Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL064019	A. BUILDING: _____ B. WING _____	10/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNIGHT'S FAMILY CARE HOME # 2	312 CLEO STREET ROCKY MOUNT, NC 27801

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on October 10, 2025 to October 13, 2025.	C 000	Staff will educate & inform all residents of the importance evacuating the facility when the alarm sounds. Designated fire exits are marked with a red reflector. Director/Supervisor will schedule annual safety training with the Rocky Mount Fire Marshall & will monitor all staff. 10/14/2025 Management, staff & residents were trained on Fire Safety procedures by the Rocky Mount Fire Marshall. Staff & residents know how to evacuate & where the exits are located when they hear the fire alarm. Director/Supervisor will schedule annual fire safety training with the Rocky Mount Fire Marshall & will monitor all staff. 10/28/2025	
C 022	10A NCAC 13G .0302 (b) Design And Construction 10A NCAC 13G .0302 Design And Construction (b) New construction, additions, alterations, modifications, and renovations to buildings shall meet the requirements of the North Carolina State Building Code: Residential Code, and the North Carolina State Building Code: Building Code, Licensed Residential Care Facilities Section at the time of construction, alteration, modifications, and renovations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure that the evacuation capabilities for 1 of 2 sampled residents (#2), who did not respond to a fire alarm were in accordance with the evacuation capability listed on the facility's current license. The findings are:	C 022		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Andi Knight | TITLE: Director | (X6) DATE: 11/26/2025

Jamaal Willis Reviewed and Acknowledged 12/12/25

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C 022	Continued From page 1 Review of the facility's current license effective 01/01/25 revealed the facility was licensed for 5 ambulatory residents. Review of Resident #2's current FL2 dated 04/01/25 revealed: -Diagnoses included mental retardation, gastroesophageal reflux, and hypertension. -The resident was ambulatory. -There was no information on orientation. Review of Resident #2's Resident Register revealed he was admitted to the facility on 05/30/14. Review of Resident #2's current FL2 dated 04/01/25 revealed: -Diagnoses included mental retardation, gastroesophageal reflux, and hypertension. -Resident was ambulatory. -There was no information on orientation. Review of Resident #2's Resident Register revealed he was admitted to the facility on 05/30/14. Observation of the facility on 10/10/25 from 12:10pm-12:20pm revealed: -The administrator pressed the smoke detector initiating a fire alarm. -Resident #1 exited his bedroom and went outside and sat on the porch. -Resident #2 remained in his bedroom. Interview with Resident #2 on 10/10/25 at 3:50pm revealed: -He was asleep and did not hear the fire alarm. -If he heard a smoke alarm, he would exit the house.	C 022		

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C 022	Continued From page 2 Interview with the Administrator on 10/10/25 at 2:00pm revealed: -Resident #2 was able to evacuate the home during fire drills. -He did not participate during the fire drill because he was feeling sick and was asleep. -Both residents were able to evacuate the home during a fire drill without prompting. -It was a safety concern if the residents could not evacuate the home without prompting during a fire drill. Observation of the facility on 10/13/25 from 9:50am-10:00am revealed: -The administrator pressed the smoke detector initiating a fire alarm. -Resident #2 exited his bedroom and went outside to a tree near the driveway. -Resident #1 was not in the facility at the time. Interview with Resident #2 on 10/13/25 at 10:05pm revealed: -He usually heard the fire drill and exited the facility. -They were supposed to stand by the tree near the driveway when the fire alarm went off. -The staff told them when they were able to come back inside the house. -He was sick and was feeling groggy during the fire drill on 10/10/25. Interview with the Administrator on 10/13/25 at 6:20pm revealed Resident #2 had a cold and was not feeling well, he had taken some cold medicine and was asleep during the fire drill on 10/10/25. Telephone interview with Resident #2's primary care provider (PCP) on 10/13/25 at 9:35am revealed:	C 022		

