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
	FCL023007	A. BUILDING: _____ B. WING _____	12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GORDON'S FAMILY CARE HOME	3727 RUBE SPANGLER ROAD LAWNDALE, NC 28090

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C 000	Initial Comments The Adult Care Licensure Section completed an annual survey on 12/02/25.	C 000		
C 202	10A NCAC 13G .0702 (a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination, and Immunizations (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 3 of 3 sampled residents (#1, #2, and #3) were tested for tuberculosis disease (TB) using a two-step skin test upon admission. The findings are: 1. Review of Resident #1's current FL2 dated 11/13/25 revealed diagnoses included dementia, depression, breast cancer, history of stroke, seizures, type II diabetes, glaucoma, and adrenal gland disease. Review of Resident #1's record revealed there was no Resident Register. Review of Resident #1's record revealed there	C 202	202(a) upon admission each resident had their Step one and step two Tuberculosis Test. Resident one #1, resident #2 two and resident #3 three completed. all residents folders will be monitered and check daily for six months. 12/3/25 Resident #1 Resident two #2 and #3 TB Test are completed. all resident folders will be checked daily and monitored for six months. 12/3/25 1. Resident #1 Resident Register is completed all resident folders will be monitered for six months. and check each folder daily. 12/3/25	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Terrie Gordon — TITLE: Administrator — (X6) DATE: 12/3/25

AS Reviewed and Acknowledged 01/12/26

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C 202	Continued From page 1 was no documentation a two-step TB skin test was completed. Interview with Resident #1 on 12/02/25 at 1:45pm revealed she did not remember having a TB test completed at the facility. Refer to the interview with the Administrator on 12/02/25 at 12:26pm. 2. Review of Resident #2's current FL2 dated 01/06/25 revealed diagnoses included bipolar disorder, seizures, schizophrenia, and hypothyroidism. Review of Resident #2's record revealed there was no Resident Register. Review of Resident #2's record revealed there was no documentation a two-step TB skin test was completed. Interview with the Administrator on 12/02/25 at 8:35am revealed that Resident #2 was in a day treatment program and would not be in the facility until 4:00pm. Refer to the interview with the Administrator on 12/02/25 at 12:26pm. 3. Review of Resident #3's current FL2 dated 01/07/25 revealed diagnoses included type II diabetes, depression, and paranoid schizophrenia. Review of Resident #3's record revealed there was no Resident Register. Review of Resident #3's record revealed there was no documentation a two-step TB skin test	C 202	Resident #1's two step TB Skin test is Completed 12/3/25 2. Resident #2 Resident Register is Completed 12/3/25 · Resident #2's two step TB Skin test is completed 12/3/25 3. Review of Resident #3's Resident Register is done. See completion date. and will be monitored by administrator. Resident #1, Resident #2 and #3 will be monitored for six months and check folder daily. 12/3/25	

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C 202	Continued From page 2 was completed. Interview with Resident #3 on 12/02/25 at 1:45pm revealed he did not remember having a TB test completed at the facility. Refer to the interview with the Administrator on 12/02/25 at 12:26pm. Interview with the Administrator on 12/02/25 at 12:26pm revealed: -All 3 of her residents had been residing at the facility for 14 years or longer. -She remembered all 3 of residents getting TB tests completed. -She remembered thinning the records, but did not know where she placed all the paperwork showing the results for the TB tests.	C 202	Resident #3's two step skeen test is completed.	12/3/25
			all resident's #1 #2 and #3 are completed and in present folders. will be monitered for six months and folder check daily.	12/3/25
C 230	10A NCAC 13G .0801 (a) (b) Resident Assessment 10A NCAC 13G .0801 Resident Assessment (a) The facility shall complete an assessment of each resident within 30 days following admission and annually thereafter. (b) The facility shall use the assessment instrument and instructional manual established by the Department or an instrument developed by the facility that contains at least the same information as required on the instrument established by the Department. The assessment shall be completed by an individual who has met the requirements of Rule .0508 of this Subchapter. If the facility develops its own assessment instrument, the facility shall ensure that the individual responsible for completing the resident assessment has completed training on	C 230	a. Residents #1, #2 and #3 assessment and new residents will be completed within 30 days upon admission and annually thereafter. The administrator will monitor all assessments. and folders daily for six months.	12/3/25

