PRINTED: 11/24/2025
FORM APPROVED

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
	HAL008034	A. BUILDING: _____ B. WING _____	R 10/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey from 10/29/25 to 10/31/25.	{D 000}	**In response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies or Correction is prepared solely as a matter of compliance with State Law.**	
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide personal care assistance for 2 of 5 sampled residents (#1, #2) who required staff assistance with fingernail care. The findings are: 1. Review of Resident #1's current FL-2 dated 10/16/25 revealed: -Diagnoses included Alzheimer's disease with late onset, dementia, obstructive and reflux uropathy, essential hypertension, and fracture of lower end of lower extremity. -The resident was constantly disoriented. -The resident was non-ambulatory. -The resident was incontinent of bowel and bladder. -The resident required assistance with bathing and dressing. Review of Resident #1's Resident Register dated 04/03/25 revealed: -The resident was admitted to the facility on 04/03/25.	D 269	**10A NCAC 13F. 0901 (a) Personal Care and Supervision** **Facility PCA staff and MA staff are responsible for providing personal care to all residents, while providing personal care they should observe resident's nails for any debris, or length that can be hazardous to themselves or others.** 12/8/25 **The Activity Director also will schedule a spa Day weekly for the residents to ensure nails are cut/filed and free from any debris.** 12/8/25 **Facility Care Manager will be responsible for scheduling appointments for residents that are diabetics to have their nails cut.** 12/8/25 **Random reviews of skin assessments to ensure appropriate follow-up**

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

RaVonna Walker, ED December 14, 202

STATE FORM 6899 UW8M12 If continuation sheet 1 of 73

Reviewed and Acknowledged SJS 1/5/26

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D 269	Continued From page 7 medication aides (MA). -The staff could cut the residents' nails as long as the residents were not diabetic. -If the resident was diabetic then a nurse or podiatrist would have to take care of them. Observation of Resident #2 on 10/31/25 at 9:20am revealed his fingernails were cleaned and trimmed. Interview with Resident #2's primary care provider (PCP) on 10/30/25 at 2:38pm revealed: -She did not remember when she last saw Resident #2 but did not remember any personal care issues. -Resident #2 could be aggressive at times; there were times he would not let her assess him. -Resident #2 was a controlled diabetic and she would not have any concerns with facility staff cutting and cleaning his nails. Interview with the Divisional Vice President of Operations (DVPO) on 10/30/25 at 1:45pm revealed: -Resident nail care was done in the facility by the PCAs or MAs. -The staff could cut the residents' nails as long as the residents were not diabetic. -If the resident was diabetic then the PCA/MA could file the resident's nails. -The corporate nurse could cut the resident's nails if the residents were diabetic. -The podiatrist would trim the residents' fingernails too. -She expected that nail care be done with all showers and baths and trimmed as needed.	D 269		
{D 270}	10A NCAC 13F .0901(b) Personal Care and Supervision	{D 270}	**10A NCAC 13F .0901 (b) Personal Care and Supervision**	

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{D 270}	Continued From page 12 Observation of Resident #4 on 10/31/25 at 9:15am revealed: -Resident #4 was in her wheelchair in the hallway where a television was located for residents to view. -Resident #4 was initially sitting outside of her doorway in her wheelchair with no chair alarm observed on her wheelchair. -A personal care aide (PCA) was observed standing near the table that the television was on. -The PCA moved Resident #4 at 9:19am in her wheelchair to the end of the table and locked her wheelchair. Interview with a personal care aide (PCA) on 10/31/25 at 9:16am revealed: -She knew that Resident #4 fell on 10/28/25. -When Resident #4 was found by staff and injury was noted to the leg. -15-minute checks were implemented, meaning that PCA's would look at Resident #4 every 15 minutes. -If a chair alarm was used it was put in place by hospice and PCA's were responsible to maintain function of the chair alarm afterward. -They had the alarm in Resident #4's recliner chair, but if she got up to the wheelchair then it would be put in the wheelchair. -The alarm would function in the wheelchair. -When doing 15-minute checks she would check the alarm. Interview with a medication aide (MA) on 10/31/25 at 9:27am revealed: -Resident #4 was encouraged to use a call bell, 15-minute checks were being used for Resident #4, and staff was trying to make sure Resident #4 was near PCA staff. -Resident #4 used the wheelchair as needed.	{D 270}		

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{D 270}	Continued From page 13 -Resident #4 did not use a chair alarm. -If hospice ordered a chair alarm or fall mat hospice would bring it to the facility. -If new orders for chair alarms were given then MA's were responsible to notify PCA's and make sure that PCA's were trained on the alarms. -Hospice would relay orders for chair alarms to the Special Care Unit Coordinator (SCC) or MA's. -If MA's were notified of chair alarms by hospice they should notify the SCC. -There was a binder to keep orders from Resident #4's hospice provider. -Staff was responsible to check the binder at each shift and check hospice notes for any new orders. Interview with the SCC on 10/31/25 at 3:30pm revealed: -She had not seen Resident #4's chair alarm until the surveyor notified her of it today. -She had not heard Resident #4's chair alarm go off at all. -When residents had a chair alarm it would be moved from chair to chair depending on where the resident was sitting, and staff knew that. -Proper documentation did not happen at shift change and that was why staff did not know about the chair alarms. -She would participate in shift change discussions or make herself available by phone to make sure communication happened. Telephone interview with a representative from Resident #4's hospice provider on 10/31/25 at 2:55pm revealed: -Normally residents with chair alarms should have the chair alarm if there was nobody with them and supervising them. -The bed alarm should be on if the resident was sleeping unattended.	{D 270}		

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{D 270}	Continued From page 14 Interview with Resident #4's primary care provider PCP on 10/30/25 at 2:11pm revealed: -Resident #4 got up without remembering to use the call bell and would fall. -She evaluated Resident #4 one time before the resident switched to hospice care. -The hospice provider would take the lead, but she was still notified of accidents and falls. -She knew of two falls, but there could be more. -If Resident #4 needed a fall mat, bed alarm, or chair alarm then she would be involved. -She was waiting to see what hospice would order for Resident #4. Interview with Resident #4 on 10/29/25 at 1:08pm revealed: -She fell and messed up her left leg. -There was pain with the injury. Interview with Resident #4 on 10/30/25 at 10:30am revealed: -The injury to her leg happened on Monday(10/27/29), and she also hit her head. -She had pain when she moved the leg around. -There were two places on the leg that were injured. Interview with Resident #4's family member on 10/30/25 at 1:40pm revealed: -Resident #4 had a fall on 10/28/25 and one every week since her admission. -Resident #4 just got back from the hospital for a UTI with sepsis, and was there about four days. -Resident #4's sugar had been low and he was concerned. -He thought Resident #4 had been falling because her sugar was low. -She had tumors removed from her bladder a week before she came to the facility.	{D 270}		

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{D 270}	Continued From page 15 -Resident #4 had incontinence. -Resident #4 falls when she gets up to try to walk without the walker. -Resident #4 fell once at the bathroom door with the walker, but all other falls occurred without the walker. -Resident #4 did not fall when he was with Resident #4, but he felt that the facility was not at fault because they could not watch her 24/7. -Resident #4 had fallen at his house a few times when other family members were watching Resident #4, but never with him. Interview with the Administrator on 10/31/25 at 4:35pm revealed -She had concerns that Resident #4 had falls and could be injured. -She had heard Resident #4's chair alarm go off previously when staff pressed the button to ensure that it was working. -Staff should make sure the alarm was with Resident #4 wherever Resident #4 was sitting, whether in the chair, wheelchair, or in the bed.	{D 270}		
{D 358}	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A1 VIOLATION	{D 358}	**10A NCAC 13F .1004 (a) Medication Administration** **Regional Clinical Director Inservice all MA(s), Care Manager, and Administrator on Medication Administration.** **12/8/25** **Physician's Orders to EMAR cart audits are done weekly by SCC and MA.** **12/8/25**	