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C 022	Continued From page 3 -Resident #2 did not have any disorientation or signs of dementia. -She was not concerned with Resident #2's ability to evacuate the home during a fire alarm.	C 022	On October 10, 2025, Knight Family Care Home # 2 was undergoing repairs from the August 12th Site Survey. Some of the original site visit violations were corrected by the second visit. Recommendations from both visits have been completed. The Plan of Action was submitted to the Construction Division for review. We have not heard from them yet. Again, all recommendations have been addressed. The tub has been replaced. Monthly facility inspections for cleanliness & repairs will be conducted by the Director. 11/13/2025	
C 078	10A NCAC 13G .0315 (a)(5) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping and Furnishings (a) A family care home shall: (5) be maintained in an uncluttered, clean, and orderly manner, free of all obstructions and hazards; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to ensure the facility was maintained in an uncluttered, clean, and orderly manner, free of all obstructions and hazards; related to holes in floorboards, walls and ceilings, grime and dirt on walls and floors throughout the facility, and throw rugs being used in hallway, living room and bedroom. The findings are: Review of The North Carolina Division of Health	C 078		

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C 078	Continued From page 4 Service Regulation Construction Section Survey completed on 08/12/25 revealed: -It was observed the facility had multiple scatter rugs. -It was observed that the facility had loose floors outside the hallway bathroom that could potentially lead to a trip/fall hazard. -It was observed that the bedrooms had high touch points that needed cleaning including, walls, floors, nightstands, beds, windowsills, and cove basing. -It was observed that the textured ceiling in multiple rooms including the living room, dining room , bedrooms, and bathroom were peeling and flaking off. -It was observed that the facility is undergoing roof repairs, and that the facility had multiple pieces of sheetrock missing. -It was observed there were missing light fixture globes throughout the facility. -It was stated fire drills were being prompting. Observation of the facility's floor on 10/10/25 at 8:30am revealed: -There was a throw rug in the hallway. -There was a throw rug in the living room. -There was a large plastic tarp on the floor in the living room. -The wooden floors in the hall were not complete, there were openings and cracks in the floorboards. -The floors had a buildup of grime and dirt throughout the facility in bedrooms and bathroom. Observations of the ceiling in the hallway on 10/10/25 at 8:30am revealed a missing globe on the light fixture. Observations of the walls throughout the facility on 10/10/25 at various times between 8:30am	C 078		

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C 078	Continued From page 5 and 5:00pm revealed: -The walls had a buildup of grime and dirt throughout the facility in bedrooms and hallway bathroom. -There was unpainted patches in the walls where sheetrock was visible in the front room. Observations of bedroom #2 on 10/10/25 at various times between 8:30am and 5:00pm revealed: -There was a resident occupying in this bedroom. -There was a throw rug on the floor. -There were missing baseboards. -There was a 4x6 piece of wood approximately 3 feet long on the floor in front of the walk-in closet. -The floor inside of the walk-in closet was full of dirt and sheetrock debris. -There were large holes in the ceiling of the walk-in closet. -Insulation was visible through the holes in the ceiling and walls in the walk-in closet. Observations of the hallway bathroom on 10/10/25 at various times between 8:30am to 5:00pm revealed: -The bathtub had buildup of dirt and grime on the floor and walls. -There was what appeared to be rust and mildew stains in the bathtub. -There was hole in the tub approximately 3 inches in diameter that had rust and what appeared to be caulking material on the floor of the bathtub. Interview with the resident who resided in bedroom #2 on 10/10/25 at 9:15am revealed: -The walk-in closet in his room had holes in the ceilings. -Squirrels and other animals were able to get into his closet through the holes in the ceiling. -He heard animals in his closet throughout the	C 078		

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C 078	Continued From page 6 night. -The 4x6 piece of wood was placed on the floor in front of his closet so that animals could not get into his room under the door. -He did not remember how long his closet had holes in the ceiling. Interview with the Administrator on 10/10/25 at 6:40pm revealed: -He hired a contractor to complete work throughout the facility. -The floors in the hallway had been replaced on around 08/27/25 and the contractor was scheduled to come back out to fill in the cracks and exposed areas. -The contractor was scheduled to do work on the ceiling that was why the plastic tarp was on the living room floor. -There was water damage to the sheetrock in the closet of bedroom #2, the contractor was scheduled to fix the holes in the ceiling and wall in the closet. -He placed the 4x6 piece of wood in front of the closet door in Bedroom #2 in order to keep the resident from going into the closet. -The cracks in the fiberglass in the bathtub were an attempt by him to make repairs, the contractor was scheduled to fix the issue. -He was aware that throw rugs should not be used in the facility. -He was responsible for ensuring the facility was cleaned routinely. -He was responsible for the general upkeep in the facility. The facility failed to maintain an environment that was clean, orderly and free of obstructions and hazards as evidenced by wood flooring in the hallway and scatter rugs throughout the facility causing a potential trip hazard for residents. The	C 078		

