) on 10/22/25 at 10:45am.<br><br>Refer to the interview with a second MA on 10/23/25 at 2:00pm.<br><br>Telephone interview with a third PCA on 10/22/25 at 10:02pm.<br><br>Refer to interview with the Special Care Unit Coordinator (SCC) on 10/22/25 at 2:40pm.<br><br>Refer to interview with the ED on 10/22/25 at 2:19pm and 4:55pm.<br><br>Refer to the interview with the ED on 10/23/25 at | D 067 | | |

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| D 067 | Continued From page 13<br>12:25pm.<br><br>Refer to the telephone interview with the Administrator on 10/22/25 at 12:20pm.<br>_____<br>Interview with the facility's contracted mental health provider (MHP) on 10/22/25 at 9:50am revealed:<br>-She did not know of any of the residents in the facility who would try to exit the facility from the AL.<br>-The residents in the AL were free to go outside and were not monitored while outside.<br>-The doors were not alarmed in the AL, and she had never heard the alarms going off.<br><br>Interview with the facility's contracted primary care provider (PCP) on 10/22/25 at 4:35pm revealed:<br>-The doors to the facility did not have alarms when he visited the facility.<br>-There were no residents in the AL with exit seeking or wandering behaviors.<br>-If there were residents who were identified as disoriented and had exit seeking behaviors then the staff would need to be around and put the door alarms into place.<br><br>Interview with three residents in the AL on 10/22/25 at 10:10am revealed:<br>-They had never heard the alarms on the front or back doors to the facility.<br>-They had never tried to go outside at night because they were told the doors were either locked or alarmed.<br>-They could go outside and sit on the front porch anytime they wanted during the daytime.<br>-They could sit on the front porch alone.<br>-Staff did not check on them while they were outside. | D 067 | | |

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| D 067 | Continued From page 14<br><br>Interview with a fourth resident in the AL on 10/23/25 at 12:16pm revealed:<br>-He smoked and could go outside to the smoking porch anytime he wanted.<br>-Sometimes there were other residents who did not smoke sitting outside on the smoking porch with him.<br>-Staff were never with him when he smoked unless they were smoking too.<br>-He used the back door or the door in the employee breakroom to go to the smoking porch.<br>-The doors were never alarmed.<br>-He did not know if the doors were locked at night because he only smoked one or two times after dinner and did not go back outside.<br><br>Interview with a personal care aide (PCA) on 10/22/25 at 10:30am revealed:<br>-The residents from the AL could go outside and smoke on the back porch anytime they wanted.<br>-Staff did not have to be outside with the residents from the AL while they smoked.<br>-The doors to the facility were locked during the night but she was not sure when.<br>-She had not heard door alarms for the front or back doors.<br><br>Interview with a second PCA on 10/22/25 at 10:35am revealed:<br>-The residents in the AL could go outside during the day.<br>-The residents did not need to be supervised while outside.<br>-There were some confused residents in the AL, but no one needed to be watched while they were outside.<br>-She was not sure if the residents were allowed to go outside at night.<br>-She thought the doors were all locked at night, | D 067 | | |

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but she did not know what time.

Telephone interview with a third PCA on 10/22/25 at 10:02pm revealed:
-There were 5 residents who got up at night and had to be watched.
-One of the residents had psychotic episodes, one had memory loss, and the third resident had a "good mind" but went to the doors at night.
-A fourth resident got up at night and was confused.
-A fifth resident "crawled" up and down the hall and staff kept an eye on her too.

Interview with a medication aide (MA) on 10/22/25 at 10:45am revealed:
-The residents could go outside unsupervised and sit on the front or back porch any time they wanted during the day.
-The residents did not go outside to smoke after 7:00pm; it was the residents' choice.
-The doors were locked every night at 8:00pm but they were not alarmed just locked.
-There was a resident who was confused about the layout on the AL side and could not find her room.
-Staff would have to redirect her around the facility.
-The resident was allowed to sit on the front porch unsupervised, but staff usually sat with her.
-She could come into the facility from the porch on her own, but she could not find her own room.
-She had never tried to walk off the front porch.
-There was a resident in the AL who would check the doors at night to see if they were locked but she never went out of one.
-The emergency exits were always alarmed but the front and back doors were not alarmed.
-The door in the employee breakroom was not alarmed, and some residents went out the

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breakroom door to the back porch to smoke.

Interview with a second MA on 10/23/25 at 2:00pm revealed:
-The front and back doors were only locked at night and not alarmed until a resident left the facility on 10/12/25 and the police brought her back.
-After 10/12/25, the Executive Director (ED) wanted the alarms on the doors turned on at night.
-The door alarms were turned on around 11:00pm when the last of the staff came into the building for third shift.
-The second shift staff had never locked or alarmed the front doors until the resident walked out on 10/12/25.
-The staff came in and left through the front door and the employee breakroom.
-The employee breakroom had a keypad, but the door was always unlocked and not alarmed so the keypad was not needed.
-Residents used the door in the employee breakroom to go outside.

Interview with the Special Care Unit Coordinator (SCC) on 10/22/25 at 2:40pm revealed:
-The front and back doors were not alarmed during the day because of the high amount of traffic coming in and out of the facility.
-The front door alarm was turned on between 7:00pm and 8:00pm when the door was locked and turned off between 6:30am and 7:00pm when the door was unlocked; the door alarm was continuous until it was disarmed at a panel.
-She was not sure if the doors could be opened from the inside once they were locked.
-There were no resident concerns about anybody going out the front door because there were no exit seekers or wandering residents.

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-She also covered the AL so she knew there were no residents who were identified as intermittently or constantly disoriented in the AL; if they were they would be in the Special Care Unit (SCU).

Interviews with the ED on 10/22/25 at 2:19pm and 4:55pm revealed:
-The front door and the back door alarms were bypassed during the day.
-They had moved confused residents from AL to the SCU to make sure the residents were always secured.
-Staff were trained when the door alarm was heard they were to walk outside and look around.
-The staff locked the front and back doors and set the door alarms at 8:30pm and turned them off at 6:00am.
-The doors were not alarmed during the day because of the number of people including vendors, deliveries and visitors that came in and out of them.
-None of the residents tried to leave.
-There was one resident who would try to open the doors because she had dementia, but she was in a wheelchair and could not open the doors.
-There was a second resident who was confused and was constantly looking for her family member, but she never tried to leave the facility.
-The second resident would get more confused after the family member visited and left.
-The employee breakroom had a keypad for the staff to use when they entered and left the facility.

Interview with the ED on 10/23/25 at 12:25pm revealed:
-There were only three residents identified as consistently or intermittently disoriented on the AL side of the facility.
-She had not audited the residents' record in the

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| D 067 | Continued From page 18<br><br>AL side to see if there were any other residents who were identified as disoriented; she was only going based on personal observation.<br>-There had only been one elopement from the facility and that was earlier in the month.<br>-She did not alarm the doors in the AL during the day because she thought if she was in the process of moving disoriented residents to the SCU she did not have to alarm the doors.<br>-She had begun the process of moving the residents who were identified on the FL-2 and confused from the AL to the SCU once it was brought to her attention on 10/22/25; she had not done a review of FL-2s for all the residents in the AL yet.<br>-The entrance door and the door to the smoking area were not alarmed during the day.<br>-The door to the employee breakroom did not have to be alarmed because it had a keypad.<br>-About two weeks ago the employees were instructed to park at the back of the building and to use the employee breakroom door for second and third shifts so the alarm on the front door would not need to be turned off when the employees were coming and leaving for their shifts.<br><br>Telephone interview with the Administrator on 10/22/25 at 12:20pm revealed:<br>-The doors on the AL side of the facility were locked every evening around 8:00pm or 9:00pm and unlocked at 7:00am.<br>-The front door and the smoking area door were not alarmed during the day.<br>-The residents had the right to go outside anytime they wanted during the day.<br>-The doors were only alarmed after they were locked at night.<br>-There were no exit seeking residents and no wandering residents to her knowledge. | D 067 | | |

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| D 067 | Continued From page 19<br><br>-She knew there were residents with dementia diagnoses in the AL.<br>-She was not familiar with the rule area for door alarms and would have to verify the rule to see if there were residents at risk.<br>-Her concern would be that if there were residents identified as disoriented it could pose a risk to the resident.<br>-The facility focused on exit seeking behaviors and residents who wandered.<br>-If a resident was identified as a wanderer, they would assign one on one PCA coverage and move them to the SCU.<br>-The residents would need to be evaluated and moved to the SCU or the facility would have to set the door alarms all day; whichever was best for the residents.<br><br>_____<br>The facility failed to ensure 3 of 8 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 unsupervised and without staff's knowledge. A resident (#6), who was intermittently disoriented, without staff's knowledge left the facility through a door that was not alarmed, walked to a local restaurant and was returned to the facility by local law enforcement before staff realized she was gone. The facility's failure resulted in a substantial risk for serious physical harm to the residents and constitutes a Type A2 Violation.<br><br>_____<br>The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 10/22/25.<br><br>CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 22, 2025. | D 067 | | |

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| D 074 | Continued From page 20 | D 074 | | |
| D 074 | 10A NCAC 13F .0306 (a)(1) Housekeeping And Furnishings<br><br>10A NCAC 13F .0306 Housekeeping And Furnishings<br><br>(a) Adult care homes shall:<br>(1) have walls, ceilings, and floors or floor coverings that are clean, safe, and functional; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities.<br><br>This Rule is not met as evidenced by:<br>Based on observation, interviews, and record review, the facility failed to ensure the floors in the facility were kept clean and in good repair related to the carpet in the assisted living.<br><br>The findings are:<br><br>1. Observation of the facility on 10/21/25 at 8:53am revealed:<br>-There was an odor in the hallways.<br>-The carpet in the hallways was soiled and appeared dark in color.<br>-At the door thresholds of 13 occupied rooms, the | D 074 | Facility had already requested quote for the flooring to be replaced. Facility was waiting on quote to be sent for review.<br><br>Per the flooring company the flooring is on backorder until the beginning of 2026. Install date is scheduled for 1/15/2026 | 12/7/2025 |

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carpet was almost black in color.
-Outside of the activity room, laundry room, parlor, and dining room, the carpet appeared dark in color.

Interview with a family member on 10/21/25 at 3:17pm revealed:
-She visited when she could.
-The carpet was old and dirty.
-There were odors in the hallways and the resident rooms.
-She had never seen anyone shampooing the carpets.

Interview with a second family member on 10/21/25 at 3:42pm revealed:
-She thought the carpet in the facility was very dirty.
-The carpet also had an odor.
-The carpet was very old and difficult to clean.
-She thought the carpet needed to be replaced.
-She had seen the housekeeper shampoo the carpet but she was using a small household shampooer and she felt like they needed a more industrial cleaner.

Interview with a personal care aide (PCA) on 10/21/25 at 4:05pm revealed:
-The carpet in the entire facility needed to be replaced.
-The carpet was old and dirty and it made the facility have odors.

Interview with a medication aide (MA) on 10/21/25 at 4:15pm revealed:
-The carpet in the facility was old and dirty.
-The residents, staff, and family members would all benefit from the carpet being replaced.
-There were odors in the facility that she believed were from the dirty carpet.

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-She had seen the housekeeper using the carpet shampooer but she thought the machine was too small for the facility.

Interview with the housekeeper on 10/21/25 at 12:07pm revealed:
-She was the only housekeeper for the facility.
-The carpet was old, and it was dirty.
-It was hard to clean the residents' rooms and keep the carpet clean.
-She had a carpet shampooer that she used but she did not use it every day.
-The last time she used the carpet shampooer was about a month ago.
-If she had more help, she could do more.

Interview with the Maintenance Director on 10/22/25 at 9:13am revealed:
-He worked a few days a week at the facility.
-The carpet in the facility was old.
-There was a lot of foot traffic in the facility and that contributed to the dirty carpet.
-He thought something needed to be done; hard flooring would be a better option.
-When he could, about once a month, he helped shampoo the carpet.
-The Director was aware of the condition of the carpet.
-He did not know if anything was being done about the condition of the carpet in the facility.

Interview with the Executive Director (ED) on 10/21/25 at 11:53am revealed:
-There was only one housekeeper for the whole facility.
-The Maintenance Director divided his time between two facilities.
-There was not a policy on how often the carpet should be shampooed.
-The housekeeper and the Maintenance Director

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both shampooed the carpet, but she did not know how often.
-The carpet was very old and needed to be replaced.

Interview with the Administrator on 10/22/25 at 12:07pm revealed:
-She did not know the schedule of when and how often the carpets were shampooed.
-She did not notice the carpet being excessively dirty.
2. Observation of the carpeting on the assisted living (AL) in the facility on 10/21/25 at 11:20am revealed:
-There was a one-and-a-half-foot long tear in the carpet in the hallway in front of a conference room.
-The edges of the tear were frayed and had begun to curl up.
-There were two sections of the carpet in the entryway that were frayed.
-There was a section of the carpet that ran the width of the hallway that had a role in it and was also pulling up.
-There was a one-foot-long separation in the carpet near the employee breakroom that was lifting and was frayed.

Review of the facility's environmental inspection report from the local county health department dated 09/11/25 revealed:
-There was a note that the carpet was splitting in the hallway near resident rooms, the intersections of the hallways near the nurses' station, near the whirlpool room, the activity room and the main entrance hallway.
-No demerits were given for the condition of the carpets.

Interview with three residents on 10/22/25 at

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| D 074 | Continued From page 24<br><br>10:10am revealed:<br>-The carpet in the hallways was beginning to show more "wear and tear" recently.<br>-The carpet had been coming up and tearing for years, and the facility staff cut it with scissors and glued it back down.<br>-They had not heard of anyone tripping on the torn carpet, but it could happen because some of the residents did not pick up their feet when they walked.<br><br>Interview with the Housekeeper on 10/22/25 at 8:12am revealed:<br>-The carpets were starting to fray; they had been fraying for a couple of years.<br>-The facility needed to change the worn carpet out with new carpet.<br>-The Director told her about 6 months ago that they were going to replace the carpet.<br>-She had seen the Maintenance Director gluing the carpet down in places.<br>-She shampooed the carpet in sections, and she had not seen the carpet fraying when she shampooed it.<br>-She had worked at the facility a long time and she thought the carpet was almost 20 years old.<br>-She was not aware of any residents tripping on the frayed carpet.<br><br>Interview with the Executive Director (ED) on 10/22/25 at 9:38am revealed:<br>-The carpets in the hallways had been on the floor since 2005.<br>-She noticed the carpets started to fray around 2019.<br>-The maintenance director trimmed the frayed sections and glued them down.<br>-She was told by corporate they were going to redo the building soon including the laying new carpet. | D 074 | | |

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| D 074 | Continued From page 25<br>-The new carpet got delayed and she did not know why.<br>-She was told at one point by corporate that the facility was next in line to get new carpet.<br>-The inspector from the local health department told her that the carpet needed to be replaced.<br>-She sent the last local health inspection and pictures to her corporate office.<br>-Her concern with the carpet was a trip and fall hazard because a resident could trip on the areas that were pulling up and were frayed if they were not glued down.<br>-A resident using a walker could trip and fall if their shoe or their walker caught on a damaged part of the carpet.<br>-There were no complaints about the carpet from residents or their families.<br>-No residents had tripped on the carpet and fallen.<br><br>Telephone interview with the Administrator on 10/22/25 at 2:00pm revealed:<br>-She had noticed the frayed carpet in the facility.<br>-She thought the carpet needed to be replaced where it was fraying.<br>-She thought the facility's cooperate office had gotten a quote to replace it, but she was not sure.<br>-It could become a trip hazard if it got worse.<br><br>Attempted telephone interview with the Maintenance Director on 10/22/25 at 4:55pm was unsuccessful. | D 074 | | |
| D 184 | 10A NCAC 13F .0605 (a) General Staffing Requirements for Adult Care<br><br>10A NCAC 13F .0605 General Staffing Requirements for Adult Care Homes | D 184 | | |

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| D 184 | Continued From page 26<br>(a) Adult care homes shall staff based on the facility's resident census and provide staffing to meet the care and supervision needs of the residents in accordance with the rules of this Subchapter.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observations, interviews, and record reviews, the facility failed to ensure the minimum requirements for aide hours were met in the Special Care Unit (SCU) and Assisted Living (AL) for 12 of 39 shifts sampled from 08/29/25-10/20/25.<br><br>The findings are:<br><br>Review of the facility's current license, effective 01/01/25, revealed the facility was licensed for a capacity of 70 beds, including AL with a capacity of 39 beds and the SCU with a capacity of 31 beds.<br><br>Review of the census dated 08/29/25 revealed:<br>-There was a census of 30 residents residing on the AL unit, which required sixteen hours of aide duty for first and second shift, and eight hours of aide duty on third shift.<br>-There was a census of 29 residents residing on the SCU, which required 29 hours of aide duty for first and second shift, and 25.2 hours of aide duty on third shift. | D 184 | Human Resources/Director is continually hiring additional employees for the facility.<br><br>Director/Facility will use census and acuity levels of residents to determine how many staff are needed.<br><br>Employees were retrained by Director on facility expectations with attendance and call-out policies.<br><br>SIC will notify on-call management staff immediately if someone fails to follow facility policy on call out and does not show for their shift. On-call management staff will go in and work the shift to ensure staffing is in accordance of 10A NCAC 13F .0605<br><br>Director will monitor staffing in the facility x 5 days per week x 5 weeks; randomly thereafter. | 12/7/2025 |

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-There would be a total of 44 aide hours required for the facility on the first shift and second shift, and 33.2 aide hours required for the facility on the third shift.