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{D 358}	Continued From page 16 The Type A1 Violation is abated. Non-compliance continues. THIS IS A TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 4 of 6 residents (#6, #7, #8, #9) observed during the medication pass including errors with medication for anxiety (#6), mild pain and fever (#7), an antacid (#8), and an antipsychotic (#9); and for 3 of 5 residents sampled for record review (#1, #4, #5) including errors with a blood thinner (#1); insulin (#5); an antibiotic for infection, medication for diabetes, dementia, mild pain and fever, insomnia, constipation, breathing problems, high cholesterol, nerve pain, an antipsychotic, a skin protectant cream, topical medications for inflammatory skin conditions, and vitamin supplements (#4). The findings are: 1. The medication error rate was 16% as evidenced by 4 errors out of 25 opportunities during the 8:00am medication pass on 10/29/25. a. Review of Resident #6's current FL-2 dated 01/08/25 revealed diagnoses included Alzheimer's disease. Fredrickson type iia hyperlipoproteinemia, gastroesophageal reflux disease, insomnia and vitamin D deficiency. Review of Resident #6's Resident Register revealed she was admitted on 12/02/24. Review of signed physician orders for Resident #6 dated 09/30/25 revealed there was an order	{D 358}	**Any discrepancies are reviewed in daily stand up with follow up on Order Processing Systems daily to ensure all orders have been reviewed, clarified, and ordered.** **Ensure medication reconciliation has been Completed upon new admits, new orders, and hospice admits.** **Hospice to meet with SCC and/or ED upon each visit to review notes and new orders.** **SCC to audit 5 resident charts weekly, ED to review.**	**12/8/25** **12/8/25** **12/8/25** **12/8/25**

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{D 358}	Continued From page 17 for lorazepam tablets 0.5mg take one tablet twice daily (used to treat agitation and anxiety). Observation of the 8:00am medication pass on 10/29/25 revealed: -Resident #6's lorazepam 0.5mg tablet was labeled take one tablet twice daily. -There were 6 tablets in the bubble pack. -The medication aide (MA) popped the bubble pack over the medication cup and the tablet was dispensed into the plastic medication cup for administration. -Resident #6 received her medications at 9:15am for the 8:00am medication pass. Review of Resident #6's October 2025 electronic medication administration record (eMAR) dated 10/01/25 - 10/29/25 revealed: -There was an entry for lorazepam 0.5mg 1 tablet twice daily, scheduled at 8:00am and 8:00pm. -Lorazepam 0.5mg was documented as administered at 8:00am and 8:00pm from 10/01/25- 10/28/25 and at 8:00am on 10/29/25. Interview with Resident #6's primary care provider (PCP) on 10/30/25 at 2:38pm revealed: -Resident #6 had lorazepam 0.5mg ordered twice a day for anxiety. -The doses were staggered to be given to help keep her calm. -There should not be any problem getting it late as long as the 8:00pm dose was given closer to 9:00pm. -If it was given closer to 8:00pm, Resident #6 may be a little more sedated. Based on observations, interviews, and record reviews it was determined that Resident #6 was not interviewable.	{D 358}		

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{D 358}	Continued From page 18 Refer to interview with a MA on 10/29/25 at 1:15pm. Refer to interview with the Special Care Coordinator (SCC) on 10/30/25 at 2:27pm. Refer to interview with the Administrator on 10/30/25 at 3:30pm. b. Review of Resident #7's current FL-2 dated 01/08/25 revealed diagnoses included dementia, hypertension, hyperlipidemia, history of colon cancer, benign prostatic hypertrophy, vitamin D deficiency and vitamin B12 deficiency. Review of Resident #7's Resident Register revealed he was admitted on 07/03/25. Review of signed physician orders for Resident #7 dated 01/08/25 revealed there was an order for acetaminophen tablets 500mg take one tablet three times a day (used to treat mild-moderate pain). Observation of the 8:00am medication pass on 10/29/25 revealed: -Resident #7's medications were packaged in multi-dose packs (MDPs). -The medication aide (MA) prepared and administered medications in the morning MDP which included 1 acetaminophen tablet 500mg to Resident #7 at 9:24am. Review of Resident #7's October 2025 eMAR dated 10/01/25 - 10/30/25 revealed: -There was an entry for acetaminophen tablet 500mg take one tablet three times a day (scheduled at 8:00am, 2:00pm, and 8:00pm. -Acetaminophen tablet 500mg was documented as administered at 8:00am, 2:00pm, and 8:00pm	{D 358}		

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{D 358}	Continued From page 19 from 10/01/25- 10/30/25. Interview with Resident #7's primary care provider (PCP) on 10/30/25 at 2:38pm revealed: -Resident #7 had acetaminophen 500mg ordered three times a day for mild pain. -There should not be any problem getting it late since he was only getting a total of 1500mg in a 24 hour time period. Based on observations, interviews, and record reviews it was determined that Resident #7 was not interviewable. Refer to interview with a MA on 10/29/25 at 1:15pm. Refer to interview with the Special Care Coordinator (SCC) on 10/30/25 at 2:27pm. Refer to interview with the Administrator on 10/30/25 at 3:30pm. c. Review of Resident #8's current FL-2 dated 07/17/25 revealed diagnoses included Alzheimer's dementia, hypertension, venous insufficiency. Review of Resident #8's Resident Register revealed he was admitted on 07/03/25. Review of signed physician orders for Resident #8 dated 08/29/25 revealed there was an order for Tums chewable tablets 200mg take one tablet twice daily (used to treat heartburn, indigestion and upset stomach). Observation of the 8:00am medication pass on 10/29/25 revealed: -Resident #8's medications were packaged in	{D 358}		

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{D 358}	Continued From page 20 multi-dose packs (MDPs) except his Tums which was in a separate bottle. -The medication aide (MA) prepared the MDP and placed them in a plastic medication cup. -She used the bottle top of the TUMS to retrieve one tablet of the Tums and placed it into a separate plastic medication cup. -She administered medications in the morning MDP and gave Resident #8 his TUMS which she instructed Resident #8 to chew at 9:32am. Review of Resident #8's October 2025 eMAR dated 10/01/25 - 10/30/25 revealed: -There was an entry for Tums tablets 200mg take one tablet twice a day (scheduled at 8:00am and 8:00pm) for antacid. -Tums tablets 200mg were documented as administered at 8:00am and 8:00pm from 10/01/25- 10/30/25. Interview with Resident #8's primary care provider (PCP) on 10/30/25 at 2:38pm revealed: -Resident #8 had TUMS antacid ordered twice a day for indigestion. -There would not be any problem getting it late. Based on observations, interviews, and record reviews it was determined that Resident #8 was not interviewable. Refer to interview with a MA on 10/29/25 at 1:15pm. Refer to interview with the Special Care Coordinator (SCC) on 10/30/25 at 2:27pm. Refer to interview with the Administrator on 10/30/25 at 3:30pm. d. Review of Resident #9's current FL-2 dated	{D 358}		