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C 078	Continued From page 7 bathtub and bathroom floors were damaged and unclean. A resident's walk-in closet had holes in the wall and ceiling with exposed insulation, and a 4x6 piece of wood was used to keep door closed and secure and the resident reported hearing sounds of animals throughout the night coming from the closet. The facility's failure was detrimental to the health, safety and welfare of the residents which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/10/25 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED November 27, 2025.	C 078		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and	C 342	Staff will ~~follow~~ complete all medication adherence documents according to established policy. The physician has discontinued medication that the client refused to take. Appropriate notations were made. MAR + Medication Logs will be stored in the same book so that document updates can be made simultaneously. Director/Supervisor will document + monitor monthly. 10/15/2025	

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C 342	Continued From page 8 (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). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure medication administration records (MAR) were accurate for 1 of 2 residents (#1) for a controlled substance. The findings are: Review of the facility's medication administration policy dated September 2013 revealed: -Always initial and sign the signature sheet of the part of the medication administration record (MAR) on which initials are to be identified. -It was important to initial each sheet of the MAR to allow for clear tracking of who gave what medication. -When the medication pass is complete, recheck the MAR to make sure all medications have been administered and documented appropriately. Review of Resident #1's current FL2 dated 09/17/25 revealed diagnoses included schizophrenia, stage 3 kidney failure, and high blood pressure. Review of Resident #1's Resident Register revealed he was admitted to the facility on 12/09/10. Review of Resident #1's physician order form dated 09/02/25 revealed an order for clonazepam 0.5 milligram take one tablet by mouth at bedtime or as needed (prn) (clonazepam is used to treat	C 342		

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C 342	Continued From page 9 anxiety). Review of an email sent to the Administrator from the resident's mental health provider on 01/30/25 at 10:59am revealed the resident was taking clonazepam twice daily for anxiety, after an assessment with this patient it was decided to decrease this medication to nightly and as needed daily during the day for anxiety and agitation. Observation of Resident #1's medications on hand on 10/10/25 at 2:28pm revealed there was a bubble pack containing 11 of 30 clonazepam 0.5 milligram (mg) tablets take one tablet by mouth at bedtime or as needed (prn) for anxiety and agitation with a dispense date of 08/21/25. Review of Resident #1's August 2025 MAR revealed: -There was an entry for clonazepam 0.5mg tablets, take one tablet by mouth at bedtime or as needed daily for anxiety or agitation. -Clonazepam 0.5mg was documented as refused 08/04/25-08/06/25 for the 8:00am dosage. -Clonazepam 0.5mg was not documented as administered 08/01/25 through 08/03/25 or 08/07/25 through 08/31/25 for the 8:00am dosage. -Clonazepam 0.5mg was documented as administered 08/03/25 through 08/10/25 for the 8:00pm dosage. -Clonazepam 0.5mg was not documented as administered 08/01/25 through 08/02/25 or 08/11/25 through 08/31/25 for the 8:00pm dosage. Review of Resident #1's September 2025 MAR revealed: -There was an entry for clonazepam 0.5mg, take	C 342		

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C 342	Continued From page 10 one tablet by mouth at bedtime or as needed daily for anxiety or agitation. -Clonazepam 0.5mg was not documented as administered 09/01/25 through 09/30/25 for the 8:00pm dosage. Review of Resident #1's October 2025 MAR from 10/01/25 to 10/09/25 revealed: -There was an entry for clonazepam 0.5mg tablets, take one tablet by mouth at bedtime or as needed daily for anxiety or agitation. -Clonazepam 0.5mg was not documented as administered 10/01/25 through 10/10/25 for the 8:00pm dosage. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 10/10/25 at 11:00am revealed: -The pharmacy supplied the MARs to the facility each month to be completed by facility staff. -She expected the facility staff to document medications being administered on the MAR accurately. Interview with the Administrator on 10/10/25 at 2:15pm revealed: -He stopped documenting the clonazepam 0.5mg tablets on 08/11/25 because Resident #1 began refusing to take the medication. -He thought that he could use the controled substance log (CSL) in place of the MAR to document the administration of this medication, but he had not accurately documented the administration on the CSL. -He did not document the administration of Resident #1's medication on the MAR from 08/11/25 through 10/09/25. -He was responsible for documentation of all medications administered on the MAR.	C 342		