Review of the schedule for 08/29/25 for the first shift revealed one MA was assigned to the AL and a second MA was assigned to the SCU, one PCA was assigned to the AL, two other PCAs were unassigned and scheduled to work at 10:00am.

Review of the employee punch cards for the 7:00am to 3:00pm shift on 08/29/25 revealed there was a total of 20.5 aide hours provided for the first shift, leaving the facility short 7.5 aide hours.

Review of the census dated 08/29/25 revealed:
-There was a census of 30 residents residing on the AL unit, which required sixteen hours of aide duty for first and second shift, and eight hours of aide duty on third shift.
-There was a census of 29 residents residing on the SCU, which required 29 hours of aide duty for first and second shift, and 25.25 hours of aide duty on third shift.
-There would be a total of 44 aide hours required for the facility on the first shift and second shift, and 33.25 aide hours required for the facility on the third shift.

Review of the schedule for 08/29/25 for the 11:00pm to 7:00am shift revealed one MA was assigned to both the AL and SCU, one PCA was assigned to the AL, and one PCA was assigned to the SCU.

Review of the employee punch cards for third shift on 08/29/25 revealed there was a total of 23.5 aide hours provided for the third shift,

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leaving the facility short 9.75 hours.

Review of the census dated 08/31/25 revealed:
-There was a census of 30 residents residing on the AL unit, which required sixteen hours of aide duty for first and second shift, and eight hours of aide duty on third shift.
-There was a census of 29 residents residing on the SCU, which required 29 hours of aide duty for first and second shift, and 25.25 hours of aide duty on third shift.
-There would be a total of 44 aide hours required for the facility on the first shift and second shift, and 33.25 aide hours required for the facility on the third shift.

Review of the schedule for 08/31/25 for the 7:00am to 3:00pm shift revealed one MA was assigned to the AL. There was not a MA assigned to the SCU for first shift. There was one PCA assigned to the AL and one PCA assigned to the SCU.

Review of the employee punch cards for first shift on 08/31/25 revealed there was a total of 34.5 aide hours provided for the third shift, leaving the facility short 9.5 hours.

Review of the census dated 08/31/25 revealed:
-There was a census of 30 residents residing on the AL unit, which required sixteen hours of aide duty for first and second shift, and eight hours of aide duty on third shift.
-There was a census of 29 residents residing on the SCU, which required 29 hours of aide duty for first and second shift, and 25.25 hours of aide duty on third shift.
-There would be a total of 44 aide hours required for the facility on the first shift and second shift, and 33.25 aide hours required for the facility on

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the third shift.

Review of the schedule for 08/31/25 for the 3:00pm to 11:00pm shift revealed:
-There was one MA assigned to the AL and one MA assigned to the SCU.
-There was one PCA assigned to the AL and one PCA assigned to the SCU.

Review of the employee punch cards for second shift on 08/31/25 revealed there was a total of 39.75 aide hours provided for the third shift, leaving the facility short 4.25 hours.

Review of the census dated 09/13/25 revealed:
-There was a census of 30 residents residing on the AL unit, which required sixteen hours of aide duty for first and second shift, and eight hours of aide duty on third shift.
-There was a census of 29 residents residing on the SCU, which required 29 hours of aide duty for first and second shift, and 25.2 hours of aide duty on third shift.
-There would be a total of 44 aide hours required for the facility on the first shift and second shift, and 33.2 aide hours required for the facility on the third shift.

Review of the schedule for 09/13/25 for the 11:00pm-7:00am shift revealed one MA assigned to both the AL and the SCU and one PCA assigned to the SCU.

Review of the employee punch cards for 09/13/25 revealed there was a total of 23.0 aide hours provided for the third shift, leaving the facility short 10.2 aide hours.

Review of the census dated 09/14/25 revealed:
-There was a census of 30 residents residing on

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the AL unit, which required sixteen hours of aide duty for first and second shift, and eight hours of aide duty on third shift.
-There was a census of 29 residents residing on the SCU, which required 29 hours of aide duty for first and second shift, and 25.2 hours of aide duty on third shift.
-There would be a total of 44 aide hours required for the facility on the first shift and second shift, and 33.2 aide hours required for the facility on the third shift.

Review of the schedule for 09/14/25 for the 11:00pm-7:00am shift revealed one MA assigned to on both the AL and the SCU and one PCA assigned to the AL and two PCAs to the SCU.

Review of the employee punch cards for 09/14/25 revealed there was a total of 24.0 aide hours provided for the third shift, leaving the facility short 9.2 aide hours.

Review of the census dated 10/10/25 revealed:
-There was a census of 28 residents residing on the AL unit, which required sixteen hours of aide duty for first and second shift, and eight hours of aide duty on third shift.
-There was a census of 28 residents residing on the SCU, which required 28 hours of aide duty for first and second shift, and 22.4 hours of aide duty on third shift.
-There would be a total of 30.4 aide hours required for the facility on the third shift.

Review of the schedule for 10/10/25 for the 11:00pm-7:00am shift revealed one MA was assigned to both the AL and SCU, one PCA was assigned to the AL, and one PCA was assigned to the SCU.

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Review of the employee punch cards for third shift on 10/10/25 revealed:
-There was a total of 28 aide hours provided for the third shift, leaving the facility short, 2.4 aide hours.
-There was one PCA who punched out at 3:00am, leaving 2 PCAs for the facility from 3:00am-6:30am; a third PCA punched in at 6:30am.
Review of the census dated 10/11/25 revealed:
-There was a census of 28 residents residing on the AL unit, which required sixteen hours of aide duty for first and second shift, and eight hours of aide duty on third shift.
-There was a census of 28 residents residing on the SCU, which required 28 hours of aide duty for first and second shift, and 22.4 hours of aide duty on third shift.
-There would be a total of 44 aide hours required for the facility on the first shift and second shift, and 30.4 aide hours on the third shift.

Review of the schedule for 10/11/25 for the 7:00am-3:00pm shift revealed one MA was assigned to both the AL and SCU, one PCA was assigned to the AL, and two PCAs were assigned to the SCU.

Review of the employee punch cards for first shift on 10/11/25 revealed there was a total of 26 aide hours provided for the first shift, leaving the facility short 18 aide hours.

Review of the schedule for 10/11/25 for the 3:00pm-11:00pm shift revealed one MA was assigned to the AL and a second MA was assigned to the SCU, one PCA was assigned to the AL, and one PCA was assigned to the SCU.

Review of the employee punch cards for second

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shift on 10/11/25 revealed:
-There was a total of 39 aide hours provided for the second shift, leaving the facility short 5 aide hours.
-There were three PCAs who worked 3:00pm-11:00pm.
-There was one MA who punched out at 10:00pm.
-There was a second MA punched out at 10:15pm
-There was a third MA who punched in at 10:00pm.

Review of the schedule for 10/11/25 for the 11:00pm-7:00am shift revealed:
-There was one MA assigned to both the AL and SCU, and one PCA was assigned to the AL.
-There was no PCA assigned to the SCU.

Review of the employee punch cards for third shift on 10/11/25 revealed there was a total of 23.25 aide hours provided for the third shift, leaving the facility short 6.25 aide hours.

Review of the census dated 10/12/25 revealed:
-There was a census of 28 residents residing on the AL unit, which required sixteen hours of aide duty for first and second shift, and eight hours of aide duty on third shift.
-There was a census of 28 residents residing on the SCU, which required 28 hours of aide duty for first and second shift, and 22.4 hours of aide duty on third shift.
-There would be a total of 44 aide hours required for the facility on first shift and second shift, and 30.4 aide hours on third shift.

Review of the schedule for 10/12/25 for the 7:00am-3:00pm shift revealed one MA was assigned to both the AL and SCU, one PCA was

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assigned to the AL, and two PCAs were assigned to the SCU.

Review of the employee punch cards for the first shift on 10/12/25 revealed there was a total of 34 aide hours provided for the first shift, leaving the facility short 10 aide hours.

Review of the schedule for 10/12/25 for the 11:00pm-7:00am shift revealed there was one MA assigned to both the AL and SCU, one PCA assigned to the AL, and one PCA assigned to the SCU.

Review of the employee punch cards for third shift on 10/12/25 revealed:
-There was a total of 27.25 aide hours provided, leaving the facility short 5.25 aide hours.
-Two PCAs worked from 11:00pm-7:00am, and a third PCA punched out at 12:21am, leaving 2 PCAs for the facility from 12:21am-5:45am when there should have been a third staff member.
-A MA worked and punched out at 12:26am, and a second MA punched in at 1:02am, leaving the facility without a MA for thirty minutes.

Confidential interview with a staff member revealed:
-There were staff who clocked in on the time clock but did not actually work.
-The staff may have worked two shifts straight, and as soon as the second shift staff left the facility, the staff would get their pillow and covers and go to sleep.

Observation of the SCU on 10/21/25 at 8:15am revealed there were two personal care aides (PCA) and one medication aide (MA); there should have been 3.5 staff members .

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| D 184 | Continued From page 34<br><br>Observation of the lunch meal on 10/21/25 from 11:49am-12:15pm revealed:<br>-The PCAs and the MA assisted the residents into the dining room.<br>-The PCAs and the MA served the residents' meals that were plated by the dietary staff.<br>-The PCAs and the MA cleaned the food and beverages off the tables and wiped them off.<br><br>Observation of the AL unit on 10/23/25 at 8:00am revealed the Executive Director was administering medications to the residents.<br><br>Interview with the two PCAs in the SCU on 10/21/25 at 8:50am revealed there were usually two PCAs and one MA on first shift in the SCU.<br><br>Interview with two residents on the AL on 10/21/25 at 8:35am revealed:<br>-They had to wait for staff to assist them to the bathroom.<br>-They used the call bell but it would take staff up to a half an hour to respond.<br>-It did not matter what time of day it was staff took a long time to answer.<br>-They did not ask why it took so long for staff to answer the call bells.<br>-Some days the staff would complain about being short of help.<br><br>Telephone interview with a resident's power of attorney (POA) on 10/23/25 at 11:50am revealed:<br>-The facility seemed to have a hard time keeping staff.<br>-He had seen the Executive Director would work on the floor some days and administering medications.<br>-The Executive Director had told him the facility was short staff because it was difficult to hire new staff. | D 184 | | |

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| D 184 | Continued From page 35<br><br>Interview with a PCA on 10/22/25 at 4:18pm revealed:<br>-There were usually two PCAs in AL and two or three PCAs in the SCU, but there were times when there would only be two PCAs in the SCU.<br>-Sometimes there would only be one MA for the facility, and at some point, a second MA would come in.<br><br>Interview with a second PCA on 10/22/25 at 4:44pm revealed:<br>-She usually worked second or third shift.<br>-The SCU usually had two PCAs and a MA who worked both the SCU and AL.<br>-There had been times when there was one PCA for the SCU and one PCA for the AL, and the MA did both the AL and the SCU.<br>-The MA helped her with the residents in the SCU.<br><br>Interview with a MA on 10/22/25 at 4:43pm revealed:<br>-On second shift, there were times when there would be two PCAs in the SCU and one PCA in AL, and she floated back and forth between SCU and AL.<br>-As long as there were two PCAs, she did not have to stop her medication pass to assist with a two-person transfer.<br><br>Telephone interview with a PCA on 10/22/25 at 8:10pm revealed:<br>-In AL, there was usually one PCA and a MA who worked both the AL and the SCU.<br>-She could not say how long the MA was on the AL or the SCU.<br>-There were 2 residents in the AL who were a two-person transfer.<br>-The PCAs also had to wash the residents' | D 184 | | |

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clothes and linens.
-She washed 5-7 loads of residents' clothes at night.

Interview with a PCA on 10/23/25 at 9:55am revealed:
-She only worked first shift.
-Sometimes there were 2 PCAs that worked in the SCU on first shift and sometimes there were 3; it depended on the schedule.
-She had worked with just one PCA on the SCU, but it was a while ago, she could not remember the date.
-When there were just 2 PCAs on the SCU on first shift, she was able to get everything done that needed to get done, it just took longer.
-She was able to get showers done that were scheduled and incontinent care provided.
-The PCAs worked together.
-The PCAs were responsible for helping at meal service.
-They did not have anyone that needed feeding assistance in the SCU at this time.
-The MA also helped with care when they had a resident that was having a hard time.
-The MA helped with meals by passing out the beverages and assisting residents into the dining room.

Interview with a second PCA on 10/23/25 at 10:05am revealed:
-There had been times when she was the only PCA working first shift in the AL.
-If she needed assistance with a two-person transfer, she would ask the MA.
-There were 4-5 residents in AL who needed two staff members with transfers.
-Ten AL residents needed assistance with toileting every two hours.
-The SCC and the Executive Director helped with

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resident care in the AL at times.
-There had been times when she was the only PCA in the facility, and the only MA was working in the SCU.
-In the SCU, staff had to work in the dining room as well.
-She would help set up the tables with beverages, silverware, and serve the plates.
-After the meals, the PCAs and MAs cleaned up the tables and swept the floor.

Interview with a third PCA on 10/23/25 at 10:14am revealed in the SCU, the PCAs cleaned up the tables after meals, swept, sprayed down the tables, and prepared the dining room for the next meal.

Interview with a MA on 10/23/25 at 10:14am revealed:
-The SCU staff cleaned up the dishes at meals, wiped out the microwave, swept the floor, and wiped down the tables.
-Sometimes there would be one MA and one PCA in the SCU because another PCA was running late, but a second shift PCA may come in early.
-Staff would try to help out by coming in early, or staff stayed over from the previous shift.

Telephone interview with a second MA on 10/23/25 at 12:25pm revealed:
-She usually only worked whenever there was a need.
-She usually worked first or second shift on the weekends.
-She worked both the AL and the SCU.
-There were times when she and one PCA were covering the entire facility for up to four hours until another staff member came in.
-The Executive Director "wore a lot of hats", but she could not do it all.

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-The Executive Director was working all the time.
-The staff and residents deserved better.
-When there was not a proper ratio for staff to residents, something was not going to be done but staff made sure the residents had meals and medications, but small things mattered too, like getting a shower, doing activities, or going outside and there was not enough time for those.

Telephone interview with a third MA on 10/23/25 at 4:04pm revealed:
-There were usually two PCAs in the SCU and one PCA in AL on the third shift, and the MA worked both sides.
-There had been one night when there was one PCA in the SCU and one PCA in AL, and no other PCAs came in the entire shift.
-There were other times when another staff member would punch in early to work at 3:00am or 5:00am.