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C 230	Continued From page 3 how to conduct the assessment using the facility's assessment instrument. The assessment shall be a functional assessment to determine the resident's level of functioning to include psychosocial well-being, cognitive status, and physical functioning in activities of daily living. The assessment instrument established by the Department shall include the following: (1) resident identification and demographic information; (2) current diagnoses; (3) current medications; (4) the resident's ability to self-administer medications; (5) the resident's ability to perform activities of daily living, including bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting, and eating; (6) mental health history; (7) social history, to include family structure, previous employment and education, lifestyle habits and activities, interests related to community involvement, hobbies, religious practices, and cultural background; (8) mood and behaviors; (9) nutritional status, including specialized diet or dietary needs; (10) skin integrity; (11) memory, orientation and cognition; (12) vision and hearing; (13) speech and communication; (14) assistive devices needed; and (15) a list of and contact information for health care providers or services used by the resident. The assessment instrument established by the Department is available on the Division of Health Service Regulation website at https://policies.ncdhhs.gov/divisional/health-benefits-nc-medicaid/forms/dma-3050r-adult-care-hom	C 230	C230- The assessment rules will follow Div. of Health service Regulations and will be monitored by the administrator. Administrator will monitor for six months and check folders daily.	12/3/25

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C 230	Continued From page 4 e-personal-care-physician/@@display-file/form_file/dma-3050R.pdf. at no cost. This Rule is not met as evidenced by: Based on interviews and record reviews, an initial assessment had not been completed within 72 hours of admission for 3 of 3 sampled residents (#1, #2, and #3) living in the home. The findings are: 1. Review of Resident #1's current FL2 dated 11/13/25 revealed diagnoses included dementia, depression, breast cancer, history of stroke, seizures, type II diabetes, glaucoma, and adrenal gland disease. Review of Resident #1's record revealed there was no Resident Register. Review of Resident #1's record revealed: -There was no documentation of an initial assessment completed for Resident #1. -There was a care plan dated 12/14/21. Refer to the interview with the Administrator on 12/02/25 at 1:45pm. 2. Review of Resident #2's current FL2 dated 01/06/25 revealed diagnoses included bipolar disorder, seizures, schizophrenia, and hypothyroidism. Review of Resident #2's record revealed there was no Resident Register. Review of Resident #2's record revealed: -There was no documentation of an initial assessment completed for Resident #2.	C 230	C 230 - All residents #1, Resident #2 and #3 have been located and completed. Resident #1, 1. Resident Register 2. step one and two TB skin Test 3. Care plan and assessment. and will be monitored by administrator. and folders check daily. 12/3/25 C 230 - Resident #2 Paperwork have been located and completed. 1. Resident Register 2. step one and two TB skin test. 3. care plan and assessment. and will be monitored by administrator. and check daily. 12/3/25	

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C 230	Continued From page 5 -There was a care plan dated 12/14/21. Refer to the interview with the Administrator on 12/02/25. 3. Review of Resident #3's current FL2 dated 01/07/25 revealed diagnoses included type II diabetes, depression, and paranoid schizophrenia. Review of Resident #3's record revealed there was no Resident Register. Review of Resident #3's record revealed: -There was no documentation of an initial assessment completed for Resident #3. -There was no documentation of any care plans completed for Resident #3. Refer to the interview with the Administrator on 12/02/25 at 1:45pm. Interview with the Administrator on 12/02/25 at 1:45pm revealed: -All of her residents had been residing in her facility for 14 years or longer. -She thought Resident Registers were completed within 72 hours of admission, but she did not know what happened to them. -She did not know if an initial resident assessment had been completed for her residents. -She had thinned the records, but she was not sure what happened to the paperwork. -It was her responsibility to make sure paperwork was completed.	C 230	C230- Resident #3 Paperwork have been located and Completed. 1. Resident Register 2. step one and two TB skin test 3. Care plans and assessment. And now will be monitored by administrator. and check daily for six months. 12/3/25 C230- Resident #1 Resident #2 and Resident #3 Resident Register have been updated and sign by doctor. Ad ministrator will monitor and check folders daily. for six months. 12/3/25	
C 236	10A NCAC 13G .0802 (a) (c) Resident Care Plan	C 236		