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C 342	Continued From page 11 Telephone interview with Resident #1's primary care provider (PCP) on 10/13/25 at 9:35am revealed; -She expected the Administrator to ensure MARs were accurate for the residents. -She was aware that the resident refused the clonazepam 0.5 mg tablets often. -She did not prescribe the resident's clonazepam 0.5 mg tablets, his mental health provider prescribed it. Attempted telephone interview with Resident #1's mental health provider on 10/10/25 at 12:47pm was unsuccessful.	C 342		
C 362	10A NCAC 13G .1007 (b) Medication Disposition 10A NCAC 13G .1007 Medication Disposition (b) Medications, excluding controlled medications, that are expired, discontinued, prescribed for a deceased resident or deteriorated shall be stored separately from actively used medications until disposed of. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure an expired medication was stored separately from actively used medications until disposed of for 1 of 2 residents (#2). The findings are: Review of Resident #2's current FL2 dated 04/01/25 revealed diagnoses included mental retardation, gastroesophageal reflux, and hypertension.	C 362	Director/Supervisor will check all medication in residents' medication storage bins & medicine bins. Discontinued or expired medications will be disposed as required & notations made in the Medication Disposal Log. Director/Supervisor will check all medication logs quarterly. 10/15/2025	

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C 362	Continued From page 12 Review of Resident #2's Resident Register revealed he was admitted to the facility on 05/30/14. Review of a physician order form dated 03/25/25 revealed an order for ibuprofen 600 milligram (mg) tablets take one tablet as needed(prn) (ibuprofen is used to treat mild pain). Observation of Resident #2's medications on hand on 06/13/25 at 11:20am revealed there was a bubble pack containing 30 of 30 ibuprofen 600 mg tablets with a dispense date of 07/23/21 and an expiration date of 04/30/2022. Review of Resident #2's August 2025 MAR from 08/01/25 to 08/31/25 revealed: -There was an entry for ibuprofen 600 mg tablets. -Ibuprofen 600 mg was not documented as administered. Review of Resident #2's September 2025 MAR from 09/01/25 to 09/30/25 revealed: -There was an entry for ibuprofen 600 mg tablets. -Ibuprofen 600 mg was not documented as administered. Review of Resident #2's October 2025 MAR from 10/01/25 to 10/10/25 revealed: -There was an entry for ibuprofen 600 mg tablets. -Ibuprofen 600 mg was not documented as administered. Interview with the Administrator on 10/10/25 at 11:35am revealed: -He was aware that expired medications should not be stored with active medications. -He audited the medications for each resident monthly.	C 362		

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C 362	Continued From page 13 -He audited resident prn medications quarterly. -He must have overlooked this medication when he audited Resident #2's ibuprofen. -He was responsible for ensuring expired medications were disposed of and not stored with active medications. Telephone interview with Resident #2's Primary Care Provider (PCP on 10/13/25 at 9:35am revealed; -She expected the Administrator in the facility to dispose of expired medications. -She did not have any concerns for this expired medication because it had not been administered to the resident.	C 362		
C 367	10A NCAC 13G .1008(a) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (a) A family care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to ensure the controlled substance logs were fully completed for the administration of controlled substances for a resident (#1) with orders for a controlled substance. The findings are: Review of Resident #1's current FL2 dated 09/17/25 revealed diagnoses included schizophrenia, stage 3 kidney failure, and high	C 367		

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	FCL064019	A. BUILDING: _____ B. WING _____	10/13/2025

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C 367	Continued From page 14 blood pressure. Review of Resident #1's Resident Register revealed he was admitted to the facility on 12/09/10. Review of Resident #1's physician order form dated 09/02/25 revealed an order for clonazepam 0.5 milligram (mg) tablets take one tablet by mouth at bedtime or as needed daily (clonazepam is used for treating for anxiety). Review of Resident #1's medications on hand on 10/10/25 at 2:28pm revealed: -Resident #1 had clonazepam 0.5mg, take one tablet by mouth at bedtime or as needed daily for anxiety or agitation. -There was a bubble pack of clonazepam 0.5mg with 11 of 30 tablets remaining. Review of Resident #1's physician order form dated 09/02/25 revealed an order for clonazepam 0.5 milligram (mg) tablets take one tablet by mouth at bedtime or as needed daily (clonazepam is used for treating for anxiety). Review of Resident #1's controlled substance log (CSLs) for clonazepam 0.5mg dated 07/24/25 revealed: -The CSL documented 30 doses of clonazepam 0.5mg were received on 07/24/25. -The CSL had a pharmacy label for clonazepam 0.5mg, take one tablet by mouth at bedtime or as needed daily for anxiety or agitation. -There were columns for date, time, amount remaining, wasted, checked by, and signature. -Clonazepam 0.5mg, one tablet for the evening dose was documented as administered on 6 occasions. -Clonazepam 0.5mg, one tablet for the evening	C 367		