Interview with the SCU Coordinator (SCC) on 10/21/25 at 10:16am revealed:
-She was responsible for making the schedule for the SCU and AL.
-She scheduled one MA and two PCAs for the SCU for both first and second shifts.
-She scheduled one MA and two PCAs for the AL for both first and second shifts.
-She scheduled one MA for the facility and two or three PCAs for the SCU and one PCA for the AL for the third shift.
-Sometimes, in addition to a MA for the facility, she may only have one PCA for the SCU and one PCA for the AL because that was all she had to work with.
-She scheduled staff to come in early to help cover the shifts.
-If staff came in early, they were supposed to go to the SCU to work since that unit required more

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staff.
-Staff called out, "People do not want to work".

Interviews with the SCC on 10/23/25 at 9:15am and 11:26am revealed:
-For the first and second shifts in AL, she needed one MA and two PCAs.
-For the third shift in AL, she needed one MA and one PCA.
-For the SCU, she needed 3.5 staff on first and second shift and 2.5 staff on third shift.
-She did not have enough staff.
-When she did not have enough staff to schedule, she or the Executive Director would come in and work.
-She punched in and out when she worked.
-The Executive Director did not punch in and out when she worked.
-If either she or the Executive Director worked, their initials would be on the electronic medication administration record (eMAR).
-When she worked as a MA she would assist with resident care on the floor when she was needed.
-The SCU staff were responsible for sweeping the dining room floor, wiping down tables cleaning tables after meals, and pushing the food cart back to the main dining room.

Interview with the Executive Director on 10/23/25 at 11:50am and 1:08pm revealed:
-SCU staff were responsible for sweeping the dining room floor, wiping down tables, clearing tables after meals, and pushing the food cart back to the main dining room.
-She had worked as a MA and as the MA, she also helped with PCA duties when needed.
-Today, 10/23/25, there was no MA scheduled for AL, so she was working as the AL MA.
-Staff worked well together.
-She had worked as a MA on all three shifts.

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| D 184 | Continued From page 40<br><br>-She was salaried and did not punch so her hours were not able to be calculated.<br>-Her initials would be on the eMAR when she worked as a MA.<br>-She knew there were days when there were not enough staff scheduled to work, and that was why she was in the facility working all the time.<br>-She worked at the facility 24/7 when there was not enough staff.<br>-She worked at the facility every weekend.<br>-She had to work all three shifts when needed.<br><br>Attempted telephone interview with the Administrator on 10/23/25 at 1:32pm was unsuccessful.<br><br>_____<br>The facility failed to ensure correct staffing levels to meet the needs of the residents. Residents complained of having to wait for call bells to be answered, waiting for assistance with incontinent care and the elopement of a resident. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.<br><br>_____<br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/23/25.<br><br>THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 7, 2025 | D 184 | | |
| D 234 | 10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio<br><br>10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations<br>(a) Upon admission to an adult care home each | D 234 | | |

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| D 234 | Continued From page 41<br>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.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to ensure 1 of 5 sampled residents (#4) had completed the two-step tuberculosis (TB) testing in compliance with the control measures adopted by the Commission for Public Health.<br><br>The findings are:<br><br>Review of Resident #4's current FL2 dated 02/04/25 revealed diagnoses included dementia, cerebral palsy, diabetes mellitus type 2, myasthenia gravis, hypertension, and hyperlipidemia.<br><br>Review of Resident #4's Resident Register revealed an admission date of 03/09/16.<br><br>Review of Resident #4's record revealed:<br>-There was documentation that a 1st step TB skin test was administered on 03/02/16 and read on 03/04/16 with negative results.<br>-There was no documentation a 2nd step TB skin test was administered for Resident #4<br><br>Interview with Resident #4 on 10/23/25 at 10:35am revealed: | D 234 | Director/Marketing will ensure all residents have received their first TB test upon admission and SCUC/Designee will ensure all residents have received their second TB test in compliance with the control measures adopted by the commission of health services.<br><br>SCUC will audit at least 5 random resident charts monthly to ensure all have TB test in accordance of rule 10A NCAC 13F .0703(a)<br><br>QI team will audit resident charts randomly to ensure all residents have TB test in accordance of rule 10A NCAC 13F .0703(a) any residents found not to have TB completed will receive as soon as possible. | 12/7/2025 |

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| D 234 | Continued From page 42<br>-She had lived at the facility for a long time.<br>-She did not recall anything about a TB skin test.<br><br>Interview with the Special Care Unit Coordinator (SCC) on 10/23/25 at 10:47am revealed:<br>-The business office manager (BOM) was responsible for TB skin tests on admission.<br>-She thought the Director was responsible for making sure the 2nd step TB skin tests were completed.<br>-She was not aware Resident #4 did not have a 2nd step TB skin test.<br><br>Interview with the Executive Director (ED) on 10/22/25 at 11:53am revealed:<br>-The BOM made sure residents had a 1st step TB skin test completed on admission.<br>-She and the SCC were responsible for obtaining the 2nd step TB skin test.<br>-She did not know why Resident #4 only had a 1st step TB skin test in her record.<br><br>Telephone interview with the Administrator on 10/22/25 at 12:07pm revealed:<br>-The SCC and the ED were responsible for making sure 2-step TB skin tests were completed.<br>-She expected 2-step TB skin tests to be completed.<br><br>Attempted telephone interview with Resident #4's primary care provider (PCP) on 10/22/25 at 10:56am was unsuccessful. | D 234 | | |
| D 253 | 10A NCAC 13F .0801 (a) (b) Resident Assessment<br><br>10A NCAC 13F .0801 Resident Assessment | D 253 | | |

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| D 253 | Continued From page 43<br>(a) The facility shall complete an assessment of each resident within 30 days following admission and annually thereafter.<br>(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:<br>(1) resident identification and demographic information;<br>(2) current diagnoses;<br>(3) current medications;<br>(4) the resident's ability to self-administer medications;<br>(5) the resident's ability to perform activities of daily living, including bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting, and eating;<br>(6) mental health history;<br>(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; | D 253 | SCUC/Designee audited all annual care plans to assure they have been completed and signed by physician. Any care plans found not in compliance were completed.<br><br>Director will audit at least 3 resident care plan per month x4 months, then randomly thereafter to assure resident care plans have been completed and signed by physician.<br><br>Quality Improvement Department/Compliance Department will conduct audit of the facility at least quarterly or as needed basis to monitor resident rights and ensure compliance. | 12/7/2025 |

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| D 253 | Continued From page 44<br>(8) mood and behaviors;<br>(9) nutritional status, including specialized diet or dietary needs;<br>(10) skin integrity;<br>(11) memory, orientation and cognition;<br>(12) vision and hearing;<br>(13) speech and communication;<br>(14) assistive devices needed; and<br>(15) a list of and contact information for health care providers or services used by the resident.<br>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.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interview, the facility failed to ensure 1 of 5 sampled residents (#1) had an annual care plan completed that was signed by a physician.<br><br>The findings are:<br><br>Review of Resident #1's current FL2 dated 02/04/25 revealed:<br>-Diagnoses included dementia, cerebral palsy, diabetes mellitus type 2, myasthenia gravis, | D 253 | | |

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| D 253 | Continued From page 45 | D 253 | | |

hypertension, and hyperlipidemia.
-The resident ambulatory with a walker.
-The resident was incontinent of bowel and bladder.
-The resident was intermittently disoriented.

Review of Resident #1's Resident Register revealed an admission date of 09/22/15.

Review of Resident #1's record revealed:
-There was a care plan completed 05/08/23.
-There was not an updated care plan completed for Resident #1.

Review of Resident #1's care plan dated 05/08/23 revealed Resident #1 required assistance from staff with bathing, dressing, toileting, and grooming.

Interview with the Special Care Unit Coordinator (SCC) on 10/23/25 at 10:47am revealed:
-She was responsible for making sure the resident care plans were updated annually and signed by the physician.
-Resident #1's care plan had to be faxed to his primary care provider (PCP) because he did not come to the facility.
-After she faxed the care plan to Resident #1's PCP, he would sign it and fax it back to the facility.
-Sometimes she did not get the care plan back and would have to call the PCP's office several times.
-She was shocked there was not an updated care plan in Resident #1's record.
-She was not aware Resident #1's care plan was not updated.
-She must not have gotten it back from the PCP.

Interview with the Executive Director (ED) on

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| D 253 | Continued From page 46<br><br>10/22/25 at 11:53am revealed:<br>-The SCC was responsible for making sure the care plans were updated annually.<br>-She did not know what happened with Resident #1's care plan.<br>-She was not aware Resident #1 did not have an updated care plan.<br><br>Telephone interview with the Administrator on 10/22/25 at 12:07pm revealed:<br>-The SCC and the ED were responsible for completing annual care plans.<br>-She expected the residents care plan to be updated annually and signed by the physician. | D 253 | | |
| D 270 | 10A NCAC 13F .0901(b) Personal Care and Supervision<br><br>10A NCAC 13F .0901 Personal Care and Supervision<br>(b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.<br><br>This Rule is not met as evidenced by:<br>TYPE A2 VIOLATION<br><br>Based on observations, record reviews, and interviews, the facility failed to ensure 1 of 4 sampled residents (#6) identified as intermittently disoriented was supervised resulting in the resident leaving the facility without staff's knowledge. | D 270 | | |

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| D 270 | Continued From page 47<br><br>The findings are:<br><br>Review of the facility's undated supervision of wandering residents policy revealed:<br>-The facility would not admit residents who were considered wanderers or at high risk for wandering.<br>-Should a current resident begin to exhibit signs of wandering the resident would be reassessed for appropriate placement and an immediate discharge notice would be issued.<br>-The remainder of the policy would apply to a resident for as long as the resident remained in the facility.<br>-The facility would identify residents who would walk around unrestricted and were a threat to leave the facility unattended due to their confusion.<br>-Pre-admission screening would include review of the FL-2, the hospital discharge summary or other written information and obtaining and review of information from family members, placement agencies and responsible persons regarding any history or the risk of wandering.<br>-After admission safeguards and assessments would include implementation of a list of wandering residents.<br>-The list of wandering residents would be made available to staff.<br>-Staff would be informed upon admission and as necessary if the potential existed for a resident to wander.<br>-Reassessments and change in the care plan would be performed accordingly when significant change occurred which would indicate the resident's potential to wander.<br>-Supervision and implementation of routine checks, monitoring devices and or techniques according to the need of each resident. | D 270 | Resident exhibited a new onset of impaired decision-making (wandering) signaling a significant change in her condition of which the facility immediately contacted the physician to seek referral for locked special care unit or other appropriate interventions as deemed necessary by physician.<br><br>Facility will respond immediately in the case of an accident or incident involving a resident to provide care according to the needs of the residents, (such as obtaining assistive devices, increased supervision, seeking advice from physician/OT/PT/ST, etc.)<br><br>SCUC/Designee will identify any needed interventions for residents exhibiting a need for supervision and ensure staff are trained on each individual residents needs.<br><br>SIC will brief oncoming SIC of any changes in residents' condition to ensure staff are aware on oncoming shift.<br><br>Director/Designee will conduct stand up meeting 5 days/week with staff to follow up on resident supervision concerns/issues and other medical/ physical conditions.<br><br>Director will monitor supervision provided to residents based on need identified in the care plan x 5 days per week | 11/22/2025 |

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-Environmental safeguards would include checking the door alarms regularly to ensure they were working properly.
-Notifying staff when alarms failed and request staff to assure extra precautions for residents at risk of wandering.
-Repairing the alarm system as soon as practicable.

Review of Resident #6's current FL2 dated 08/03/25 revealed:
-Diagnoses included hypertension, osteopenia and Alzheimer's disease.
-She was ambulatory.
-She was intermittently disoriented.
-Level of care was assisted living.

Review of Resident #6's care plan dated 10/13/25 revealed:
-There was a reassessment date of 06/30/25 and a significant change in condition date of 10/13/25.
-The Special Care Unit Coordinator (SCC) signed the care plan on 06/30/25.
-Resident #6's primary care provider (PCP) signed the care plan on 07/01/25; the PCP had not signed the care plan updated due to significant change in condition.
-Resident #6 navigated through the facility on her own, sometimes she was resistant to walking and going on outings and was exit seeking but had been moved to the special care unit (SCU); the note was not dated.
-She was sometimes disoriented and forgetful.
-She required staff supervision with eating
-She required limited assistance from staff with bathing, dressing and personal hygiene.

Review of Resident #6's progress notes revealed:
-On 10/28/24, Resident #6 was observed roaming the hallways with no pants or underwear on; she

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was easily redirected back to her room.
-On 10/30/24, Resident #6 was roaming the hallways and was redirected by staff five times.
-Resident #6 stated she was going home; she was later observed in the parking lot with her purse and a bag stating she was going home.
-Resident #6's PCP was notified; the PCP requested staff do 30-minute checks.
-On 11/06/24, Resident #6 had a dementia break where her dementia got worse and she was wandering; she was observed for a recurrence and if the wandering increased, she would be assessed for the SCU.
-There was a note dated 10/13/25, Resident #6 was brought back to the facility by the local police after she was found at a local restaurant.
-A new FL-2 was faxed to the PCP for recommendation to move Resident #6 to the SCU.
-On 10/16/25, Resident #6 was moved to the SCU.

Review of Resident #6's record revealed there was no incident report dated 10/12/25.

Review of the local weather report for the area revealed on 10/12/25 from 10:02pm to 10:54pm, the temperature was 59 degrees Fahrenheit (°F), and there was a light rain.

Review of a local police department report dated 10/12/25 revealed:
-On 10/12/25 at 10:27pm, the dispatch received a call about a lost elderly woman standing outside of a restaurant.
-The responding police officers found Resident #6 walking outside the restaurant; she appeared confused, and she told the police officers she was lost.
-Resident #6 identified herself and told the police

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officers she did not know how she got to the restaurant; she said she must have walked and gotten lost during the walk.
-Resident #6 refused emergency medical services (EMS).
-Resident #6 told the police officers she wanted to go home and gave them a driver's license with an address to a private residence.
-Resident #6 asked the police officers to transport her to the address on the driver's license.
-While in route to the private residence the police officers checked the names associated with the address and were able to contact Resident #6's power of attorney (POA).
-The POA told the police officers Resident #6 resided at a named local assisted living facility; the police officers took Resident #6 to the facility.
-The police officers escorted Resident #6 into the facility and confirmed with the facility staff that she was a resident.
-Resident #6 was then escorted to her room by the police officers; she stated, "this is my room" and thanked them for their assistance.
-The call was completed at 10:57pm; Resident #6 was with the police officers for a total of 27 minutes.

Telephone interview with a Lieutenant from the local police department's investigations unit on 10/23/25 at 9:55am revealed:
-On 10/12/25 around 10:30pm the police dispatch received a request for a wellness check from a civilian about a confused elderly woman at a local restaurant.
-The elderly woman was outside in the rain and was on foot in the drive through at the restaurant; she told the caller she was lost.
-Police officers were dispatched to the restaurant where they encountered the elderly woman who identified herself.