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{D 358}	Continued From page 21 06/12/25 revealed diagnoses included Alzheimer's disease, chronic diastolic heart failure, hyperlipidemia, allergic rhinitis, hypothyroidism, unspecified osteoarthritis, gastroesophageal reflux disease, and hypertensive heart disease. Review of Resident #9's Resident Register revealed he was admitted on 06/09/25. Review of signed physician orders for Resident #9 dated 09/12/25 revealed there was an order for Haloperidol lactate (Haldol) concentrate 2 mg/mL take one mL twice a day for agitation. Observation of the 8:00am medication pass on 10/29/25 revealed: -Resident #9's medication was packaged in multi-dose packs (MDPs) except her Haldol which was liquid in a bottle. -The medication aide (MA) prepared the MDP and placed it in a plastic medication cup with apple sauce. -She used the measuring syringe with the Haldol and drew up 1 mL as ordered and placed it in the apple sauce. -She administered medication in the morning MDP and Haldol in the apple sauce to Resident #9 at 9:45am. Review of Resident #9's October 2025 eMAR dated 10/01/25 - 10/30/25 revealed: -There was an entry for Haldol 1mL take twice a day (scheduled at 8:00am and 8:00pm) (used to treat acute agitation). - Haldol 1mL was documented as administered at 8:00am and 8:00pm from 10/01/25-10/30/25 with refusals noted on 10/16/25 at 8:00am and 10/03/25, 10/04/25, 10/16/15, 10/17/25, 10/18/25 at 8:00pm.	{D 358}		

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{D 358}	Continued From page 22 Based on observations, interviews, and record reviews it was determined that Resident #9 was not interviewable. Interview with a medication aide (MA) on 10/29/25 at 1:15pm revealed: -She had been running late to work that morning. -She had made the Special Care Coordinator (SCC) aware that she was running late. -No one had started administering medications for her assigned residents when she arrived to work so she began her medication pass (did not remember the exact time she arrived). -She would normally be at work a little before 7:00am and start her medication pass. -She would normally complete her medication pass by 8:30am-8:40am. -She knew that medications were to be given one hour before the scheduled time to one hour after the scheduled time. -She knew that the medications for some of the last residents were going to be late (after the one hour allowed time for administration) due to her being late for work. -When medications were not administered as ordered, it was a medication error, and the MA would let the PCP know to see if there were other orders needed for the resident. Interview with the SCC on 10/30/25 at 2:27pm revealed: -The MAs were responsible for the medication pass. -If they were late they were to let her and or the Administrator know. -It was very unusual for the MA to be late. -She was not at the facility when the MA notified them that she was going to be late. -By the time she arrived at the facility, the MA was	{D 358}		

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{D 358}	Continued From page 23 already there and had begun her medication pass. -The process was when the MA was going to be late, the MA from the previous shift would normally stay or try to find another MA to cover. -If that was not possible, then she (SCC) or the Administrator would cover as they were MAs as well. Interview with the Administrator on 10/30/25 at 3:30pm revealed: -If a MA was late, they should notify the SCC or her. -The SCC was not at the facility that morning. -The MA was never late, that was unusual for her to be late. -If another MA could not cover until the MA arrived, the SCC or Administrator could cover until she arrived. -With the state survey going on, it threw everyone off. Interview with Resident #9's primary care provider (PCP) on 10/30/25 at 2:38pm revealed: -Resident #9 had Haldol 2mg ordered twice a day for agitation. -She was glad Resident #9 took her medications, as she refused quite often. -The doses were staggered to be given to help keep her calm. -There should not be any problem getting it late as long as the 8:00pm dose was given closer to 9:00pm. -If it was given closer to 8:00pm, Resident #9 may be a little more sedated. 2. Review of Resident #1's current FL-2 dated 10/16/25 revealed: -Diagnoses included Alzheimer's disease with late onset, dementia, obstructive and reflux uropathy, essential hypertension, and fracture of lower end	{D 358}		

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{D 358}	Continued From page 24 of lower extremity. -There was an order for Xarelto 10mg 1 tablet once daily for deep vein thrombosis (DVT) prevention. (Xarelto is a blood thinner used to treat and prevent blood clots. DVT occurs when a blood clot forms in one or more of the deep veins of the body.) Review of Resident #1's prescription for a rehabilitation facility provider dated 10/02/25 revealed an order for Xarelto 10mg 1 tablet once a day for DVT prevention. Review of Resident #1's facility progress note dated 10/08/25 at 11:49am revealed the resident returned to the facility from a rehabilitation facility on 10/08/25. Review of Resident #1's discharge planning and summary form from a rehabilitation facility dated 10/08/25 revealed: -The resident's discharge diagnosis included right hip fracture with routine healing. -Xarelto 10mg 1 tablet once daily for DVT prevention was included on a list of medications the resident should be taking. -Xarelto was noted to be last administered to Resident #1 on 10/08/25 at 8:10am at the rehabilitation facility. Review of Resident #1's electronic physician's order dated 10/09/25 from a rehabilitation provider revealed: -There was an order for Xarelto 10mg 1 tablet daily for DVT prevention. -The order was documented as created (entered into the electronic medication administration record system) on 10/09/25 at 12:22pm. -The order was not documented as verified by the facility until 10/13/25 at 3:06pm by the Special	{D 358}		

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{D 358}	Continued From page 25 Care Unit Coordinator (SCC). Review of Resident #1's medication release form from the rehabilitation facility dated 10/08/25 revealed: -There was a controlled substance medication for pain documented as being released to the resident. -There were no other medications, including Xarelto listed on the medication release form. Review of Resident #1's facility progress note dated 10/19/25 at 12:37pm revealed: -The resident's primary care provider (PCP) was contacted and notified that Resident #1 needed her Xarelto. -The facility staff asked the PCP for a hold order and the PCP stated she would send it in. Review of Resident #1's October 2025 eMAR dated 10/01/25 - 10/29/25 revealed: -There was documentation on the first page of the eMAR that Resident #1 was out of the facility and in the hospital from 10/01/25 - 10/08/25 (8:00am). -There was an entry for Xarelto 10 mg 1 tablet once daily for DVT prevention, scheduled at 5:00pm. -There was an "x" marked each day from 10/01/25 - 10/12/25 and none documented as administered during that time frame. -The first dose of Xarelto 10mg was documented as administered on 10/13/25, 5 days after returning to the facility on 10/08/25. -There was no documentation to indicate why there was a delay in starting Xarelto. -Xarelto 10mg was documented as administered 4 days from 10/13/25 - 10/16/25 for the first entry. -The start date was noted as 10/09/25 for the first entry for Xarelto 10mg.	{D 358}		

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{D 358}	Continued From page 26 -There was a second entry for Xarelto 10mg 1 tablet once daily for DVT prevention. -The start date for the second entry was 10/16/25. -The first dose documented for the second entry for Xarelto was 10/17/25. -Xarelto 10mg was documented as administered 11 days from 10/17/25 - 10/27/25 for the second entry. -Xarelto was documented as not administered, on hold on 10/28/25. Observation of Resident #1's medications on hand on 10/30/25 at 3:22pm revealed: -There was a supply of Xarelto 10mg tablets dispensed by a back-up pharmacy on 10/29/25. -The instructions were to take 1 tablet once daily for DVT prevention. -There were 5 of 5 Xarelto 10mg tablets remaining. Interview with Resident #1 on 10/29/25 at 9:15am revealed she received medications every day, but she did not know what medications she received. Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/30/25 at 3:42pm revealed: -They received Resident #1's prescription dated 10/02/25 on 10/02/25 and they put it on the resident's profile but did not dispense it because the resident had not returned to the facility yet. -They received Resident #1's physician's order dated 10/09/25 for Xarelto 10mg on 10/09/25 and entered it into the eMAR system. -Their pharmacy billing department sent faxes to the facility on 10/09/25 and 10/10/25 for the facility to get signature from Resident #1's guardian to authorize dispensing the medication due to the high cost of the medication.	{D 358}		