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C 236	Continued From page 6 10A NCAC 13G .0802 Resident Care Plan (a) The facility shall develop and implement a care plan for each resident based on the resident's assessment completed in accordance with Rule .0801 of this Section. The care plan shall be resident-centered and include the resident's preferences related to the provision of care and services. A copy of each resident's current care plan shall be maintained in a location in the facility where it can be accessed by facility staff who are responsible for the implementation of the care plan. (c) The care plan shall include the following: (1) a description of services, supervision, tasks, and level of assistance to be provided to address the resident's needs identified in the resident's assessment in Rule .0801 of this Section; (2) frequency of the services or tasks to be performed; (3) revisions of tasks and frequency based on reassessments in accordance with Rule .0801 of this Section; (4) licensed health professional tasks required according to Rule .0903 of this Section; (5) a dated signature of the assessor upon completion; and (6) a dated signature of the resident's physician or physician extender as defined in Rule .0102 of this Subchapter within 15 days of completion of the care plan certifying the resident is under this physician's care and has a medical diagnosis with associated physical or mental limitations warranting the provision of the personal care services in the above care plan in accordance with G.S. 131D-2.15. This shall not apply to residents assessed through the Medicaid State Plan Personal Care Services Assessment for the portion of the assessment covering tasks needed	C 236	C236- The resident care plan will be followed out, as the description for Resident #1 and Resident #2 and resident #3 and monitored by administrator. administrator will monitor each folder for six months and check daily.	12/3/25

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C 236	Continued From page 7 for each activity of daily living of this Rule for which care planning and signing are directed by Medicaid. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure care plans were completed annually or completed within 30 days following admission for 3 of 3 sampled residents (#1, #2, and #3). The findings are: 1. Review of Resident #1's current FL2 dated 11/13/25 revealed diagnoses included dementia, depression, breast cancer, history of stroke, seizures, type II diabetes, glaucoma, and adrenal gland disease. Review of Resident #1's record revealed there was no Resident Register. Review of Resident #1's record revealed: -There was a care plan dated 12/14/21 for Resident #1. -There was no care plan completed within 30 days following admission available for review for Resident #1. -There was no care plan completed within the past year for Resident #1. Refer to the interview with the Administrator on 12/02/25 at 1:45pm. 2. Review of Resident #2's current FL2 dated 01/06/25 revealed diagnoses included bipolar disorder, seizures, schizophrenia, and	C 236	1. C 236- Care plans was not completed and sign by dr for a couple of years. now Resident #1 resident #2 and resident #3 have been completed and signed by doctor. 12/3/25 Resident #1's record is completed with his resident register. 12/3/25 Resident #1's completed with his care plan. and will be monitor by administrator. for a six month period. 12/3/25 2.	

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C 236	Continued From page 8 hypothyroidism. Review of Resident #2's record revealed there was no Resident Register. Review of Resident #2's record revealed: -There was a care plan dated 12/14/21. -There was no care plan completed within 30 days following admission available for review for Resident #2. -There was no care plan completed within the past year for Resident #2. Refer to the interview with the Administrator on 12/02/25 at 1:45pm. 3. Review of Resident #3's current FL2 dated 01/07/25 revealed diagnoses included type II diabetes, depression, and paranoid schizophrenia. Review of Resident #3's record revealed there was no Resident Register. Review of Resident #3's record revealed: -There was no care plan completed within 30 days following admission available for review for Resident #3. -There was no care plan completed within the past year for Resident #3. Refer to the interview with the Administrator on 12/02/25 at 1:45pm. Interview with the Administrator on 12/02/25 at 1:45pm revealed: -She knew care plans should be completed within 30 days of admission and updated annually. -She had forgotten that care plans needed to be updated annually and had not been making sure	C 236	2. Resident #2 record is completed with update Resident Register. 12/3/25 #2 resident Care plan is updated and signed by doctor. and will be monitored by administrator. and checked daily. 12/3/25 #3 Resident Care plan is current and signed by doctor. and will be monitored by administrator. 12/3/25 Administrator will monitor for six months checking each resident folder daily. To ensure proper guidelines.	

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C 236	Continued From page 9 care plans got completed. -She thought all 3 Residents had care plans but could not locate one of them. -She had thinned the records, but did not know where she had placed all the paperwork. -It was her responsibility to make sure paperwork was completed.	C 236	C 236- all three resident care plans have been located and updated and placed in main folders. and will be monitored by administrator. Administrator will moniter for six months by checking residents folders daily.	2/3/25