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| D 270 | Continued From page 51<br>-She told the police officers she was lost and gave them an address to a residence where she said she lived.<br>-The officers discovered she did not live at the address she provided but were able to reach her POA who told them she resided at a named assisted living facility in the area.<br>-There were no reports from the assisted living facility of a resident elopement or a missing resident.<br>-The police officers returned Resident #6 to the facility.<br>-The facility staff identified the elderly woman as Resident #6 and that she resided at the facility; the staff were not aware she had left the facility or the facility property.<br><br>Telephone interview with Resident #6's POA on 10/23/25 at 11:50am revealed:<br>-He received a telephone call from the local police department on 10/12/25 in the evening around 11:00pm.<br>-The police officer told him Resident #6 was at a local restaurant and was lost so they transported her to her former residence.<br>-A neighbor recognized Resident #6 and gave the police officers the POA's name and telephone number.<br>-He told the police officer Resident #6 resided at the named facility so the officers returned her to the facility.<br>-He was not contacted by the Executive Director (ED) about the elopement.<br>-He went to the facility the next day, 10/13/25, to see Resident #6 and the ED told him about the elopement when she saw him.<br>-The ED told him Resident #6 left the facility without being detected because the staff turned off the door alarm to go outside and did not turn it back on when they came in. | D 270 | | |

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| D 270 | Continued From page 52<br>-Resident #6 was moved to the SCU after the elopement; the ED told him it was the facility's policy to move a resident to the SCU after an elopement.<br>-The incident on 10/12/25 was the first time Resident #6 had tried to leave the facility in the four and a half years she had lived there.<br>-To his knowledge Resident #6 had never tried to leave; he knew she walked into the yard at the facility sometime in 2021, but the staff saw her and brought her back inside.<br>-Resident #6 was moved from her home to the facility due to her diminished [mental] capacity.<br><br>Telephone interview with the Adult Home Specialist (AHS) from the county Department of Social Services (DSS) on 10/23/25 at 10:45am revealed:<br>-On 06/18/25, while the AHS was conducting an onsite visit the ED told her the facility staff were watching Resident #6 because she had been trying to exit the facility.<br>-The staff had witnessed Resident #6 attempting to exit the facility and she was outside in the parking lot.<br>-The staff saw her leave through the front door and were by her side as she walked around outside.<br>-According to the ED, Resident #6 did not elope or leave the property; staff walked with the resident and walked her back into the facility.<br><br>Interview with a housekeeper on 10/23/25 at 2:35pm revealed:<br>-About two to three months ago she saw Resident #6 outside of the facility alone.<br>-Resident #6 was on the sidewalk next to the parking lot.<br>-She knew Resident #6 should not be outside by herself, so she went out to get her. | D 270 | | |

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-She went outside and brought Resident #6 inside; the resident had no problem following her back inside.
-She did not think Resident #6 should be outside alone because it was a safety issue.
-There was a busy road in front of the facility and Resident #6 should not be on or near the busy road.
-She let the ED know she found Resident #6 outside and brought her back into the facility.

Interview with a medication aide (MA) on 10/23/25 at 1:40pm revealed:
-She worked second shift and was working from 2:30pm to 11:00pm on 10/12/25, when Resident #6 was brought back to the facility by the local police.
-She and the other MA did not know Resident #6 was out of the facility until the police officers brought her back.
-The last time she had seen Resident #6 was after dinner at 5:20pm when the resident was walking from the dining room back to her room.
-The next time she saw Resident #6 was when the police brought her back around 10:30pm.
-She and the other MA started rounds at 10:00pm and had just finished when the police showed up.
-They did not check on Resident #6 as part of the evening rounds; she was not one of the residents they checked on because she used the toilet on her own and did not want to be bothered or messed with.
-There were no rounds done at shift change; shift change consisted of the staff standing and discussing the residents and the day.
-There was no telling when the facility staff would have realized Resident #6 was missing if the police officers had not brought her back.
-The front doors, employee entrance and smoking area door were not alarmed until after

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third shift staff arrived and the second shift left for the day.
-Third shift MAs and staff began showing up around 10:00pm and last staff came in around 11:00pm.
-The third shift staff set the alarms for the evening; she had never set the door alarms on second shift.
-She thought it was raining when the police brought Resident #6 back to the facility; they came to the medication room and told her they thought they had one of the [facility's] residents.
-She asked Resident #6 where she was going when the police officers found her; Resident #6 was confused, she said she was going home and gave her previous house address.
-She and the officers walked Resident #6 to her room.
-After she got Resident #6 to bed, she called the ED to let her know.
-The only change she had noted in Resident #6 was she was beginning to refuse showers and becoming a little combative about showers.

Interview with the SCC on 10/23/25 at 1:40pm revealed:
-Resident #6 would sit outside on the front porch and not try to walk away.
-One day in June 2025 a housekeeper found Resident #6 outside at the edge of the parking lot but not in the parking lot.
-She had not noticed any increased confusion in Resident #6.
-The staff should have walked around the AL during shift change and "laid eyes" on all the residents.
-The staff should constantly be walking around and always be aware of where the residents were.
-If Resident #6 had increased confusion, then the

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staff should have increased their monitoring of her.
-She was not aware of Resident #6 leaving the facility at night before the incident on 10/12/25.

Interviews with the ED on 10/23/25 at 8:15am and 12:25pm revealed:
-About a week ago, 10/12/25, Resident #6 walked out of the facility to a local restaurant.
-The police brought her back to the facility before 11:00pm after she told them her name and her address.
-The facility staff did not know Resident #6 had left the facility and the property until the police brought her back.
-The last time Resident #6 was seen was about 30 minutes before the police officers brought her back to the facility.
-The staff would check on Resident #6 every two hours to see what she was doing.
-The MA saw Resident #6 in her bed asleep when she did rounds around 10:00pm.
-Resident #6 was only gone for about 20 minutes; it had to be less than thirty minutes.
-The staff did not do a check on each resident or resident count at shift change; they were only required to discuss the residents and what had gone on that day.
-At 11:00pm the third shift would have done their scheduled rounds on certain residents, including Resident #6 and would have discovered the resident was missing at that time.
-Resident #6 must have gone outside during the time the staff had turned off the door alarm for the front door during shift change or when two PCAs placed a pumpkin on the front porch and did not reset the alarm.
-Resident #6 had her shoes on, her sweater and had her purse with her when the police officers brought her back to the facility.

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| D 270 | Continued From page 56<br>-Resident #6 was usually quiet and would walk around the facility with her sweater and her purse; she would say she was going home.<br>-Resident #6 had not tried to leave the facility or go outside that day.<br>-Resident #6 lived at the facility for over three years and had tried to walk out of the facility before.<br>-When Resident #6 walked outside in the past, the staff would see her and go get her; Resident #6 would tell the staff she was going home when they asked why she was outside.<br>-The farthest the resident had walked was to the parking lot when she went to a white car she thought was hers and said she was going to drive it home; that was about a year ago.<br>-The staff realized they needed to watch Resident #6 after she was found in the parking lot beside someone else's car.<br>-The staff were required to go outside with Resident #6 after she was found in the parking lot.<br>-Resident #6 settled into the facility and her routine was to go from her room to the dining room and back to her room.<br>-There was an incident with Resident #6 one night in the early spring of 2025 between 9:00pm and 10:00pm.<br>-The staff had disarmed the front door for the ED to leave, and Resident #6 went outside undetected while the door was not alarmed.<br>-Resident #6 went outside to the parking lot; she saw the resident walking out ahead of her.<br>-She called the facility from the parking lot and told the MA Resident #6 "walked right out past you".<br>-When the staff brought Resident #6 back inside the facility the resident told the staff she was going home and told them her former address.<br>-Resident #6 was admitted to the facility with a | D 270 | | |

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| D 270 | Continued From page 57<br>dementia diagnosis so she knew she would have to move Resident #6 to the SCU at some point.<br><br>Attempted telephone interview with the Administrator 10/23/25 at 1:30pm was unsuccessful.<br><br>Based on observations, interviews and record reviews it was determined Resident #6 was not interviewable.<br><br>_____<br>The facility failed to ensure 1 of 4 residents (Resident #6) who was identified as disoriented and had a diagnosis of dementia was properly supervised resulting in Resident #6 leaving the facility alone at night and walking to a local restaurant without staff knowledge and was returned to the facility by local law enforcement. This failure resulted in substantial risk for physical harm to the resident and constitutes a Type A2 Violation.<br><br>_____<br>The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 10/23/25.<br><br>CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 11, 2025. | D 270 | | |
| D 273 | 10A NCAC 13F .0902(b) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record | D 273 | | |

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| D 273 | Continued From page 58<br>review, the facility failed to assure referral and follow up to meet the needs of the residents for 1 of 5 sampled residents (#1) related to obtaining a mental health referral.<br><br>The findings are:<br><br>Review of Resident #1's current FL2 dated 02/04/25 revealed:<br>-Diagnoses included dementia, cerebral palsy, myasthenia gravis, hypertension, hyperlipidemia, and diabetes mellitus type 2.<br>-He was intermittently disoriented.<br>-He needed personal care assistance from staff with bathing.<br><br>Review of a progress note dated 07/12/25 revealed:<br>-Resident #1's clothes were wet from incontinence.<br>-A staff member entered his room to assist him, and he swung at her.<br><br>Review of a progress note dated 07/13/25 revealed:<br>-Resident #1's clothes were wet from incontinence.<br>-When a staff member attempted to assist, he refused, got agitated, and began yelling.<br><br>Observation of Resident #1 on 10/21/25 at 11:20am revealed:<br>-The surveyor asked Resident #1 if he was going to the dining room for lunch.<br>-Resident #1 yelled at the surveyor that he was not going to the dining room for lunch.<br><br>Interview with a personal care aide (PCA) on 10/22/25 at 10:10am revealed:<br>-Resident #1 had incontinent episodes. | D 273 | SCUC reviewed all recent (30 days) discharge summaries and orders and assure any orders needing to be referred to outside agencies or providers are completed. All referrals will be followed-up on immediately on ensure accuracy and correct documentation.<br><br>SCUC and/or designee will review new orders x 5 days per week to ensure each order is referred to and appropriate agency if indicated.<br><br>Director/Designee will audit all orders once per week x4 weeks, then once per month ongoing to assure any orders needing to be referred to outside agencies or providers are completed<br><br>QI department will conduct quarterly audits of the facility to ensure compliance with rule area. | 12/7/2025 |

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-If he did not want to be bothered, he would refuse care.
-Sometimes Resident #1 would be verbally aggressive and attempt to hit the staff.

Interview with Resident #1's family member on 10/22/25 at 9:49am revealed:
-She was never asked by the facility to consent for mental health services.
-Resident #1 got agitated sometimes when he did not want to do something.
-She thought Resident #1 could benefit from mental health services.

Interview with the facility's contracted mental health provider (MHP) on 10/22/25 at 9:40am revealed:
-She did not see Resident #1 for mental health services.
-She had not been asked to see Resident #1.
-His behaviors could benefit from mental health services.

Interview with the Special Care Unit Coordinator (SCC) on 10/22/25 at 10:34am revealed:
-If a resident needed mental health services, she would ask the primary care provider (PCP) for a referral and then let the MHP know.
-They used to get consent from the resident and/or family on admission, but they were not allowed to do that anymore.
-She thought Resident #1's behaviors could be a psychiatric issue.
-She recalled asking Resident #1's family before for consent for mental health services and they said no.

Interview with the Administrator on 10/22/25 at 12:07pm revealed:
-Any resident that was admitted to the facility with

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| D 273 | Continued From page 60<br>a psychiatric diagnosis, a consent was obtained for a mental health referral.<br>-She did not know if a consent was obtained for Resident #1.<br>-If a resident showed a change or started exhibiting behaviors, the PCP should be contacted and it would be up to them to order a mental health referral. | D 273 | | |
| D 276 | 10A NCAC 13F .0902(c)(3-4) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(c) The facility shall assure documentation of the following in the resident's record:<br>(3) written procedures, treatments or orders from a physician or other licensed health professional; and<br>(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to ensure primary care provider's (PCP) orders were implemented for 2 of 5 sampled residents (#2 and #5) related to the use of compression stockings.<br><br>The findings are:<br><br>1. Review of Resident #2's current FL2 dated 08/25/25 revealed:<br>-Diagnoses included hypertension and Alzheimer's disease.<br>-The resident required assistance from staff with bathing and dressing.<br>-There was an order for compression stockings, put on in the morning and taken off in the | D 276 | SCUC/Designee retrained Medication Aides for implementation of new orders, documenting vitals and treatments as per physician's orders.<br><br>SCUC will review MARs weekly to ensure implementation of new orders, documentation of vitals and treatments are being completed timely.<br><br>Director and/or Designee will audit orders randomly to ensure written procedures, treatments or orders from a physician are implemented timely. | 12/7/2025 |

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| D 276 | Continued From page 61 | D 276 | | |

evening.

Review of Resident #2's care plan dated 08/25/25 revealed:
-She needed extensive assistance with bathing and dressing.
-Her Licensed Health Professional Support (LHPS) tasks included compression stockings.

Review of Resident #2's LHPS assessment form dated 03/26/25 and 07/01/25 revealed:
-Resident #2 had an order for compression stockings.
-Resident #2 was not wearing compression stockings at the time of the assessment.

Review of Resident #2's care notes dated 10/05/25 revealed:
-Resident #2 had bilateral lower leg swelling.
-Resident #2 was wearing compression stockings.
-Resident #2 was placed in a recliner with legs elevated, and compression stockings were removed.
-Resident #2's legs were noted to be red.
-Resident #2 was found on the floor beside the recliner.
-Resident #2 was sent to the emergency department (ED) to be evaluated.

Review of Resident #2's after-visit summary dated 10/05/25 revealed:
-The reason the resident was seen in the ED was for leg swelling.
-Resident #2 was diagnosed with cellulitis.

Observation of Resident #2 at various times on 10/21/25 between 8:30am-3:30pm revealed:
-She was not wearing compression stockings.
-She was wearing socks with an elastic band.

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| D 276 | Continued From page 62<br>-Both legs had noted swelling from her ankle to mid-calf.<br>-There were indentations in both legs from the elastic band of the socks.<br><br>Review of Resident #2's October 2025 electronic medication administration record (eMAR) from 10/01/25-10/21/25 revealed there was documentation compression stockings were applied every day at 5:00am and removed at 5:00pm.<br><br>Observation of Resident #2 on 10/22/25 at 7:30am and 9:30am revealed:<br>-She was wearing compression stockings.<br>-The compression stockings were bunched up around her ankles on both legs, with swelling above and below each of the wrinkles in the compression stockings.<br><br>Review of the National Institute of Health Medical Library article, Side Effects of Compression Stockings dated 05/27/14 revealed:<br>-Although the application of compression stockings can appear simple, it must be remembered that inappropriately worn stockings have the potential to cause significant problems.<br>-Unevenly distributed and excess pressure may break the skin, especially in older people with thin, brittle skin.<br>-It was important to ensure patients were appropriately assessed and monitored for suitability for compression stockings and that measures were taken to ensure they are worn appropriately.<br>-If not managed accordingly, compression stockings may cause unintended harm.<br>-It was of particular importance to ensure that there were no folds in the fabric, allowing even distribution of pressure throughout the limb, and | D 276 | | |

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to avoid creating a focus of higher pressure over one specific area

Interview with a medication aide (MA) on 10/22/25 at 9:45am revealed:
-She did not notice Resident #2's was not wearing compression stockings on 10/21/25.
-Third shift staff applied Resident #2's stockings.
-Resident #2 had "a lot" of swelling in her legs.
-Resident #2 walked a lot, which caused increased swelling.
-On 10/18/25, Resident #2's legs were visibly "big", and the compression stockings could not be applied.

Interview with the Special Care Unit Coordinator (SCC) on 10/22/25 at 10:16am revealed:
-Resident #2 was recently sent to the hospital for lower leg edema.
-If Resident #2's compression stockings were not applied correctly, the resident could develop sores from the compression "cutting" into the skin.

Interview with the Executive Director (ED) on 10/22/25 at 9:57am revealed:
-Resident #2 was recently sent to the Director for bilateral edema.
-Resident #2 had compression stockings on but still had swelling in her legs.
-When she pulled Resident #2's compression stockings down, she could see the legs were red.
-Compression stockings should be smooth when applied.
-If Resident #2's compression stockings were not applied correctly, it could cause Resident #2 to have circulation issues as well as cause more swelling in the area.

Telephone interview with Resident #2's primary

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| D 276 | Continued From page 64 | D 276 | | |

care provider (PCP) on 10/22/25 at 4:25pm revealed if a resident had an order for compression stockings, he expected the resident to be wearing them as prescribed.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/23/25 at 9:09am revealed Resident #2's compression stockings were not applied correctly, pulled up to the ankle, and tight; it could cause the resident to experience pain in the area where the stockings were not smooth.

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

Attempted telephone interview with the LHPS nurse on 10/22/25 at 10:43am was unsuccessful.

Refer to the interview with the third shift MA on 10/22/25 at 10:38am.

Refer to the interview with the ED on 10/22/25 at 9:57am.

Refer to the interview with the SCC on 10/22/25 at 10:16am.

Refer to the telephone interview with the Administrator on 10/22/25 at 12:11pm.

Refer to the telephone interview with a pharmacist from the facility's contracted pharmacy on 10/23/25 at 9:09am.

2. Review of Resident #5's current FL2 dated 04/15/25 revealed:
-Diagnoses included hypertension and Alzheimer's disease.
-The resident required assistance from staff with

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| D 276 | Continued From page 65 | D 276 | | |

bathing.