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{D 358}	Continued From page 27 -Their billing department did not receive authorization back from the facility. -On 10/29/25, the facility contacted the pharmacy and said they needed Resident #1's Xarelto. -Their pharmacy billing department finally got authorization on 10/29/25 so the back-up pharmacy dispensed Xarelto 10mg for Resident #1 on 10/29/25. Interview with the SCC on 10/30/25 at 5:35pm revealed: -Resident #1 returned to the facility from a rehabilitation facility on 10/08/25. -The rehabilitation facility sent some medications with Resident #1 when she returned to the facility on 10/08/825, including some Xarelto 10mg tablets. -She did not recall how many Xarelto 10mg tablets were sent to the facility with the resident on 10/08/25 and she did not document the medications received from the rehabilitation facility. -The rehabilitation facility sent a medication release form, but it only had a controlled substance listed on it. -The facility's contracted pharmacy usually entered orders into the eMAR system. -She was responsible for approving orders in the eMAR system for the order to become active. -Two or three medication aides (MAs) also had access to approve orders in the eMAR system. -Sometimes it took orders a while to "pop up" in the eMAR system. -She did not recall why there was a delay in approving and starting Resident #1's Xarelto when the resident returned to the facility on 10/08/25. -She usually checked the eMARs as soon as a medication was received to make sure everything matched.	{D 358}		

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{D 358}	Continued From page 28 -She was not aware until 10/27/25 that Resident #1 was out of Xarelto. -She tried to get authorization to get the Xarelto from Resident #1's guardian from a Department of Social Services (DSS) in another county because DSS was also the resident's payee. -She did not recall seeing any forms faxed from the pharmacy previously asking for authorization to pay for Resident #1's Xarelto. -The MAs should reorder medications when there was a one-week supply remaining. -The MAs should let her know if medication was not received when ordered. -On 10/27/25, Resident #1's PCP told her to hold Resident #1's Xarelto on 10/28/25 only, while they tried to get a supply on hand. -The PCP paid for 5 tablets of Xarelto for Resident #1 out of her own pocket that were received by the facility on 10/29/25 from the back-up pharmacy. Interview with the Administrator on 10/30/25 at 5:55pm revealed: -She did not know about a delay in starting Resident #1's Xarelto or any other issues with the Xarelto. -The SCC was responsible for approving/verifying orders in the eMAR after the orders were entered into the eMAR by the pharmacy. -The MAs did weekly medication cart audits. -The MAs should start the reorder process when there was a 5 to 8-day supply remaining. Interview with Resident #1's PCP on 10/30/25 at 2:10pm revealed: -Resident #1 fell and broke her right hip just prior to September 2025. -Resident #1 was in the hospital and then sent to a rehabilitation facility after she broke her right hip.	{D 358}		

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{D 358}	Continued From page 29 -She just found out about issues with Resident #1's Xarelto yesterday, 10/29/25. -She was not sure why there was a delay in starting Resident #1's Xarelto when she returned to the facility from rehabilitation. -She thought there may have been a cost issue and she gave a hold order for one day to give them time to get it to the facility. -A delay in receiving Xarelto or missing doses of Xarelto could result in the resident having a DVT which could lead to heart attack or stroke. -It could also result in more interventions being necessary to dissolve a blood clot. 3. Review of Resident #4's FL-2 dated 09/25/25 revealed: -Diagnoses included Alzheimer's dementia, chronic obstructive pulmonary disease (COPD), chronic kidney disease stage III, osteoporosis, essential hypertension, diabetes mellitus type II, and hyperlipidemia. -The recommended level of care was domiciliary memory care. Review of Resident #4's Resident Register revealed she was admitted to the facility on 09/23/25. a. Review of an incident report dated 10/20/25 at 1:48pm revealed: -Resident #4 had a medical incident with slurred speech and leaning to the left side. -The resident was transported by emergency medical services (EMS) and admitted to the hospital. Review of Resident #4's hospital discharge summary dated 10/23/25 revealed: -Resident #4 was admitted 10/20/25 with a diagnosis of pyelonephritis (pyelonephritis is a bacterial infection causing inflammation of the	{D 358}		

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{D 358}	Continued From page 30 kidneys). -Resident #4 was discharged on 10/23/25 with diagnoses of pyelonephritis, urinary tract infection (UTI), type II diabetes with chronic kidney disease, stage 3a chronic kidney disease, chronic obstructive pulmonary disease, and essential hypertension. -There was an order for Macrobid 100mg take one in the morning and one before bedtime for five days and do not give with antacids (Macrobid is antibiotic medication commonly used to treat UTI's). -The document was electronically signed on 10/23/25. Review of hospice visit note dated 10/29/25 revealed: -Resident #4 had a current UTI and was on antibiotic therapy. -The note was electronically signed. Review of Resident #4's October 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Macrobid 100mg take one capsule twice daily for five days and do not give with antacids scheduled for 8:00am and 8:00pm. -Macrobid was not documented as administered on 10/23/25-10/26/25 at 8:00am and 8:00pm with no reason documented. -Macrobid 100mg was not documented as administered once by exception on 10/27/25 at 8:00am not administered due to "verification". -Macrobid 100mg was documented as administered at 8:00pm on 10/27/25. -Macrobid 100mg take one capsule twice daily was documented as administered on 10/28/25. -Macrobid 100mg was documented as administered at 8:00am on 10/29/25.	{D 358}		

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{D 358}	Continued From page 31 Observation of Resident #4's medications on hand on 10/30/25 at 9:47am revealed there was no Macrobid on hand for Resident #4. Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/30/25 at 3:42pm revealed: -Macrobid had not been dispensed by the pharmacy for Resident #4. -The pharmacy had orders dated 10/23/25 for Macrobid for Resident #4. -There was a note that the facility contacted the pharmacy to ask that Macrobid not be sent on 10/23/25. Telephone interview with a pharmacist from Resident #4's outside pharmacy on 10/31/25 at 4:27pm revealed: -The pharmacy did not receive a hospital discharge summary or orders for Resident #4 from 10/23/25. -The last medication the pharmacy dispensed for Resident #4 was dispensed on 09/16/25. -There was no record that the pharmacy had ever dispensed Macrobid for Resident #4. Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/31/25 at 2:59pm revealed: -The pharmacy staff usually entered orders into the eMAR system. -The facility staff were responsible for approving/verifying orders in the eMAR system before the orders became active. -The facility staff also had access to enter orders into the eMAR system if needed. -They received Resident #4's FL-2 on 09/23/25 with a fax cover sheet indicating the resident was a new admission, "profile only".	{D 358}		

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{D 358}	Continued From page 32 -The fax cover sheet also noted not to send any medications now. -They marked the resident as "profile only", meaning they would not dispense any medications unless the facility notified them a medication was needed or the facility notified them to remove the "profile only" status. -They received Resident #4's hospital discharge summary dated 10/23/25 with an order for Macrobid 100mg after the 5:00pm cut off on 10/23/25. -Resident #4's hospital discharge summary was processed and entered into the eMAR system on 10/24/25. -The order for Macrobid was entered into the eMAR system on 10/24/25 but not dispensed because Resident #4 was marked as "profile only". -They did not receive a request from the facility to dispense Macrobid. -They never dispensed any Macrobid for Resident #4. Interview with a medication aide (MA) on 10/30/25 at 3:17pm revealed: -Resident #4 had already started taking Macrobid on 10/24/25 and it should be completed, but the eMAR may not have had the entry right away. -Every once in a while there was a delay in the eMAR entry showing up. Interview with the Special Care Unit Coordinator (SCC) on 10/30/25 at 5:35pm revealed she was responsible for approving orders on the eMAR for new medications. Second Interview with the SCC on 10/31/25 at 3:30pm revealed: -When orders were received the facility faxed orders to the pharmacy or emailed them.	{D 358}		