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C 367	Continued From page 15 dose was documented as wasted on 9 occasions. -On 08/05/25 clonazepam 0.5mg was documented as wasted and the amount remaining was 20 tabs. -On 08/05/25 there was a note in the signature section reporting "talked to doctor about refusing medications". -On 08/06/25 clonazepam 0.5mg was not documented as administered. -On 08/07/25 clonazepam 0.5mg was documented as administered and the amount remaining was 12 tabs. -On 08/11/25 there was a note in the signature section reporting "refused medication 08/11-08/20, dr appointment on 08/21". Review of Resident #1's medication administration record (MAR) for August of 2025 revealed: -There was an entry for clonazepam 0.5 mg take one tablet twice daily. -On 08/01/25 through 08/10/25 the clonazepam 0.5mg take one tablet twice daily was documented as refused. -From 08/10/25 through 08/31/25 there were no documented entries for clonazepam 0.5mg take one tablet twice daily. -There was an entry for clonazepam 0.5mg take one tablet at bedtime or as needed daily for anxiety or agitation. -There were no documented entries for the clonazepam 0.5mg take one tablet at bedtime or as needed daily for anxiety or agitation from 08/01/25 through 08/31/25. Review of Resident #1's controlled substance log (CSLs) for clonazepam 0.5mg dated 08/26/25 revealed: -The CSL documented 30 doses of clonazepam 0.5mg received on 08/26/25.	C 367		

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C 367	Continued From page 16 -The CSL had a pharmacy label for clonazepam 0.5mg, take one tablet by mouth at bedtime or as needed daily for anxiety or agitation. -There were columns for date, time, amount remaining, wasted, checked by, and signature. -Clonazepam 0.5mg, one tablet for the evening dose was documented as administered on 17 occasions. -Clonazepam 0.5mg, one tablet for the evening dose was documented as wasted on 1 occasion. -According to documentation there should have been 12 clonazepam 0.5mg tabs available in the bubble pack. Review of Resident #1's MAR for September of 2025 revealed: -There was an entry for clonazepam 0.5 mg take one tablet twice daily. -There were no documented entries for the clonazepam 0.5 mg take one tablet twice daily from 09/01/25 through 09/30/25. -There was an entry for clonazepam 0.5 mg take one tablet at bedtime or as needed daily for anxiety or agitation. -There were no documented entries for the clonazepam 0.5 mg take one tablet at bedtime or as needed daily for anxiety or agitation from 09/01/25 through 09/30/25. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 10/10/25 at 11:00am revealed: -The pharmacy supplied the CSLs to the facility each month to be completed by facility staff. -She expected the facility staff to document medications being administered on the CSLs accurately. Interview with the Administrator on 10/11/25 at 4:48pm revealed:	C 367		

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C 367	Continued From page 17 -The CSL logs were supplied and required by the pharmacy for all controlled substances. -When he administered a controlled substance, he wrote the number of doses remaining, signed his name, and placed his initials. -He was not aware that he had not accurately documented the clonazepam 0.5mg for the month of September. -He stopped documenting the clonazepam on the CSL due to resident refusals. -He did not know why the medication was documented as 20 tablets remaining on 08/05/25 and then 12 tablets remaining on 08/07/25. -He believed he counted the medication incorrectly or documented the medication remaining incorrectly. -He was responsible for ensuring that controlled substances were documented on the CSL accurately. -It was important to keep accurate CSLs to keep track of medications administered and the amount remaining. Telephone interview with Resident #1's primary care provider (PCP) on 10/13/25 at 9:35am revealed she expected the Administrator to ensure the CSLs were accurate for the residents. Attempted telephone interview with Resident #1's mental health provider on 10/10/25 at 12:47pm was unsuccessful.	C 367		