Review of Resident #5's care plan dated 09/23/25 revealed:
-She needed extensive assistance from staff with bathing and dressing.
-Her Licensed Health Professional Support (LHPS) tasks included compression stockings.

Review of Resident #5's LHPS assessment form dated 07/25/25 revealed no tasks for compression stockings.

Observation of Resident #5 at various times on 10/21/25 between 8:30am-3:12pm revealed:
-She was not wearing compression stockings.
-She was wearing socks with an elastic band.
-There were indentations in both legs from the elastic band of the socks.

Review of Resident #5's October 2025 electronic medication administration record (eMAR) from 10/01/25-10/21/25 revealed there was documentation that compression stockings were applied daily at 5:00am and removed at 4:00pm.

Interview with a medication aide (MA) on 10/22/25 at 9:45am revealed:
-She did not notice Resident #5 was not wearing compression stockings on 10/21/25.
-Third shift staff applied Resident #5's stockings.
-Resident #5 took a daily fluid pill.

Interview with Resident #5 on 10/22/25 at 3:12pm revealed:
-She sometimes wore compression stockings.
-She wore compression stockings to "get the swelling down".
-She wore compression stockings "about three times per week".

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-She did not refuse to wear compression stockings.
-She did not know why she did not wear compression stockings every day.
-She had gained weight from fluid.
-She could tell because her legs were swollen.
-When she laid down in the bed, the swelling went down.

Telephone interview with Resident #5's primary care provider (PCP) on 10/22/25 at 4:25pm revealed if a resident had an order for compression stockings, he expected the resident to be wearing them as prescribed.

Attempted telephone interview with the LHPS nurse on 10/22/25 at 10:43am was unsuccessful.

Refer to the interview with the third shift MA on 10/22/25 at 10:38am.

Refer to the interview with the ED on 10/22/25 at 9:57am.

Refer to the interview with the SCC on 10/22/25 at 10:16am.

Refer to the telephone interview with the Administrator on 10/22/25 at 12:11pm.

Refer to the telephone interview with a pharmacist from the facility's contracted pharmacy on 10/23/25 at 9:09am.

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Telephone interview with the third shift MA on 10/22/25 at 10:38am revealed:
-She worked third shift on 10/21/25.
-The MAs were responsible for applying the residents' compression stockings.
-She did not apply the resident's compression

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stockings because the stockings were wet.
-She could only find one pair of compression stockings for each of the residents, and the stockings were still wet.
-Some of the compression stockings were torn, and some did not have a resident's name on them, so those could not be applied.

Interview with the ED on 10/22/25 at 9:57am revealed:
-The MAs were responsible for applying compression stockings before the resident got out of bed.
-She was concerned staff were not following orders if the residents did not have compression stockings on.

Interview with the SCC on 10/22/25 at 10:16am revealed:
-The MA on the third shift was responsible for applying compression stockings.
-The staff on first shift should check the residents to make sure the compression stockings were applied.
-She saw that none of the residents had on compression stockings on 10/21/25.
-She was concerned that if the compression stockings were not applied as ordered, the residents' swelling would not be controlled.

Telephone interview with the Administrator on 10/22/25 at 12:11pm revealed:
-If a resident could not apply their own compression stockings, she expected the staff to apply them.
-She expected the orders to be followed.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/23/25 at 9:09am revealed:

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| D 276 | Continued From page 68<br>-Compression stockings were used for swelling.<br>-Swelling was caused by the pooling of fluid from decreased mobility or from heart issues.<br>-Swelling could cause the skin to stretch, which could be painful.<br>-Swelling in the lower extremities could cause loss of feeling, which could increase the risk of falls. | D 276 | | |
| D 286 | 10A NCAC 13F .0904(b)(1) Nutrition and Food Service<br><br>10A NCAC 13F .0904 Nutrition and Food Service<br>(b) Food Preparation and Service in Adult Care Homes:<br>(1) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers.<br><br>This Rule is not met as evidenced by:<br>Based on observations and interviews, the facility failed to ensure that mealtime table service included a non-disposable place setting including glasses for the residents' supplements in the Special Care Unit (SCU).<br><br>The findings are:<br><br>Observations of the lunch meal service in the SCU on 10/21/25 from 11:48am-12:10pm revealed four residents were served a nutritional | D 286 | Dietary staff will assure a non disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers will be placed at each meal time for all residents unless otherwise documented based on needed or resident preference.<br><br>Dietary manager will monitor 2 meals per week x3 weeks, then randomly thereafter to ensure all residents receive place settings in accordance to 10A NCAC 13F .0904(b)(1).<br><br>Director will monitor meals randomly to ensure all residents receive a place setting in accordance to 10A NCAC 13F .0904(b)(1)<br><br>QI department will audit quarterly or on an as needed basis to ensure all residents receive place settings in accordance to 10A NCAC 13F .0904(b)(1) | 12/7/2025 |

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supplement in a disposable carton; there were no glasses to pour the supplements into.

Observations of the breakfast meal service in the assisted living (AL) on 10/22/25 from 7:25am to 8:09am revealed four residents were served a nutritional supplement in a disposable carton; there were no glasses to pour the supplements into.

Interview with a personal care aide (PCA) on 10/22/25 at 8:42am revealed:
-Staff opened the cartons of the nutritional supplement for the residents because the residents had trouble opening the cartons.
-No one had ever asked her to pour the nutritional supplement into a glass, but if a resident was struggling to drink out of the carton, she would pour it into a glass.

Interview with a medication aide (MA) on 10/22/25 at 8:48am revealed:
-Staff always opened the cartons of nutritional supplements for the residents.
-She had told the kitchen manager that more cups were needed in the SCU at meals.
-If she poured the nutritional supplement into a glass, she would not have enough glasses for other beverages.

Interview with the SCU Coordinator on 10/22/25 at 8:49am revealed staff should pour the nutritional supplements into a glass to serve.

Interview with the Dietary Manager on 10/22/25 at 9:00am revealed she was not aware that the nutritional supplements were to be served in a glass when served with the meal.

Interview with the Executive Director on 10/22/25

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| D 286 | Continued From page 70<br>at 9:57am revealed supplements should be served in a cup when served at meals.<br><br>Telephone interview with the Administrator on 10/22/25 at 12:11pm revealed if a nutritional supplement was served with a meal, the supplement should be served based on the resident's preference, in a cup or in the carton, whatever the resident preferred.<br><br>Based on observations and interviews, the residents who were served a nutritional supplement were not interviewable. | D 286 | | |
| D 296 | 10A NCAC 13F .0904(c)(7) Nutrition And Food Service<br><br>10A NCAC 13F .0904 Nutrition And Food Service<br>(c) Menus in Adult Care Homes:<br>(7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff.<br><br>This Rule is not met as evidenced by:<br>Based on interviews and record reviews, the facility failed to have a matching therapeutic diet menus for food service guidance for 2 of 3 sampled residents (#1 and #5) who had a physician's order for a no concentrated sweets (NCS) diet (#1) and a mechanical soft (MS) diet (#5). | D 296 | Director retrained dietary staff on matching therapeutic diet menu for all residents. If there is no menu for diet order, SCUC/designee will contact phsycian for clarification.<br><br>SCUSDesignee will review diet orders to the diet order sheet in the kitchen weekly x 4, then monthly x3 then randomly thereafter to ensure the diet orders are correct. | 12/7/2025 |

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| D 296 | Continued From page 71<br>The findings are:<br><br>1. Review of Resident #1's current FL2 dated 02/04/25 revealed diagnoses included dementia, cerebral palsy, diabetes mellitus type 2, myasthenia gravis, hypertension, and hyperlipidemia.<br><br>Review of Resident #1's diet order dated 09/25/25 revealed Resident #1 was ordered a NCS diet.<br><br>Review of the facility's therapeutic diet menus for the week of 10/20/25 revealed there was no NCS diet available for food service guidance.<br><br>Observation of Resident #1's lunch meal service on 10/21/25 at 11:49am revealed he was served chicken parmesan with tomato sauce and spaghetti noodles, cauliflower a roll and a piece of angel food cake.<br><br>Interview with Resident #1 on 10/21/25 at 12:06pm revealed:<br>-He was diabetic.<br>-He was not on a diabetic diet of any kind.<br><br>Interview with the Kitchen Manager on 10/21/25 at 2:10pm revealed:<br>-The food supply company provided weekly menus and therapeutic diet menus.<br>-The food supply company usually sent a hard copy of the therapeutic menu.<br>-The therapeutic diet menu did not have a NCS diet.<br>-She followed the consistent carbohydrate diet and made sure the desserts were sugar free.<br>-She also looked online for guidance for food options for diabetic residents. | D 296 | | |

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| D 296 | Continued From page 72<br><br>Interview with the Executive Director (ED) on 10/21/25 at 3:20pm revealed:<br>-She was responsible for ensuring there were therapeutic diet menus for the staff to follow when preparing meals.<br>-She thought there was a NCS therapeutic diet menu for the kitchen staff to follow.<br>-She knew a consistent carbohydrate diet was controlling carbohydrates and was not the same as a NCS diet.<br>-The facility's house diet for diabetic residents was the NCS diet, not the consistent carbohydrate diet.<br>-Someone should have realized there was no NCS diet on the therapeutic diet menu; it was overlooked.<br><br>Telephone interview with the Administrator on 10/22/25 at 12:20pm revealed:<br>-The ED was responsible for ensuring the therapeutic diet menus were given to the Kitchen Manager for the kitchen to use.<br>-She had not seen therapeutic diet menus for the facility, but she thought the Director was taking care of them.<br>-The kitchen staff needed the therapeutic diet menus, so they knew what to provide for the residents' meals.<br>-She thought the consistent carbohydrate diet was the same as the NCS diet.<br>-The facility needed to follow the diet orders as the physician had written them.<br><br>Attempted telephone interview with Resident #1's primary care provider on 10/21/25 at 4:35pm was unsuccessful.<br><br>2. Review of Resident #5's current FL2 dated 04/15/25 revealed:<br>-Diagnoses included hypertension and | D 296 | | |

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| D 296 | Continued From page 73<br>Alzheimer's disease.<br>-There was an order for a regular diet with chopped meat.<br><br>Review of Resident #5's care plan, dated 09/23/25, revealed that she required supervision with eating and needed prompting during meals.<br><br>Review of the facility's diet list revealed Resident #5 was ordered a MS diet.<br><br>Observation of Resident #5's lunch meal service on 10/21/25 at 11:49am revealed she was served chopped spaghetti with chopped chicken and marinara sauce, large pieces of cooked cauliflower, and a roll.<br><br>Review of the facility's therapeutic diet menus for the week of 10/20/25 revealed there was no MS diet available for food service guidance.<br><br>Interview with the Kitchen Manager on 10/21/25 at 10/21/25 at 2:10pm revealed:<br>-The food supply company provided weekly menus and therapeutic diet menus.<br>-The food supply company usually sent a hard copy of the therapeutic menu.<br>-There was no MS diet on the therapeutic diet menus.<br>-The MS diet was soft foods and chopped meats.<br>-She thought following the recipes and the guidance the recipes gave was enough.<br><br>Interview with the Executive Director on 10/21/25 at 12:25pm revealed:<br>-She had contacted her corporate office and was told the cooks used the recipes as guidance when preparing the meals; the recipes included instructions on how to prepare items for a MS diet. | D 296 | | |

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| D 296 | Continued From page 74<br>-She was told MS was a consistency and that was why there was no menu.<br>-She was responsible for ensuring there were therapeutic diet menus for the staff to follow when preparing meals.<br><br>Telephone interview with the Administrator on 10/22/25 at 12:20pm revealed:<br>-The ED was responsible for ensuring the therapeutic diet menus were given to the Kitchen Manager for the kitchen to use.<br>-She had not seen therapeutic diet menus for the facility, but she thought the Director was taking care of them.<br>-The kitchen staff needed the therapeutic diet menus, so they knew what to provide for the residents' meals.<br>-The facility needed to follow the diet orders as the physician had written them.<br>-The MS diet was just a texture modification to be sure the resident can chew and swallow the food.<br>-The MS diet was the same menu as the regular menu, just some items were traded out like a dinner roll; but the staff would need to know what the residents could have and not have.<br><br>Attempted telephone interview with Resident #5's primary care provider on 10/21/25 at 4:35pm was unsuccessful. | D 296 | | |
| D 298 | 10A NCAC 13F .0904(d)(2) Nutrition And Food Service<br><br>10A NCAC 13F .0904 Nutrition And Food Service<br>(d) Food Requirements in Adult Care Homes:<br>(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 | D 298 | | |

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| D 298 | Continued From page 75<br>day and shown on the menu as snacks.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to offer or make available three snacks a day for the residents.<br><br>The findings are:<br><br>Review of the facility's cycle week-at-glance menu for the current week revealed snacks were not listed on the menu.<br><br>Interview with three residents on 10/22/25 at 10:10am revealed:<br>-They used to have snacks three times a day; after each meal.<br>-The staff would walk around and let them know there were snacks or bring them with them to their rooms.<br>-Sometimes there was a cart with snacks in front of the medication room.<br>-Snacks were not offered after dinner anymore.<br>-They would eat snacks if they knew when they were available.<br><br>Interview with a resident on 10/22/25 at 10:25am revealed:<br>-The facility had good snacks, but you had to know when they put the snacks out or you missed them.<br>-Sometimes one or two residents would take all the snacks and not leave any for the rest of the | D 298 | Staff will serve snacks in the facility 3 times a day in accordance with rule 10A NCAC 13F .0904 (d)(2)<br><br>Director/Designee will ensure there are snacks in the facility and that they are offered 3 times a day in accordance with rule 10A NCAC 13F .0904 (d)(2)<br><br>QI Department/Compliance Director will conduct audits to facility at least quarterly to ensure there are snacks in the facility and that they are offered 3 times a day in accordance with rule 10A NCAC 13F .0904(d)(2) | 12/7/2025 |

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| D 298 | Continued From page 76 | D 298 | | |

residents.
-Some of the staff would walk around with the snack cart but lately they just parked it in the medication room.
-She did not think snacks were offered after dinner.
-Sometimes she did not want to leave her room to go get a snack; it would be better if the staff brought them around to the rooms like they once did.

Interview with a personal care aide (PCA) on 10/22/25 at 10:35am revealed:
-Snacks were offered after every meal.
-Snacks were put on a cart in front of the medication room.
-Some of the residents would come up and get their own snack and the PCAs would take snacks to the other residents.

Interview with a medication aide (MA) on 10/22/25 at 10:45am revealed:
-Snacks were put on a cart in the medication room between meals.
-When she saw residents, she would let them know they were snacks in the medication room.
-Some of the residents would say they did not want a snack.
-The residents kept a lot of snacks in their rooms.

Interview with the Kitchen Manager on 10/22/25 at 2:10pm revealed:
-The kitchen staff prepared a snack cart with proportioned packaged items including cookies, sandwich cookies, oatmeal cream cookies, crackers, peanut butter crackers, water and assorted beverages.
-The snack cart was stocked three times a day between meals at 10:00am, 2:00pm and 7:00pm.
-The PCAs took the snack cart to the medication

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room.
-Every now and again the residents would say they did not get snacks, but they forgot.
-The PCAs were supposed to pass snacks to the residents and not leave them in the medication room.

Interview with the Executive Director (ED) on 10/22/25 at 4:55pm revealed:
-Snack time was 10:00am, 2:00pm, and 8:00pm.
-The kitchen staff prepared a snack cart and the PCAs took the cart to the medication room.
-The residents picked up what they wanted off the snack cart in the medication room.
-The PCAs were also supposed to offer snacks to the residents who did not come to the medication room to get snacks.
-The PCAs knew which residents liked and wanted snacks.
-Some of the residents already had their own snacks in their rooms.

Telephone interview with the Administrator on 10/22/25 at 12:20pm revealed:
-Snacks were offered to the residents three times a day at 10:00am, 2:00pm and 8:00pm.
-The kitchen made a cart with snacks on it and the PCAs took the cart to the residents in their rooms and offered them snacks.
-Every resident was supposed to be offered a snack between meals.
-She was not aware that the snack cart was staying in the medication room or in front of the medication room.
The ED was responsible for monitoring these snacks for the residents.
She had not received complaints from residents about snacks.