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{D 358}	Continued From page 33 -She would also call to let the pharmacy know she sent orders. -There was a cut off time with the pharmacy. -In an emergency she could call and medication could be sent through a back-up pharmacy. -She left work early that weekend (The weekend of 10/25/25 and 10/26/25), but nobody called to tell her that there was anything that needed approval on the eMAR. -She would allow MAs to implement orders but they did not feel confident. -Staff could call her because she kept her laptop with her to work from home. -On the next Monday (10/27/25) she verified any orders that had not been addressed. -Resident #4's profile only status at the pharmacy came from her because the resident's family was getting medicines from an outside pharmacy at first. -Resident #4's family member was going to get her medications from an outside pharmacy because the facility's contracted pharmacy was more expensive. -There was an instance where he got the hospital to send scripts to the outside pharmacy, but later family decided to use the facility's contracted pharmacy. -She did not know why Macrobid was not on hand for Resident #4, but she would check dispense receipts. -She did not have any record of medications delivered by family, but gave a phone number of the outside pharmacy that she thought was used, and which the family had used previously. Interview with Resident #4's primary care provider (PCP) on 10/30/25 at 2:11pm revealed: -She evaluated Resident #4 one time before the resident switched to hospice care. -She was not involved in the prescription of	{D 358}		

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{D 358}	Continued From page 34 antibiotics for Resident #4. -If the facility had trouble with antibiotics they should notify her. -Antibiotic medication should be delivered the next day at the latest. -If medicine was not started by the next day, the facility needed to call the pharmacy. -The facility should notify her by the next day if the antibiotic was not started. -She did not order Macrobid for Resident #4. -Macrobid should be started immediately or the next day after it was prescribed. Refer to interview with Resident #4's family member on 10/30/25 at 1:40pm. Refer to interview with the Administrator on 10/31/25 at 4:35pm. b. Review of Resident #4's FL-2 dated 09/25/25 revealed there was an order for glipizide-metformin tablet 2.5-500mg take two tablets twice daily (glipizide and metformin combination is used to treat high blood sugar levels related to type II diabetes). Review of an incident report dated 10/20/25 at 1:48pm revealed: -Resident #4 had a medical incident with slurred speech and leaning to the left side. -The resident was transported by emergency medical services (EMS) and admitted to the hospital. Review of Resident #4's hospital discharge summary dated 10/23/25 revealed: -Resident #4 was admitted 10/20/25 with a diagnosis of pyelonephritis. -Resident #4 was discharged on 10/23/25 with diagnoses of pyelonephritis, urinary tract	{D 358}		

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 35 infection, type II diabetes with chronic kidney disease, stage 3a chronic kidney disease, chronic obstructive pulmonary disease, and essential hypertension. -Resident #4 was admitted with severe hypoglycemia (low blood sugar) and altered mental status. -Resident #4 received treatment with dextrose containing IV fluids (dextrose is used to help treat hypoglycemia). -Resident #4 was on glipizide-metformin medication at home, which would be discontinued. -Resident #4's glipizide-metformin medication was a likely cause of hypoglycemia. -Resident #4's encephalopathy was likely secondary to hypoperfusion due to hypovolemia given lactic acidosis and hypoglycemia finger stick blood sugar (FSBS) of 48. -There was an order to discontinue glipizide-metformin 2.5-500mg tablet. -The document was electronically signed on 10/23/25. Review of Resident #4's October 2025 electronic medication administration record (eMAR) revealed: -There was an entry for glipizide-metformin tablet 2.5-500mg take two tablets twice daily scheduled for 8:00am and 8:00pm. -Glipizide-metformin tablet 2.5-500mg take two tablets twice daily was documented as administered twice a day from 10/01/25-10/14/25 and 10/16/25-10/19/25, and 10/25/25. -An exception for glipizide-metformin was documented at 8:00am on 10/15/25 with the reason that the resident was unavailable. -Glipizide-metformin tablet 2.5-500mg was documented as administered at 8:00pm only on 10/15/25.	{D 358}		

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{D 358}	Continued From page 36 -Glipizide-metformin tablet 2.5-500mg was documented as administered at 8:00am on 10/24/25. -An exception for glipizide-metformin was documented at 8:00pm on 10/24/25 with the reason that clarification was needed. -Glipizide-metformin tablet 2.5-500mg was not documented as administered 10/20/25-10/23/25 due to Resident #4's hospitalization. -Glipizide-metformin tablet 2.5-500mg take two tablets twice daily was not documented as administered at 8:00am and 8:00pm on 10/21/25-10/23/25 and 10/26/25-10/29/25 without specified reasons. Observation of Resident #4's medications on hand on 10/30/25 at 9:47am revealed Resident #4's glipizide-metformin medication was in multi-dose packs which were marked with a sticker that showed the glipizide-metformin medication was discontinued. Interview with a medication aide (MA) on 10/29/25 at 2:09pm revealed: -When multi-dose packs were used, a green sticker was placed on the list to mark that a medication was stopped. -If orders were received from the hospital they needed to be faxed to the pharmacy. -To administer medications from multi-dose packs she would open the pack, pour the medication, match the correct pill to the card, and then give the medication. -If a pill in the dose pack was discontinued she put the medication in the destroyer. -The Special Care Unit Coordinator (SCC) was responsible for faxing orders to the pharmacy. Second interview with the MA on 10/31/25 at 9:27am revealed	{D 358}		

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{D 358}	Continued From page 37 -She sent Resident #4 to the hospital when her speech was slurred and she was leaning to the left. -Resident #4 came back from the hospital and the weekend could cause a delay in discontinuing medications. -If medicines were discontinued and it was on the hospital paperwork then it may need to be clarified, and that could cause a delay in discontinuing the medication. -Clarifications were made by calling the resident's primary care provider (PCP). -MAs should clarify orders as soon as possible or immediately when hospital orders were unclear. Third interview with the SCC on 10/31/25 at 3:30pm revealed: -When orders were received the facility faxed orders to the pharmacy or emailed them. -She would also call to let the pharmacy know she sent orders. -There was a cut off time with the pharmacy. -In an emergency she could call and medication could be sent through a back-up pharmacy. -When Resident #4 came back from the hospital on 10/23/25 glipizide-metformin continued on the eMAR. -She left work early that weekend (The weekend of 10/25/25 and 10/26/25), but nobody called to tell her that there was anything that needed approval on the eMAR. -She would allow MAs to implement orders but they did not feel confident. -Staff could call her because she kept her laptop with her to work from home. -On the next Monday (10/27/25) she verified any orders that had not been addressed. -When residents came back from the hospital discontinued medication could be addressed at cart audits.	{D 358}		

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{D 358}	Continued From page 38 Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/31/25 at 2:59pm revealed: -The pharmacy staff usually entered orders into the eMAR system. -The facility staff were responsible for approving/verifying orders in the eMAR system before the orders became active. -The facility staff also had access to enter orders into the eMAR system if needed. -They received Resident #4's FL-2 on 09/23/25 with a fax cover sheet indicating the resident was a new admission, "profile only". -The fax cover sheet also noted not to send any medications now. -They marked the resident as "profile only", meaning they would not dispense any medications unless the facility notified them a medication was needed or the facility notified them to remove the "profile only" status. -They received Resident #4's hospital discharge summary dated 10/23/25 on 10/23/25 after the cut off time of 5:00pm. -Resident #4's hospital discharge summary was processed and entered into the eMAR system on 10/24/25. -They entered Resident #4's hospital discharge summary order dated 10/23/25 to stop Glipizide/Metformin 2.5/500mg into the eMAR system on 10/24/25. -The facility would have to verify the discontinue order for Glipizide/Metformin 2.5/500mg in the eMAR system for the discontinue order to become active 4. Review of Resident #5's current FL-2 dated 10/02/25 revealed diagnoses included dementia, type 2 diabetes, congestive heart failure, and stage 3 chronic kidney disease.	{D 358}		

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{D 358}	Continued From page 39 Review of signed physician orders for Resident #5 dated 10/02/25 revealed: -There was an order for Insulin Lispro Insulin Pen; 100unit/mL, check finger stick blood sugar (FSBS) four times a day at 8:00am, 12:00pm, 5:00pm, and 8:00pm and inject per sliding scale insulin (SSI), if FSBS is 0-200=0 units, 201-250=2 units, 251-300 4 units, 301-350 6 units, 351-400=8 units, 401-450=10 units; greater than or equal to 451 call the resident's primary care provider (PCP) (Insulin Lispro is a fast acting insulin used to lower blood sugar). Review of Resident #5's October 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Insulin Lispro 100unit/mL, check FSBS four times a day at 8:00am, 12:00pm, 5:00pm, and 8:00pm and inject per sliding scale insulin (SSI), if FSBS is 0-200=0 units, 201-250=2 units, 251-300 4 units, 301-350 6 units, 351-400=8 units, 401-450=10 units; greater than or equal to 451 call the resident's PCP. -Resident #5's FSBS was documented as 279 at 5:00pm on 10/22/25 and 2 units of Insulin Lispro was documented as administered when 4 units of Insulin Lispro should have been administered per the resident's sliding scale. Interview with a medication aide (MA) on 10/31/25 at 3:03pm revealed: -MAs were expected to follow PCP orders on the eMAR. -Resident #5 had a sliding scale for his diabetes and the insulin was used to help keep his blood glucose within a healthy range. -She checked the resident's FSBS and then double checked the FSBS with the SSI order that	{D 358}		

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{D 358}	Continued From page 40 was on the eMAR to ensure the resident was administered the correct amount of insulin. -She was not sure why a MA administered the incorrect number of units of insulin to Resident #5 because MAs were supposed to pay attention to the SSI order because it was ordered by the resident's PCP. Interview with the Special Care Unit Coordinator (SCC) on 10/31/25 at 9:37am revealed: -She was not aware that Resident #5 did not receive the correct amount of insulin in October 2025. -The MAs were supposed to administer the correct amount of insulin based on the resident's FSBS and the sliding scale. -The MA that administered 2 units of insulin instead of 4 units of insulin placed the resident at risk of a higher blood sugar which could make the resident feel drained, nauseated, and dizzy. -MAs should check a resident's FSBS reading at least two times and compare it with the sliding scale at least 2 times to ensure the correct amount of insulin was administered. Interview with Resident #5's PCP on 10/30/25 at 2:10pm revealed: -The MAs should follow his orders for SSI. -When Resident #5 was not given the correct number of units of insulin, the MA should have realized the mistake and should have notified her so that she was aware and could monitor the resident. -The MA that administered the incorrect units of insulin should have also notified the SCC. -When Resident #5 received less units of insulin than needed it increased the resident's risk of his blood glucose going higher which could result in hyperglycemia.	{D 358}		

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{D 358}	Continued From page 41 Interview with the Administrator on 10/30/25 at 5:55pm revealed: -MAs were expected to follow PCP orders on the eMAR. -She was not aware that Resident #5 did not receive enough units of insulin on 10/22/25. -If a MA had a question or did not understand how to follow the resident's SSI, they needed to contact the SCC or the resident's PCP. -Resident #5 could have become sick by not receiving the correct amount of insulin. Based on observations, interviews, and record reviews it was determined that Resident #5 was not interviewable. The facility failed to administer medications as ordered to 4 of 6 residents (#6, #7, #8, #9) observed during the medication pass on 10/29/25 and for 3 of 5 sampled residents (#1, #4, #5). Resident #6 received a controlled substance for anxiety ordered twice a day beyond the one-hour allowed time frame putting the resident at risk of increased sedation. Resident #9 received an oral liquid antipsychotic ordered twice a day beyond the one-hour allowed time frame putting the resident at risk of increased sedation. There was a 5-day delay in starting Resident #1's blood thinner after the resident returned from a rehabilitation facility for a fractured hip putting the resident at risk of having a deep vein thrombosis (DVT) (a blood clot) which could cause a heart attack or stroke. Resident #5 received a lower dose of sliding scale insulin than was ordered putting the resident at risk of having high blood sugar. Resident #4 had a delay in implementing multiple medication orders from a hospital discharge summary dated 10/23/25 for hypoglycemia (low blood sugar) and urinary tract infection (UTI). Resident #4's medication that	{D 358}		

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{D 358}	Continued From page 42 lowered blood sugar was ordered to be discontinued on 10/23/25 but was administered through 10/25/25 putting the resident at risk of having another episode of low blood sugar. Resident #4's antibiotic ordered on 10/23/25 was not administered to continue to treat the UTI when the resident was discharged from the hospital on 10/23/25. This failure of the facility was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/30/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 15, 2025.	{D 358}		
{D 367}	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .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	{D 367}	**10A NCAC 13F .1004 (j) Medication Administration** **Care Manager is responsible for verification of medication within 24 hours.** **If medication or treatment is not available the facility should request a hold order from the PCP within a 24-hour period to allow the medication to arrive.**	**12/8/25** **12/8/25**

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{D 367}	Continued From page 43 omission, including refusals; and, (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 record reviews and interviews the facility failed to ensure accuracy of the medication administration record for 1 of 5 sampled resident (#4) related to an antibiotic used to treat a urinary tract infection, a medication for constipation and a sleep aid. The findings are: Review of Resident #4's FL-2 dated 09/25/25 revealed: -Diagnoses included Alzheimer's dementia, chronic obstructive pulmonary disease (COPD), chronic kidney disease stage III, osteoporosis, essential hypertension, diabetes mellitus type II, and hyperlipidemia. -The recommended level of care was domiciliary memory care. Review of Resident #4's Resident Register revealed she was admitted to the facility on 09/23/25. a. Review of Resident #4's hospital discharge summary dated 10/23/25 revealed: -Resident #4 was discharged 10/23/25 with diagnoses of pyelonephritis, urinary tract infection (UTI), type II diabetes with chronic kidney disease, stage 3a chronic kidney disease, chronic	{D 367}	**If a resident is listed under "Profile Only" the facility should notify the pharmacy to fill the medication.** **The facility can use the local pharmacy if the contracted pharmacy or family can not provide the medication in a timely manner.**	12/8/25 12/8/25

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{D 367}	Continued From page 44 obstructive pulmonary disease, and essential hypertension. -There was an order for Macrobid 100mg take one in the morning and one before bedtime for five days and do not give with antacids (Macrobid is antibiotic medication commonly used to treat or prevent UTI's). -The document was electronically signed on 10/23/25. Review of Resident #4's October 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Macrobid 100mg take one capsule twice daily for five days and do not give with antacids scheduled for 8:00am and 8:00pm. -Macrobid was not documented as administered on 10/23/25-10/26/25 at 8:00am and 8:00pm with no reason documented. -Macrobid 100mg was not documented as administered once by exception on 10/27/25 at 8:00am due to "verification". -Macrobid 100mg was documented as administered at 8:00pm on 10/27/25. -Macrobid 100mg take one capsule twice daily was documented as administered on 10/28/25 at 8:00am and 8:00pm. -Macrobid 100mg was documented as administered at 8:00am on 10/29/25. Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/30/25 at 3:42pm revealed: -Macrobid had not been dispensed by the pharmacy. -The pharmacy had orders dated 10/23/25 for Macrobid. -There was a note that the facility contacted the pharmacy to ask that Macrobid not be sent on	{D 367}		