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| D 315 | Continued From page 78 | D 315 | | |
| D 315 | 10A NCAC 13F .0905 (a & b) Activities Program<br><br>10A NCAC 13F .0905 Activities Program<br>(a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community.<br>(b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his or her will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities.<br><br>This Rule is not met as evidenced by:<br>Based on observations and interviews, the facility failed to develop and implement an activity program to engage residents with each other.<br><br>The findings are:<br><br>Observation of the facility on 10/21/25 at 9:00am revealed there was no activities calendar posted for the month of October 2025.<br><br>Interview with three residents on 10/22/25 at 10:10am revealed:<br>-They had not had good activities since the Activity Director left about a year ago.<br>-They used to go on outings, but they did not go out anymore unless it was with family or to a physician's appointment.<br>-Activities would help pass the day.<br><br>Interview with a fourth resident on 10/22/25 at 10:25am revealed:<br>-The facility did more activities when they had an Activity Director. | D 315 | Activities Coordinator/ Designee will develop scheduled activities 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.<br><br>Directcor/designee will monitor to ensure that there are at least 14 hours of activities each week.<br><br>QI department/Compliance Director will conduct audits of facility at least quarterly to ensure 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. | 12/7/2025 |

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-They did a different activity every day.
-Sometimes all they did was watch the staff dance, reminisce or play bingo.
-She used to love coffee hour where they would discuss current events, she missed going on outings and just doing more social things.
-She would go on outings if the facility offered them.

Interview with the Housekeeper on 10/22/25 at 8:12am revealed:
-The facility had not had an Activity Director for about a year.
-She helped with activities for the residents.
-She loved doing activities with the residents.
-She would sing and dance with them and help with bingo.
-She played songs on her cell phone and danced.
-She would do exercises with the residents.
-She had not had any training or certifications for activities; she helped when she had the time.
-She helped with the activities every chance she could; she helped almost every day.

Interview with the facility's contracted mental health provider (MHP) on 10/22/25 at 9:50am revealed:
-She believed the facility should be doing routine activities for the residents.
-The residents would benefit 100% from routine activities.
-Social stimulation such as activities were vital to the residents' mental health and overall health.
-She used to see activities in the facility like bingo and crafts, but the facility needed a dedicated Activity Director so there would be a variety and more activities going on every day.
-The residents had noticed the decline in the activity program and some of them mentioned the Activity Director left about a year ago.

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| D 315 | Continued From page 80<br><br>Interview with a personal care aide (PCA) on 10/22/25 at 10:35am revealed:<br>-The residents would call the bingo games; they enjoyed doing their activities themselves.<br>-The residents enjoyed music.<br>-The staff would go into the resident's rooms and dance and act silly with them.<br>-The facility used to take the residents on trips to events like parades.<br>-The facility had not had a trip in a long time because they had not had an Activity Director in about a year.<br><br>Interview with a medication aide (MA) on 10/22/25 at 10:45am revealed:<br>-The facility had not had an Activity Director since she started; she did not know why.<br>-The staff all chipped in and tried to do a little something with the residents.<br>-Sometimes the residents would initiate and organize their own bingo and take turns calling the numbers.<br>-Activities were not something that were scheduled every day.<br>-The staff would play music for the residents, dance or paint their fingernails.<br>-One time someone brought balls out of a closet and staff tossed them around with the residents; everyone really enjoyed it.<br><br>Interview with the Special Care Unit Coordinator (SCC) on 10/22/25 at 2:40pm revealed:<br>-The facility staff all tried to do a little bit of activies for the residents.<br>-The staff would play bingo, and play music.<br>-The staff all pitched in to keep the residents busy.<br>-The facility had not had an Activity Director for about eight months. | D 315 | | |

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| D 315 | Continued From page 81<br>-Between all the staff doing activities she thought they did eight to ten hours of activities a week.<br><br>Interview with the Executive Director (ED) on 10/21/25 at 3:10pm revealed:<br>-The facility had not had an Activity Director since last year; it had been a year.<br>-A church group came in and played bingo with the residents and staff would paint the residents' nails.<br>-She had a list of outside groups that did activities and the special care unit (SCU) and the assisted living (AL).<br>-Every third Thursday a woman came and sang for the residents.<br>-Different staff and residents would play bingo with the residents.<br>-She thought there would be a new Activity Director starting soon because they had made an offer to someone.<br>-The person had worked as an Activity Director somewhere else.<br><br>Telephone interview with the Administrator on 10/22/25 at 12:20pm revealed:<br>-Several volunteers from the community and the staff did activities in the facility.<br>-She was not sure if the facility had 14 hours of activities scheduled per week.<br>-The facility ED was responsible for completing the activity calendar.<br>-A new Activity Director had been hired but she did not know the start date.<br>-She was not sure how long the facility had been without an Activity Director.<br>-The residents had not complained to her about not having activities in the facility.<br>-Activities increase the quality of life for the residents.<br>-The residents' families took them for outings. | D 315 | | |

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| D 315 | Continued From page 82<br>-The facility was lucky to have good community, family and staff volunteers for activities for the residents. | D 315 | | |
| D 344 | 10A NCAC 13F .1002(a) Medication Orders<br><br>10A NCAC 13F .1002 Medication Orders<br>(a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments:<br>(1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility;<br>(2) if orders are not clear or complete; or<br>(3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.<br>The facility shall ensure that this verification or clarification is documented in the resident's record.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews, observations, and interviews, the facility failed to clarify a medication order for 1 of 5 sampled residents (#2) related to an order for a medication used to treat fluid retention.<br><br>The findings are:<br><br>Review of Resident #2's current FL2 dated 08/25/25 revealed:<br>-Diagnoses included hypertension and Alzheimer's disease.<br>-There was no order for furosemide (a diuretic medication used to treat fluid retention) 40mg take one tablet as needed for fluid or edema. | D 344 | SCUC/designee will compare physician's orders once per week x 4 weeks, then once per month ongoing to medication administration record to ensure residents receive medications as ordered.<br><br>For physicians orders that need clarification the physician will be contacted by the Med Aide. Facility will document clarification of orders in resident chart<br><br>SCUC/Director will audit resident charts at least quarterly to ensure admission/readmission forms have orders clarified as needed. | 12/7/2025 |

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Review of Resident #2's primary care provider's (PCP) after-visit summary dated 07/24/25 revealed:
-Resident #2 was being seen secondary to a recent hospitalization from 07/20/25-07/21/25 with acute kidney injury (AKI).
-Resident #2's diuretics were discontinued during the hospitalization, and her renal function improved back to baseline.
-Resident #2 was discharged on furosemide as needed.
-Resident #2's hospital discharge summary was verified with the current medication list.
-Resident #2's furosemide 40mg once daily was discontinued.
-Resident #2 had an order for 40mg furosemide once daily as needed for fluid or edema.

Review of Resident #2's August 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for furosemide 40mg take one tablet daily.
-Furosemide 40mg was documented as administered once daily from 08/01/25-08/08/25, 08/10/25-08/12/25, and 08/15/25.
-There were exceptions documented on 08/09/25, 08/13/25, and 08/14/25 as the medication was discontinued.
-There was documentation the furosemide 40mg once daily was discontinued on 10/15/25 at 10:10am.
-There was no entry for furosemide 40mg one tablet as needed for fluid or edema.
-There was no documentation that furosemide 40mg as needed had been administered.

Review of Resident #2's September 2025 eMAR revealed:
-There was no entry for furosemide 40mg one

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tablet as needed for fluid or edema.
-There was no documentation furosemide 40mg had been administered.

Review of Resident #2's October 2025 eMAR from 10/01/25-10/21/25 revealed:
-There was no entry for furosemide 40mg one tablet as needed for fluid or edema.
-There was no documentation furosemide 40mg as needed had been administered from 10/01/25-10/21/25.

Observation of Resident #2's medications on hand on 10/21/25 at 12:13pm revealed:
-There was a 40mg punch card for furosemide with the direction to administer one tablet daily as needed for fluid or edema dispensed on 07/22/25.
-There were 19 of 30 tablets remaining on the punch card.

Interview with the medication aide (MA) on 10/21/25 at 12:13pm revealed:
-She had administered Resident #2's furosemide recently because of swelling in her legs.
-Resident #2 had an order for furosemide as needed for swelling.

Telephone interview with a representative from the facility's contracted pharmacy on 10/21/25 at 2:19pm revealed:
-Resident #2 did not have a current order for furosemide.
-Resident #2's daily and as needed order for furosemide was discontinued on 07/31/25.

Interview with the same MA on 10/22/25 at 9:45am revealed:
-She knew she documented when she administered Resident #2's as needed furosemide.

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| NORTH POINTE OF MAYODAN | 6970 NC HWY 135 MAYODAN, NC 27027 |

| (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 |
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| D 344 | Continued From page 85<br>-She found the entry where she documented the furosemide in the computer system under the treatment administration record (TAR).<br>-She did not know why the as needed furosemide was listed on the TAR, but that was where she documented when she administered Resident #2's furosemide.<br><br>Review of Resident #2's October TAR from 10/01/25-10/22/25 revealed:<br>-There was an entry under the column labeled as needed treatments, furosemide 40mg, take one tablet once daily as needed for fluid or edema, with an entry date of 08/15/25.<br>-Furosemide was documented as administered on 10/05/25, 10/07/25, 10/08/25, 10/17/25 and 10/18/25.<br>-There were no results documented for the dates the furosemide was administered.<br><br>Interview with the Special Care Unit Coordinator (SCC) on 10/22/25 at 10:54am revealed:<br>-Someone at the pharmacy keyed in Resident #2's order for furosemide on the TAR, and that was why it was not showing up on the eMAR.<br>-She could see the order was entered on 08/15/25, but she did not know who entered the order.<br><br>Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/22/25 at 11:00am revealed:<br>-Resident #2 did not have a current order for furosemide.<br>-An order for 40mg furosemide once daily as needed was dispensed on 07/22/25.<br>-An order to discontinue Resident #2's furosemide was received on 07/22/25.<br>-She thought the staff at the facility could enter orders, but she was not sure. | D 344 | | |

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| D 344 | Continued From page 86<br><br>Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/22/25 at 4:03pm revealed:<br>-When Resident #2 was discharged from the hospital on 07/21/25, there was an order to discontinue the daily furosemide and to continue the as needed furosemide.<br>-On 07/31/25, when the pharmacy received a handwritten order to discontinue furosemide, the only active order was the as needed, and it was therefore discontinued.<br>-Now that he was reviewing the information, he thought the order for the furosemide as needed should not have been discontinued and would still be an active order.<br>-He did not have a copy of Resident #2's FL2 dated 08/25/25.<br>-The order dated 07/31/25 was refaxed to the pharmacy on 08/14/25, but he did not see that the order was entered into their system.<br>-If an FL2 was received at the pharmacy and an active medication was not listed, the pharmacy staff would have clarified to make sure it was not left off the FL2 by accident.<br><br>Telephone interview with Resident #2's PCP on 10/22/25 at 4:25pm revealed:<br>-Fluid medication was more important to him than compression stockings.<br>-He usually only ordered furosemide for short-term use and then discontinued the medication.<br>-He had not reviewed Resident #2's eMAR.<br>-An order had been given to administer furosemide as needed.<br>-He presumed the medication was active from a previous order.<br>-If Resident #2's furosemide was not listed on the FL2, the order should have been clarified. | D 344 | | |

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| D 344 | Continued From page 87<br><br>Interview with the Executive Director on 10/23/25 at 10:32am and 11:50am revealed:<br>-Once the PCP signed the FL2, it was filed in the resident's record.<br>-The FL2 was only sent to the pharmacy if a new medication was added.<br>-Signed physician's orders were signed every six months and sent to the pharmacy.<br>-She did not know if Resident #2 had signed physician's orders more recent than the FL2.<br>-The pharmacy usually caught errors.<br><br>Interview with the SCC on 10/23/25 at 11:26am revealed:<br>-She usually completed the FL2s, sent a copy to the pharmacy, and filed the FL2.<br>-She did not complete Resident #2's FL2 because she was out of work at the time.<br>-She thought the issue was because the order was keyed on the TAR and not the eMAR, so it was missed when the FL2 was completed.<br><br>Attempted telephone interview with the Administrator on 10/23/25 at 1:32pm was unsuccessful. | D 344 | | |
| D 358 | 10A NCAC 13F .1004 (a) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(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:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures. | D 358 | | |

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| D 358 | Continued From page 88<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 5 sampled residents (#1 and #2), including a medication used to treat diabetes (#1) and a medication used to treat high blood pressure (#2).<br><br>The findings are:<br><br>1. Review of Resident #1's current FL2 dated 02/04/25 revealed:<br>-Diagnoses included dementia, cerebral palsy, diabetes mellitus type 2, myasthenia gravis, hypertension, and hyperlipidemia.<br>-There was an order for Ozempic (a medication used to lower blood sugar results) 0.5mg subcutaneously (sq) weekly.<br><br>Review of Resident #1's record revealed there was an order for Ozempic 1mg weekly.<br><br>Review of Resident #1's record revealed blood sugar results from 08/01/25 to 10/21/25 ranged from 114 to 182.<br><br>Review of Resident #1's electronic medication administration record (eMAR) for August 2025 revealed:<br>-There was an entry for Ozempic 1mg weekly with a scheduled administration time of 8:00am.<br>-Ozempic 1mg was documented as administered on 08/03/25, 08/10/25, 08/17/25, and 08/24/25.<br>-Ozempic 1mg was documented as "patient unable to take medication" on 08/31/25.<br><br>Review of Resident #1's eMAR for September 2025 revealed:<br>-There was an entry for Ozempic 1mg weekly | D 358 | Director/SCUC audited Med Carts and Orders to assure all medications are available to be administered as prescribed.<br><br>Director retrained medication aides on medication administration and medications errors.<br><br>For any med error identified, the PCP will be notified and med error report completed.<br><br>Director/SCUC will observe a minimum of two medication passes weekly x4, will observe a minimum of 3 medication passes monthly x3 and then randomly thereafter to ensure medication is administered as ordered by the physician. | 12/7/2025 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| D 358 | Continued From page 89 | D 358 | | |

with a scheduled administration time of 8:00am.
-Ozempic 1mg was documented as administered on 09/07/25, 09/14/25, 09/21/25, and 09/28/25.

Review of Resident #1's eMAR for October 2025 from 10/01/25 through 10/21/25 revealed:
-There was an entry for Ozempic 1mg weekly with a scheduled administration time of 8:00am.
-There was no documentation Ozempic 1mg was administered from 10/01/25 to 10/21/25.

Observation of Resident #1's medications on hand on 10/21/25 at 11:00am revealed:
-There was one box of Ozempic 1mg available for administration.
-The box had an opened date of 10/26/25.
-The box contained one 3ml pen of Ozempic.
-There were 4 needles included in the box.
-The needles were unopened.
-There was no other Ozempic available for administration.

Telephone interview with a representative from the facility's contracted pharmacy on 10/21/25 at 1:26pm revealed:
-The pharmacy received an order to increase Resident #1's Ozempic from 0.5mg to 1mg on 10/08/25.
-A 3ml pen of Ozempic 1mg was dispensed on 10/19/25.
-Prior to that, the pharmacy had not dispensed Ozempic since June 2025.
-The 3ml pen of Ozempic 1mg would last one month.
-Ozempic was used to lower blood sugar results.

Interview with Resident #1 on 10/21/25 at 4:30pm revealed:
-He took Ozempic every week on Sunday.
-He did not know the dose of the medication.