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{D 367}	Continued From page 45 10/23/25. Telephone interview with a pharmacist from Resident #4's outside pharmacy: -The pharmacy did not receive a hospital discharge summary or orders for Resident #4 from 10/23/25. -The last medication the pharmacy dispensed for Resident #4 was dispensed on 09/16/25. -There was no record that the pharmacy had ever dispensed Macrobid for Resident #4. Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/31/25 at 2:59pm revealed: -The pharmacy staff usually entered orders into the eMAR system. -The facility staff were responsible for approving/verifying orders in the eMAR system before the orders became active. -The facility staff also had access to enter orders into the eMAR system if needed. -They received Resident #4's FL-2 on 09/23/25 with a fax cover sheet indicating the resident was a new admission, "profile only". -The fax cover sheet also noted not to send any medications now. -They marked the resident as "profile only", meaning they would not dispense any medications unless the facility notified them a medication was needed or the facility notified them to remove the "profile only" status. -They received Resident #4's hospital discharge summary dated 10/23/25 which contained the order for Macrobid on 10/23/25 after the cut off time of 5:00pm. -Resident #4's hospital discharge summary was processed and entered into the eMAR system on 10/24/25. -The order for Macrobid was entered into the	{D 367}		

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{D 367}	Continued From page 46 eMAR system on 10/24/25 but not dispensed because Resident #4 was marked as "profile only". -They did not receive a request from the facility to dispense Macrobid. -They never dispensed any Macrobid for Resident #4. Interview with a medication aide (MA) on 10/30/25 at 3:17pm revealed: -Resident #4 had already started taking Macrobid on 10/24/25 and it should be completed, but the eMAR may not have had the entry right away. -Every once in a while there was a delay in the eMAR entry showing up. Interview with the Special Care Unit Coordinator (SCC) on 10/30/25 at 5:35pm revealed she was responsible for approving orders on the eMAR for new medications. Second interview with the SCC on 10/31/25 at 3:30pm revealed: -When orders were received the facility faxed orders to the pharmacy or emailed them. -She would also call to let the pharmacy know she sent orders. -There was a cut off time with the pharmacy. -In an emergency she can call and medication can be sent through a back-up. -She left work early that weekend, but nobody called to tell her that there was anything that needed approval on the eMAR. -She would allow MA's to implement orders but they did not feel confident. -Staff could call her because she kept her laptop with her to work from home. -On the next Monday she verified any orders that had not been addressed. -Resident #4's profile only status at the pharmacy	{D 367}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 367}	Continued From page 47 came from her because the resident's family was getting medicines from an outside pharmacy at first. -Resident #4's family member was going to get her medications from an outside pharmacy because the facility's contracted pharmacy was more expensive. -There was an instance where he got the hospital to send scripts to the outside pharmacy, but later family decided to use the facility's contracted pharmacy. -She did not know why Macrobid was not on hand, but she would check dispense receipts. -She did not have any record of medications delivered by family, but gave a phone number of the outside pharmacy that she thought was used, and which the family had used previously. Refer to interview with the Administrator on 10/31/25 at 4:35pm. b. Review of Resident #4's hospital discharge summary dated 10/23/25 revealed: -There was an order for lactulose 10 gram/15mL solution take 10g in the morning, with instructions to start taking on 10/24/25 (Lactulose is a medication used to treat constipation). -The document was electronically signed on 10/23/25. Review of Resident #4's October 2025 electronic medication administration record (eMAR) revealed: -There was an entry for lactulose 10 gram/15mL solution take 10g in the morning -Lactulose 10 gram/15mL solution take 10g in the morning was not documented as administered on 10/24/25-10/26/25. -Lactulose 10 gram/15mL solution take 10g in the morning was documented as not administered by	{D 367}		

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(D 367)	Continued From page 48 exception on 10/27/25 with reason of "verification". -Lactulose 10 gram/15mL solution take 10g in the morning was documented as administered 10/28/25 and 10/29/25. Interview with a medication aide (MA) on 10/30/25 at 10:37am revealed she thought Resident #4 had used leftover lactulose that was brought to the facility by family and she asked for resupply. Interview with the Special Care Unit Coordinator (SCC) on 10/30/25 at 5:35pm revealed she was responsible for approving orders on the eMAR for new medications. Second interview with the SCC on 10/31/25 at 3:30pm revealed: -When orders were received the facility faxed orders to the pharmacy or emailed them. -She would also call to let the pharmacy know she sent orders. -There was a cut off time with the pharmacy. -She left work early that weekend, but nobody called to tell her that there was anything that needed approval on the eMAR. -She would allow MA's to implement orders but they did not feel confident. -Staff could call her because she kept her laptop with her to work from home. -On the next Monday she verified any orders that had not been addressed. Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/31/25 at 2:59pm revealed: -The pharmacy staff usually entered orders into the eMAR system. -The facility staff were responsible for	(D 367)		

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{D 367}	Continued From page 49 approving/verifying orders in the eMAR system before the orders became active. -The facility staff also had access to enter orders into the eMAR system if needed. -They received Resident #4's FL-2 on 09/23/25 with a fax cover sheet indicating the resident was a new admission, "profile only". -The fax cover sheet also noted not to send any medications now. -They marked the resident as "profile only", meaning they would not dispense any medications unless the facility notified them a medication was needed or the facility notified them to remove the "profile only" status. -They received Resident #4's hospital discharge summary dated 10/23/25 with an order for Lactulose 10gm/15ml after the 5:00pm cut off on 10/23/25. -Resident #4's hospital discharge summary was processed and entered into the eMAR system on 10/24/25. -The order for Lactulose was entered into the eMAR system on 10/24/25 but not dispensed because Resident #4 was marked as "profile only". -They did not receive a request from the facility to dispense Lactulose until 10/30/25. -They dispensed a 30-day supply of Lactulose on 10/30/25. Refer to interview with the Administrator on 10/31/25 at 4:35pm. c. Review of Resident #4's hospital discharge summary dated 10/23/25 revealed: -There was an order for melatonin 5mg take 1 tablet daily at 8:00pm. -The document was electronically signed on 10/23/25.	{D 367}		

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{D 367}	Continued From page 50 Review of Resident #4's October 2025 electronic medication administration record (eMAR) revealed: -There was an entry for melatonin 5mg take 1 tablet daily at 8:00pm (Melatonin is a supplement commonly used to aid sleep). -Melatonin 5mg take 1 tablet daily at 8:00pm was documented as not administered 10/23/25-10/26/25. -Melatonin 5mg take 1 tablet daily at 8:00pm was documented as administered on 10/27/25 and 10/28/25. Interview with a medication aide (MA) on 10/30/25 at 10:37am revealed Resident #4's Melatonin was not on supply. Interview with the Special Care Unit Coordinator (SCC) on 10/30/25 at 5:35pm revealed she was responsible for approving orders on the eMAR for new medications. Second interview with the SCC on 10/31/25 at 3:30pm revealed: -When orders were received the facility faxed orders to the pharmacy or emailed them. -She would also call to let the pharmacy know she sent orders. -There was a cut off time with the pharmacy. -She left work early that weekend, but nobody called to tell her that there was anything that needed approval on the eMAR. -She would allow MA's to implement orders but they did not feel confident. -Staff could call her because she kept her laptop with her to work from home. -On the next Monday she verified any orders that had not been addressed. Telephone interview with a pharmacist at the	{D 367}		