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| D 358 | Continued From page 90<br>-He did not refuse his medications.<br><br>Interview with the medication aide (MA) on 10/22/25 at 4:35pm revealed:<br>-Resident #1 received Ozempic 1mg on Sundays.<br>-She administered the Ozempic to Resident #2 weekly on Sunday.<br>-At the end of September, Resident #2 ran out of Ozempic, and it was received a couple of days ago<br><br>Interview with Resident #1's primary care provider (PCP) on 10/21/25 at 2:00pm revealed:<br>-Resident #1 was on Ozempic 1mg weekly.<br>-Resident #1 was also on Tresiba (insulin used to lower blood sugars) daily.<br>-His goal was to get Resident #1 off Tresiba and continue him on the Ozempic.<br>-He was not aware Resident #1 was not receiving the Ozempic as ordered.<br>-He was frustrated that he was not receiving it as ordered because he thought he would now have to start him out at a lower dose to decrease side effects.<br>-He was not concerned about Resident #1's blood sugar results.<br>-The last hemoglobin A1c (a blood test to measure average blood sugar results over 3 months result for Resident #1 was 6.8, which was lower than the previous result.<br><br>Interview with the Executive Director (ED) on 10/22/25 at 3:15pm revealed:<br>-She was aware Resident #1's Ozempic changed from 0.5mg to 1mg but could not recall when.<br>-She was not aware the Ozempic 1mg for Resident #1 was not sent by the pharmacy until 10/19/25.<br><br>Interview with the Administrator on 10/22/25 at | D 358 | | |

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| D 358 | Continued From page 91<br><br>12:07pm revealed:<br>-She expected the Special Care Unit Coordinator (SCC) and the ED to audit medication carts and eMARs to ensure medications were on hand and to contact the pharmacy if medications were not available.<br>-She expected medications to be administered as ordered.<br><br>2. Review of Resident #2's current FL2 dated 08/25/25 revealed:<br>-Diagnoses included hypertension and Alzheimer's disease.<br>-There was an order for irbesartan (used to treat high blood pressure) 75mg take one-half tablet daily; hold if systolic blood pressure (SBP) was less than 110.<br><br>Review of Resident #2's September 2025 electronic medication administration record (eMAR) revealed:<br>-There was an entry for irbesartan 75mg take one half tablet once daily, hold if SBP was less than 110, scheduled at 8:00am.<br>-Irbesartan was not documented as administered on 09/29/25 and 09/30/25 at 8:00am, with the exception documented as medication on hold.<br>-Resident #2's BP at 8:00am on 09/29/25 was not documented, and on 09/30/25 was documented as 165/95.<br>-Resident #2's BP ranged from 114/62-165/95.<br><br>Review of Resident #2's October 2025 eMAR from 10/01/25 through 10/21/25 revealed:<br>-There was an entry for irbesartan 75mg take one half tablet once daily, hold if SBP was less than 110, scheduled at 8:00am.<br>-Irbesartan was not documented as administered on 15 out of 22 opportunities, with the exception documented as medication on hold; her SBP was | D 358 | | |

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above 110 when the medication was held.
-Irbesartan was documented as administered on 10/09/25 when the resident's SBP was 110.
-Resident #2's BP ranged from 110/57-165/89.

Observation of Resident #2's medications on hand on 10/21/25 at 12:13pm and on 10/22/25 at 9:21am revealed there was a punch card dispensed on 10/21/25 for irbesartan 75mg take one-half tablet once daily, hold if SBP was less than 110; there were 30 of 30 one-half tablets remaining on the punch card.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/22/25 at 9:15am revealed:
-Resident #2's current order was for irbesartan 75mg take one-half tablet once daily, hold if SBP was less than 110
-If Resident #2's irbesartan was not administered when the resident's BP was greater than 110, the resident could experience high BP, which could lead to heart and cardiovascular issues, increased risk of strokes, and even death.
-If Resident #2's irbesartan was administered when the resident's BP was less than 110, the resident's BP would go even lower.

Interview with a medication aide (MA) on 10/22/25 at 9:21am revealed:
-If Resident #2's SBP was below 110, she administered irbesartan.
-If Resident #2's SBP was more than 110, she held the irbesartan.
-Resident #2's BP was 120/59 today, 10/22/25, so she did not administer the irbesartan.
-She thought the symbol (less than) meant anything over that number (110), she was not supposed to administer the medication.

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| D 358 | Continued From page 93<br><br>Observation of Resident #2's BP being taken on 10/22/25 at 9:44am revealed a BP reading of 144/74.<br><br>Interview with the Special Care Unit Coordinator (SCC) on 10/22/25 at 9:26am revealed:<br>-She expected the MAs to read the order, check the medication, and administer the medication as ordered.<br>-She tried to audit the medication carts once a month.<br>-She reviewed the eMAR and noted it appeared the MA was not administering Resident #2's irbesartan when the medication should have been administered.<br><br>Interview with the Executive Director on 10/22/25 at 9:52am revealed:<br>-The pharmacy did random cart audits, and she did them as well.<br>-She also did random medication pass observations.<br>-Resident #2's order for irbesartan was to hold the medication when the resident's SBP was less than 110 and to otherwise administer the medication.<br>-If Resident #2's SBP was already low and the medication was administered, the resident's BP could "bottom out".<br>-If Resident #2's BP was high and the medication was held, the resident's BP could go even higher, and she could have a stroke.<br>-She was concerned that the MA read the symbol incorrectly.<br><br>Telephone interview with the Administrator on 10/22/25 at 12:11pm revealed she expected the medication orders to be followed correctly and medication to be administered per parameters. | D 358 | | |

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| D 358 | Continued From page 94<br><br>Telephone interview with Resident #2's primary care provider (PCP) on 10/22/25 at 4:25pm revealed:<br>-Resident #2 was ordered irbesartan to treat high BP.<br>-He would only be concerned Resident #2's irbesartan was not administered when the resident's BP was greater than 110, if the resident's BP was high.<br>-He did not think a BP reading of 165/89 was of concern.<br>-He was not concerned Resident #2's BP reading was 120/59 at 8:00am and was 144/74 at 9:44am after the resident was not administered the irbesartan.<br>-It sounded like the order needed to be clarified so the MA understood the parameter. | D 358 | | |
| D 366 | 10A NCAC 13F .1004 (i) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br><br>(i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to ensure observation of 1 of 5 residents (#4) taking their medications when the medications were left on a table in the | D 366 | | |

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| D 366 | Continued From page 95<br>resident's room.<br><br>The findings are:<br><br>Review of Resident #4's current FL2 dated 10/09/25 revealed:<br>-Diagnoses included arthritis, hyperlipidemia, hypertension, insomnia, right lumbar radiculopathy, and gastroesophageal reflux disorder.<br>-Resident #4 was intermittently disoriented.<br>-There was an order for Norvasc (used to lower blood pressure) 10mg daily.<br>-There was an order for Celexa (used to treat depression) 10mg daily.<br>-There was an order for gabapentin (used to treat nerve pain) 100mg every evening.<br><br>Observation of Resident #4's room on 10/21/25 at 8:45am revealed:<br>-There was a paper medication cup with two tablets in it on a tray table in the resident's room.<br>-Resident #4's name was written on the bottom of the paper medication cup.<br>-Resident #4 was seated in a recliner with her breakfast on the tray table.<br>-The tablets were not identifiable.<br><br>Review of Resident #4's October 2025 electronic medication administration record (eMAR) for 10/21/25 revealed:<br>-There was an entry for Norvasc 10mg daily scheduled at 8:00am.<br>-There was documentation Resident #4's Norvasc 10mg had been administered on 10/21/25.<br>-There was an entry for Celexa 10mg daily scheduled at 8:00am.<br>-There was documentation Resident #4's Celexa 10mg had been administered on 10/21/25. | D 366 | Director retrained all Medication aides on the procedures of passing medications and observing residents taking medications.<br><br>SCUD/Designee will observe a minimum of two medication passes weekly x4, will observe a minimum of 3 medication passes monthly x3 and then randomly thereafter to ensure medications are observed being taken by the resident prior to recording of the administration of the medication.<br><br>Director will perform random sweeps of rooms to ensure no medications are found.<br><br>Any staff member found not following policy and procedure will receive disciplinary action up to and including termination. | 12/7/2025 |

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| D 366 | Continued From page 96<br><br>Interview with Resident #4 on 10/21/25 at 8:45am revealed:<br>-The medication aide (MA) gave her morning medications to her and left the room.<br>-She told the MA she would take the medications after she ate her breakfast.<br>-The MA usually did not watch her take her medications.<br>-One tablet was for her high blood pressure, and the other tablet was for heart; she did not know the names of the medications or the doses.<br><br>Interview with a medication aide (MA) on 10/22/25 at 10:45am revealed:<br>-When administering medication to a resident she stayed with the resident and watched the resident take the medication; she never left a medicine cup in a room for a resident to take later.<br>-There were some residents that requested for her to leave the medication in the cup and the room, but she never did.<br>-She knew Resident #4 had medications that she administered herself, but she also had two medications the MAs administered in the mornings.<br>-She did not document administration on the eMAR until she saw the resident take the medication.<br><br>Interview with a second MA on 10/22/25 at 2:35pm revealed:<br>-Resident #4 had two medications scheduled in the mornings.<br>-Resident #4 would stop by the medication cart on her way to breakfast and take her morning medications.<br>-When Resident #4 ate breakfast in her room the MA would take it to her in a cup and watch her take it. | D 366 | | |

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| D 366 | Continued From page 97<br>-She had administered Resident #4 her two morning medications yesterday, 10/21/25 and watched her swallow them; she did not know if the medications in the cup were from the night before or from another day.<br>-She only documented on the eMAR after Resident #4 took her medications.<br><br>Interview with the Executive Director (ED) on 10/22/25 at 4:55pm revealed:<br>-The MAs were supposed to observe the resident taking their medication and make sure it was swallowed.<br>-After the MA knows the resident swallowed the medication the MA would document it as administered on the eMAR.<br>-The MAs were not allowed to leave medication in a cup in the resident's room.<br>-The MA would not know if Resident #4 took her medications if they did not watch her.<br>-If the MA did not watch Resident #4 take her medication, then they should not have documented it as administered to her on the eMAR.<br>-It would be considered a medication error if the MA did not watch the resident take the medication.<br>-That was why the MA administered the medication to the resident; to ensure she took it.<br><br>Telephone interview with the Administrator on 10/22/25 at 1:35pm revealed:<br>-The MA Should watch the residents swallow medication before leaving the resident.<br>-Medications were not allowed to be left in the room in a cup because the resident may forget to take them or another resident could take them.<br>-The medication should not be documented on the eMAR as administered until the MA was sure the medications were administered. | D 366 | | |

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| D 367 | 10A NCAC 13F .1004 (j) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(j) The resident's medication administration record (MAR) shall be accurate and include the following:<br>(1) resident's name;<br>(2) name of the medication or treatment order;<br>(3) strength and dosage or quantity of medication administered;<br>(4) instructions for administering the medication or treatment;<br>(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;<br>(6) date and time of administration;<br>(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,<br>(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).<br><br>This Rule is not met as evidenced by:<br>Based on record review and interviews, the facility failed to ensure the electronic medication administration record (eMAR) was accurate for 1 of 5 sampled residents (#1).<br><br>The findings are:<br><br>Review of Resident #1's current FL2 dated 02/04/25 revealed:<br>-Diagnoses included diabetes mellitus type 2. | D 367 | SCUC/Designee audited all MARs to ensure they are accurate per physicians orders.<br><br>SCUC will audit all MARs monthly to ensure they are accurate per physicians orders.<br><br>Director/Compliance Director will audit MARs randomly thereafter to ensure they are accurate as per physicians orders. | 12/7/2025 |

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| D 367 | Continued From page 99<br>-There was an order for Ozempic (a medication used to lower blood sugar results) 0.5mg weekly.<br><br>Review of Resident #1's record revealed a physician's order dated 07/08/25 to discontinue Ozempic 0.5mg weekly and begin Ozempic 1mg weekly.<br><br>Review of Resident #1's eMAR for August 2025 revealed:<br>-There was an entry for Ozempic 0.5mg weekly.<br>-There was an entry for Ozempic 1mg weekly.<br>-On 08/03/25 and 08/10/25, there was documentation "resident unable to take"<br>-On 08/17/25, Ozempic 0.5mg was documented as administered.<br>-On 08/31/25, there was documentation Ozempic 0.5mg was discontinued.<br><br>Review of Resident #1's eMAR for September 2025<br>-There was an entry for Ozempic 0.5mg weekly.<br>-There was an entry for Ozempic 1mg weekly.<br>-On 09/07/25, 09/14/25, 09/21/25, and 09/28/25, Ozempic 0.5mg was documented as discontinued.<br><br>Review of Resident #1's eMAR for October 2025 from 10/01/25 to 10/21/25 revealed:<br>-There was an entry for Ozempic 0.5mg weekly.<br>-There was an entry for Ozempic 1mg weekly.<br>-On 10/05/25 and 10/19/25, Ozempic 0.5mg was documented as discontinued.<br>-On 10/12/25, Ozempic 0.5mg was documented as administered.<br><br>Telephone interview with the medication aide (MA) on 10/22/25 at 1:39pm revealed:<br>-She knew there were 2 entries for Ozempic on the eMAR for Resident #1. | D 367 | | |

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| D 367 | Continued From page 100<br>-She did not have access to remove entries from the eMAR.<br>-She called the pharmacy several times to let them know there were two orders for Ozempic for Resident #1.<br>-She let the Special Care Unit Coordinator (SCC) know there were two orders for Ozempic for Resident #1.<br><br>Interview with the SCC on 10/22/25 at 10:34am revealed:<br>-She recalled the MA telling her Resident #1 had two entries for Ozempic on the eMAR.<br>-The entry for Ozempic 0.5mg should have been removed when the new order for Ozempic 1mg was received.<br>-The pharmacy usually entered and removed orders.<br>-She was also able to remove entries from the eMAR.<br>-She never removed the discontinued order from Resident #1's eMAR.<br>-She tried to do eMAR audits once or twice a month to ensure the eMARs were accurate.<br><br>Interview with the Administrator on 10/22/25 at 12:07pm revealed:<br>-When a new order was received, the SCC or the Executive Director (ED) should fax the order to the pharmacy.<br>-The pharmacy entered the orders onto the eMAR.<br>-After the new order is faxed to the pharmacy, the MA should check the eMAR to ensure the order was added or removed from the eMAR.<br>-The ED and the RCC were responsible for making sure the eMARs were accurate.<br>-She expected the eMARs to be accurate. | D 367 | | |

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| D 375 | Continued From page 101 | D 375 | | |
| D 375 | 10A NCAC 13F .1005 (a) Self-Administration Of Medications<br><br>10A NCAC 13F .1005 Self -Administration Of Medications<br>(a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met:<br>(1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and<br>(2) specific instructions for administration of prescription medications are printed on the medication label.<br><br>This Rule is not met as evidenced by:<br>Based on observation, interviews, and record review, the facility failed to ensure 1 of 1 sampled residents (#4) had a physician's order and assessment completed to self-administer medications related to a probiotic, an antioxidant, a calcium supplement, a vitamin supplement, a magnesium supplement, a pain patch, and a sleep aid.<br><br>The findings are:<br><br>Review of the facility's policy titled Management of Resident Self-Administration of Medications revised 07/06/25 revealed:<br>-The purpose of the policy was to ensure that residents who self-administered their medications were safely administering, storing, and competent to manage their medications independently.<br>-The procedure included obtaining a physician's | D 375 | SCUC/Designee will ensure all residents who self-administer medication have a signed order from their physician to self-administer medications.<br><br>SCUC/Designee will ensure all residents who self-administer medications are capable of administering their medications as per company policy.<br><br>Staff will report to the administrator immediately any medications seen in residents' rooms in order to ensure the resident has a self-administrator order.<br><br>SCUC/Director will remove any medications found in residents' rooms that do not have a physician's self administer order. | 12/7/2025 |

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| D 375 | Continued From page 102 | D 375 | | |

order for all medications the resident self-administered and completing a monthly audit form.
-The policy included if a resident was found to be non-compliant with medication self-administration or if a resident had a change in mental or physical ability to self-administer their medications, the physician would be notified.

Observation of Resident #4's room on 10/21/25 at 8:43am revealed:
-She had a nightstand with two drawers in her room.
-There was a weekly pill sorter labeled Sunday through Saturday, with morning and evening compartments in the bottom drawer of the nightstand.
-There were five tablets stored in each of the morning compartments and one tablet in the evening compartments.
-The top drawer of the nightstand had box of thirty loratadine (used to treat seasonal allergies) 10mg tablets, a partial tube of diclofenac gel (used to treat arthritis), fluticasone nasal spray (used to treat symptoms of seasonal allergies), a tube of cortisone 10 (used to relieve itching), a bottle of melatonin (used to treat insomnia) 5mg tablets, a bottle of acetaminophen (used to treat pain) 650mg, bottle of psyllium fiber (used to treat constipation) and a bottle of powdered beet (a dietary supplement).

Review of Resident #4's current FL2 dated 10/09/25 revealed:
-Diagnoses included arthritis, hyperlipidemia, hypertension, insomnia, right lumbar radiculopathy, and gastroesophageal reflux disorder.
-Resident #4 was intermittently disoriented.
-There was an order for acetaminophen 650mg

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| D 375 | Continued From page 103 | D 375 | | |

two tablets twice daily.
-There was an order for acidophilus chew (a probiotic) daily.
-There was an order for Norvasc (used to lower blood pressure) 10mg daily.
-There was an order for B-complex (a vitamin supplement) daily.
-There was an order for calcium/magnesium/vitamin d every evening.
-There was an order for Celexa (used to treat depression) 10mg daily.
-There was an order for Co-Q 10 (an antioxidant) 100mg daily.
-There was an order for gabapentin (used to treat nerve pain) 100mg every evening.
-There was an order for lidocaine patch (used to treat pain) 0.4% apply one patch daily.
-There was an order for magnesium oxide (a supplement)250mg twice daily.
-There was an order for melatonin (used to treat insomnia) 10mg at bedtime.
-There was an order for sea-omega (a dietary supplement) 1200mg twice daily.

Review of Resident #4's physician's orders dated 09/09/25 revealed:
-There was an order for Resident #4 to self-administer Tylenol 650mg take two tablets twice daily.
-There were no other orders for self-administration for Resident #4.

Review of Resident #4's record revealed there was no assessment done to determine if Resident #4 was appropriate to self-administer her medications.

Interview with Resident #4 on 10/21/25 at 8:45am revealed:
-A family member prepared her medications for

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| D 375 | Continued From page 104 | D 375 | | |

the week by placing them in her pill sorter.
-The family member also brought her other medicaitons if she wanted or needed them.
-She mixed the psyllium fiber into her beverages herself.
-She took her medications on her own because she was able too; she had the ability to take her medications on her own.
-There were two medications the facility staff administered to her; the rest of her tablets she took on her own.

Interview with the medication aide (MA) on 10/22/25 at 2:30pm revealed:
-The pharmacy sent Norvasc, Celexa, and gabapentin for Resident #4.
-Resident #4's family member brought the rest of her medications every week.
-There was an order for Resident #4 to self-administer her Tylenol.
-She could not find an order or an assessment for Resident #4 to self-administer her other medications.

Telephone interview with Resident #4's family member on 10/22/25 at 10:24am revealed:
-The MAs ordered and administered Resident #4's prescribed medications.
-She filled up a 7-day pill organizer with all of Resident #4's supplements every Sunday.
-Resident #4 knew what all her medications were.

Interview with the Executive Director (ED) on 10/22/25 at 4:55pm revealed:
-Resident #4 was high functioning.
-Resident #4's family wanted the resident to take her own medications.
-The family brought Resident #4 some of her medications.
-The facility was responsible for administering two

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| D 375 | Continued From page 105<br>of Resident #4 medications, but she administered the rest herself.<br>-She had spoken to the family about bringing medications to the facility without a physician's order for them.<br>-She thought Resident #4 had an order for self-administering her medications.<br>-She would have an assessment done by her physician to make sure she was cognitively able to self-administer medications.<br><br>Telephone interview with the Administrator on 10/22/25 at 12:20pm revealed:<br>-If staff saw medication in a resident's room, they needed to collect it and give it to the ED to see if there was an order for them.<br>-Families brought in medications for the residents all the time without the facility staff's knowledge.<br>-Residents needed to have orders for all medications and orders to self-administer those medications.<br><br>Attempted telephone interview with Resident #4's primary care provider (PCP) on 10/22/25 at 10:56am was unsuccessful. | D 375 | | |
| D 377 | 10A NCAC 13F .1006 (a) Medication Storage<br><br>10A NCAC 13F .1006 Medication Storage<br>(a) Medications that are self-administered and stored in the resident's room shall be stored in a safe and secure manner as specified in the adult care home's medication storage policy and procedures.<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews, and interviews, the facility failed to ensure that a resident's medication was stored safely and | D 377 | | |

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| D 377 | Continued From page 106<br>securely for a resident who had multiple medications in an unsecured nightstand in her room.<br><br>The findings are:<br><br>Review of the facility's policy titled Management of Resident Self-Administration of Medications revised 07/06/25 revealed the purpose of the policy was to ensure that residents who self-administered their medications were safely administering, storing, and competent to manage their medications independently.<br><br>Review of Resident #4's current FL2 dated 10/09/25 revealed:<br>-Diagnoses included arthritis, hyperlipidemia, hypertension, insomnia, right lumbar radiculopathy, and gastroesophageal reflux disorder.<br>-Resident #4 was intermittently disoriented.<br>-There was an order for Tylenol ER (used to treat pain) 650mg two tablets twice daily.<br>-There was an order for acidophilus chew (a probiotic) daily.<br>-There was an order for Norvasc (used to lower blood pressure) 10mg daily.<br>-There was an order for B-complex (a vitamin supplement) daily.<br>-There was an order for calcium/magnesium/vitamin d every evening.<br>-There was an order for Celexa (used to treat depression) 10mg daily.<br>-There was an order for Co-Q 10 (an antioxidant) 100mg daily.<br>-There was an order for gabapentin (used to treat nerve pain) 100mg every evening.<br>-There was an order for lidocaine patch (used to treat pain) 0.4% apply one patch daily.<br>-There was an order for magnesium oxide (a | D 377 | Director/Designee retrained medication aides on ensuring medications were maintained in a safe manner under locked security or under direct supervision of staff in charge of medication administration.<br><br>SCUC/SIC will monitor daily to assure medications were maintained in a safe manner under locked security or under direct supervision of staff in charge of medication administration.<br><br>Staff will report to the administrator immediately any medications seen in residents' rooms not in safe and secure manner.<br><br>Director/Compliance Director will conduct random monitoring through observations to ensure medications were maintained in a safe manner under locked security or under direct supervision of staff in charge of medication administration. | 12/7/2025 |

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supplement)250mg twice daily.
-There was an order for melatonin (used to treat insomnia) 10mg at bedtime.
-There was an order for sea-omega (a dietary supplement) 1200mg twice daily.

Observations of Resident #4's room on 10/21/25 at various times from 8:43am to 4:00pm revealed:
-The door to Resident #4's room did not have a locking mechanism.
-There was a nightstand with two drawers in the resident's room; the drawers did not have locks on them.
-Resident #4 was observed in the dining room for lunch and sitting in the common area; her room was not locked, and the medications were unsecured in her nightstand.
-There was a weekly pill sorter labeled Sunday through Saturday, with morning and evening compartments in the bottom drawer of the nightstand.
-There were five tablets stored in each of the morning compartments and one tablet in the evening compartments.
-The top drawer of the nightstand had box of thirty loratadine (used to treat seasonal allergies) 10mg tablets, a partial tube of diclofenac gel (used to treat arthritis), fluticasone nasal spray (used to treat symptoms of seasonal allergies), a tube of cortisone 10 (used to relieve itching), a bottle of melatonin (used to treat insomnia) 5mg tablets, a bottle of acetaminophen (used to treat pain) 650mg, bottle of psyllium fiber (used to treat constipation) and a bottle of powdered beet (a dietary supplement).

Interview with Resident #4 on 10/21/25 at 8:45am revealed:
-A family member prepared her medications for the week by placing them in her pill sorter.

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-Her nightstand did not lock, and neither did the door to her room.
-She hid the medication down in the bottom of each drawer.

Telephone interview with Resident #4's family member on 10/22/25 at 10:24am revealed:
-She filled up a 7-day pill organizer with all of Resident #4's supplements every Sunday.
-Resident #4 used to have a lock box in her room but she was unable to operate it anymore.
-Resident #4 kept her medications in the back of her nightstand drawer because she thought other residents would take it.
-Resident #4 knew what all her medications were.

Interview with a medication aide (MA) on 10/22/25 at 10:45am revealed:
-Resident #4 had medications in her room; a family member brought them in for her.
-She thought Resident #4 had an order for the medications in her room.
-She did not know how Resident #4 secured the medications when she was not in her room.
-She had not seen where Resident #4 stored her medications.
-The doors to the residents' rooms did not have locks on them.
-She was not aware Resident #4's medications needed to be locked up but it made sense because some of the residents had dementia and would go into each other's rooms.

Interview with a second MA on 10/22/25 at 2:35pm revealed:
-If she saw any medication in a resident room, she removed it and then checked it to see if the resident had an order to keep it at their bedside.
-Resident #4 had orders to self-administer some of her medications.

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-She was not sure how the medications were supposed to be stored when they were in a resident's room; she had never been told.

Interview with the Special Care Unit Coordinator (SCC) on 10/22/25 at 3:05pm revealed:
-Medications for residents with orders for self-administration should be kept in a lockbox in the resident's room and only the resident and the MAs should have a key.
-If staff saw medications in a resident's room and they were not locked up then the staff should lock the medication up and let the Executive Director (ED) or her know right away.
-Another resident could walk into the room and get the medications if they were not locked up.

Interview with the ED on 10/22/25 at 4:55pm revealed:
-Medications kept in the resident's rooms were kept in a lock box and the resident and facility staff had a key to the box.
-The facility provides the lockable box so she and the SCC could have a key.
-The MAs would monitor the medications daily to make sure they were always locked up while in the resident's room.
-Resident #4 was given a lockable box at one time; she did not know where it could have gone.
-Resident #4 left her room for meals and went out with her family; other residents could go into her room and swallow the medications from her nightstand, and no one would ever know.

Telephone interview with the Administrator on 10/22/25 at 12:20pm revealed:
-If staff saw medication in a resident's room, they needed to collect it and give it to the Director.
-Residents needed to have orders for medications in their room and they needed to be

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| D 377 | Continued From page 110<br>secured. | D 377 | | |
| D 466 | 10A NCAC 13F .1308(b) Special Care Unit Staffing<br><br>10A NCAC 13F .1308 Special Care Unit Staffing (b) There shall be a care coordinator on duty in the unit at least eight hours a day, five days a week. The care coordinator may be counted in the staffing required in Paragraph (a) of this Rule for units of 15 or fewer residents.<br><br>This Rule is not met as evidenced by:<br>Based on observations and interviews, the facility failed to ensure there was a care coordinator in the Special Care Unit (SCU) for 8 hours per day, 5 days per week.<br><br>The findings are:<br><br>Review of the facility's current license, effective 01/01/25, revealed the facility was licensed for a capacity of 70 beds, including Assisted Living (AL) with a capacity of 39 beds and the SCU with a capacity of 31 beds.<br><br>Review of the facility's resident census report dated 10/21/25 revealed there were 28 residents in the SCU and 28 residents in the AL.<br><br>Observation on the SCU on 10/21/25 at 8:15am revealed:<br>-There was 1 medication aide (MA) and 2 personal care aides (PCA) on duty for the first shift.<br>-The SCU Coordinator (SCC) was not in the SCU. | D 466 | Director will assure that there is a person assigned as the SCU Coordinator on the SCU 8 hours per day, five days a week.<br><br>Director/Designee will monitor to ensure SCUC is on the unit at least 8 hours a day, 5 days per weeks.<br><br>QI department/Compliance department/COO will conduct audits of facility at least quarterly or as needed basis to monitor rule areas and ensure compliance. | 12/7/2025 |

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| D 466 | Continued From page 111<br><br>Confidential interview with a staff member revealed the SCC was out of the SCU more than she was in it.<br><br>Interview with the SCC on 10/22/25 at 8:49am revealed:<br>-She was in AL a lot.<br>-She tried to equally work between AL and the SCU.<br><br>Interview with a PCA on 10/23/25 at 10:05am revealed the SCC helped with resident care in the AL.<br><br>Interview with a second PCA on 10/23/25 at 12:47pm revealed:<br>-She had seen the SCC in the AL, in the conference room, and in the AL medication room, doing a variety of things.<br>-When she worked as a PCA in the SCU, and she did not see the SCC in the SCU, and she needed the SCC, she would let the MA know she needed the SCC, and the MA would go get her.<br><br>Interview with a third PCA on 10/23/25 at 1:39pm revealed:<br>-The SCC helped get residents in AL to the dining room.<br>-She had seen the SCC doing activities in the AL dining room.<br>-The SCC covered the medication cart in both the AL and the SCU when needed.<br>-The SCC was in AL "pretty often".<br><br>Interview with a fourth PCA on 10/23/25 at 1:43pm revealed:<br>-The SCC helped with resident care in the AL, "whatever we need her to help with".<br>-She had seen the SCC in her office in the SCU, | D 466 | | |

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| D 466 | Continued From page 112<br>but if staff in AL needed something, the SCC always came to AL to help.<br><br>Interview with a housekeeper on 10/23/25 at 1:46pm revealed:<br>-She saw the SCC going back and forth between the SCU and AL all day.<br>-She had seen the SCC helping residents in AL with cares.<br><br>Interview with a MA on 10/22/25 at 10:54am and 12:33pm revealed:<br>-The facility used to have a Resident Care Coordinator (RCC) for the AL and the SCU.<br>-The SCC was not always in the SCU; she was in the AL.<br>-When she needed the SCC, she would either call her on the telephone or go out to the AL and ask her what she needed.<br>-The SCC might be in the office with the door closed, and she did not know it, but the SCC did work on the AL.<br><br>Interview with the SCC on 10/22/25 at 10:16am revealed:<br>-She was responsible for making the schedule for both the AL and the SCU.<br>-She did resident care and anything else that was needed for both the AL and the SCU.<br>-She was responsible for resident care plans, FL2s, and orders for both the AL and the SCU.<br>-She was responsible for making sure orders were processed either by doing them herself or checking behind the MAs in both the AL and the SCU when they processed orders.<br>-She worked with providers, coordinated home health and hospice as needed for the residents in both the AL and the SCU.<br>-She was in the facility at least 8 hours a day. | D 466 | | |

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| D 466 | Continued From page 113 | D 466 | | |

Observation of the AL medication room on 10/23/25 at 12:38pm revealed the SCC was in the room talking to a MA.

Interview with the Executive Director on 10/22/25 at 9:57am revealed:
-The facility had a Resident Care Coordinator (RCC) but after the last survey corporate made the RCC the SCC but the responsibilities stayed the same.
-The SCC was responsible for all of the residents in the facility.
-The SCC accepted orders, coordinated with the primary care providers (PCP), completed care plans, and anything else that needed to be done.

Interview with the SCC on 10/23/25 at 12:38pm revealed:
-During meals, she tried to split her time between the SCU and AL, doing rounds.
-She was physically in the AL doing walk-throughs, entering orders, when residents had falls, and addressing resident concerns.
-She also went to the AL when the MAs needed something.
-She was in AL right now to show a MA how to use an oxygen concentrator.

Interview with the Executive Director on 10/23/25 at 12:55pm revealed:
-Most of the SCC's computer work was done in the SCU.
-The SCC may come into the AL to work on the schedule in the conference room.
-The SCC did not really spend any time in AL.
-She did not see the SCC in AL often.

Telephone interview with the Administrator on 10/22/25 at 12:11pm revealed:
-The SCC was responsible for making sure

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| D 466 | Continued From page 114<br>physician orders were followed, staffing for the facility, communication with providers and families, completing care plans, FL2s; she had a "whole slew" of responsibilities.<br>-The facility did not have a designated RCC.<br>-The SCC did the RCC tasks, as well as the Director helped with the RCC, and she helped when she was at the facility.<br>-She was at the facility 4-5 days per week and was usually there from 10:00am-5:00pm.<br>-The SCC could do RCC tasks as long as it was in the SCU.<br>-The SCC was in the SCU 8 hours a day unless she came out for other things.<br>-The SCC may leave the SCU to make copies and "such". | D 466 | | |