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(D 367)	Continued From page 51 facility's contracted pharmacy on 10/31/25 at 2:59pm revealed: -The pharmacy staff usually entered orders into the eMAR system. -The facility staff were responsible for approving/verifying orders in the eMAR system before the orders became active. -The facility staff also had access to enter orders into the eMAR system if needed. -They received Resident #4's FL-2 on 09/23/25 with a fax cover sheet indicating the resident was a new admission, "profile only". -The fax cover sheet also noted not to send any medications now. -They marked the resident as "profile only", meaning they would not dispense any medications unless the facility notified them a medication was needed or the facility notified them to remove the "profile only" status. -They received Resident #4's hospital discharge summary dated 10/23/25 with an order for Melatonin 5mg after the 5:00pm cut off on 10/23/25. -Resident #4's hospital discharge summary was processed and entered into the eMAR system on 10/24/25. -The order for Melatonin was entered into the eMAR system on 10/24/25 but not dispensed because Resident #4 was marked as "profile only". -They did not receive a request from the facility to dispense Melatonin until 10/30/25. -They dispensed 4 Melatonin 5mg tablets on 10/30/25 to last until the next cycle fill. Refer to interview with the Administrator on 10/31/25 at 4:35pm. Interview with the Administrator on 10/31/25 at 4:35pm revealed:	(D 367)		

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{D 367}	Continued From page 52 -The SCC usually clarified orders but the Administrator or MA could if the SCC was not available. -There was probably a breakdown in communication resulting in medication changes being delayed related to Resident #4's 10/23/25 hospital discharge. -She did not know about Resident #4's profile only status. -She thought Resident #4's family may have gone to another pharmacy. -The SCC was responsible to make sure hospital discharges were reviewed, and orders were reviewed. -The MA's and SCC were responsible to make sure orders were implemented, and she followed up with verbal consultation with staff. -None of the delays or concerns were reported to her for medications.	{D 367}		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the 24-hour initial reports and/or 5-day investigative reports for the health care personnel registry (HCPR) were completed as required and in a timely manner for 1 of 2 sampled residents (#1) who had injuries of unknown origin, including a fractured hip and pelvis on one occasion and a	D 438	**10A NCAC 13F .1205 Health Care Personnel Registry** **24-hour 5-day reports initial reporting will be turned into the State within 24 hours of notification to the Administrator.** **The Administrator is responsible for investigating and completing the 24-hour 5-day reporting.** **The facility should complete an incident report on injuries of an unknown origin and report it to the state within a 24-hour timeframe of notification.**	**12/8/25** **12/8/25** **12/8/25**

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D 438	Continued From page 53 bruised, swollen left hand and swollen leg on another occasion. The findings are: Review of Resident #1's current FL-2 dated 10/16/25 revealed: -Diagnoses included Alzheimer's disease with late onset, dementia, obstructive and reflux uropathy, essential hypertension, and fracture of lower end of lower extremity. -The resident was constantly disoriented. -The resident was non-ambulatory. -The resident was incontinent of bowel and bladder. -The resident required assistance with bathing and dressing. Review of Resident #1's Resident Register dated 04/03/25 revealed: -The resident was admitted to the facility on 04/03/25. -The resident required assistance with nail care, dressing, bathing, ambulation, toileting, hair/grooming, skin care, mouth care, feeding, positioning/turning, correspondence, getting, in/out of bed, scheduling appointments, and orientation to time and place. -The resident had significant memory loss and must be directed. Review of Resident #1's current assessment and care plan dated 08/05/25 revealed: -The resident was ambulatory with a wheelchair. -The resident was incontinent of bowel and bladder. -The resident was sometimes disoriented, had significant memory loss, and must be directed. -The resident required limited assistance by staff with eating.	D 438	**If the Facility Administrator is unsure of appropriate incident reporting it is her responsibility to follow-up with the Regional Clinical Director/Divisional Vice President of Operations for guidance.** **The facility is responsible for notifying the Adult Home Care Specialist on reporting.**	

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D 438	Continued From page 54 -The resident required extensive assistance by staff with toileting, ambulation, bathing, and transferring. -The resident was totally dependent upon staff with bathing, dressing, and grooming. a. Review of Resident #1's accident/incident report dated 08/22/25 at 10:20am revealed: -The type of incident was documented as medical - elevated heart rate and lethargic. -Resident #1 was observed lying in bed in her room. -Resident #1 was transported to the hospital by emergency medical services (EMS). -The primary care provider (PCP) was notified. -The resident was admitted to the hospital. Review of Resident #1's hospital discharge summary dated 08/28/25 revealed: -Resident #1 was admitted to the hospital on 08/22/25. -At the time of presentation, Resident #1 reported not feeling well but did not have specific symptoms. -During emergency room (ER) evaluation, the resident described bruising associated with skin tears. -An x-ray was performed and demonstrated a right hip fracture as well as pelvic fractures. -The resident was admitted and surgery was done. -The resident was discharged from the hospital on 08/28/25. Observation of Resident #1 on 10/29/25 at 9:15am revealed the resident was sitting in a high back wheelchair in the hallway near her room. Interview with Resident #1 on 10/29/25 at 9:15am revealed:	D 438		

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D 438	Continued From page 55 -She thought she had fallen 2 or 3 times, but she could not recall when. -She could not recall if she was injured from any falls. Interview with a medication aide (MA) on 10/31/25 at 11:30am revealed: -She was working on first shift on 08/22/25 when Resident #1 was lethargic. -Resident #1 was in her bed and did not want to get up. -The home health nurse (HHN) came to do wound care on Resident #1's leg. -The HHN thought Resident #1's leg wound may be infected because the resident was complaining of leg pain. -No one reported a fall, and the resident would not have been able to get up from a fall without physical assistance by staff. -The Special Care Coordinator (SCC) was notified, and Resident #1 was taken by EMS to the hospital. -She did not know until after the resident was taken to the hospital that the resident had any fractures. -She did not know how Resident #1 sustained the injuries on 08/22/25. Review of Resident #1's record revealed no documentation of a 24-hour initial report or 5-day working report being completed and sent to the Health Care Personnel Registry (HCPR) for Resident #1's injuries of unknown origin on 08/22/25. Interview with the Administrator on 10/31/25 at 4:35pm revealed: -She was responsible for doing 24-hour and 5-day reports for the HCPR. -She did not know she had to report injuries of	D 438		

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D 438	Continued From page 56 unknown origin to the HCPR. -She was unable to determine what caused Resident #1's injuries on 08/22/25. -She did not report Resident #1's injuries of unknown origin on 08/22/25 because she did not know they had to be reported. -The Divisional Vice President of Operations (DVPO) educated her on the process of requirements for reporting to the HCPR on 10/29/25, so now she knew she needed to report any injuries of unknown origin. b. Observation of Resident #1 on 10/29/25 at 9:15am revealed: -The resident was sitting in a high back wheelchair in the hallway near her room. -The resident's left hand was swollen with dark purple bruising on the top of her hand that continued down the length of all 5 fingers, which were also swollen. -There was also some purple bruising on the palm of her left hand that continued down the inside of her left wrist and arm. -The palm of her left hand and her wrist were also swollen. -Both of Resident #1's lower legs were wrapped with white bandages. Interview with Resident #1 on 10/29/25 at 9:15am revealed: -She complained of left hand pain. -She was not sure how long her hand had been injured. -She was not sure what happened but she thought she might have fallen. -She thought she had a large scrape on her leg from a fall, but she was not sure. -She could not remember for sure what happened.	D 438		

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D 438	Continued From page 57 Interview with the Special Care Coordinator (SCC) on 10/29/25 at 10:15am revealed: -The injury to Resident #1's left hand "popped up" on Monday, 10/27/25. -A picture of Resident #1's injury was sent to the primary care provider (PCP) and the PCP ordered an x-ray. -They were still waiting for the results of the x-ray. -She did not know what caused the injury. -No falls had been reported, and Resident #1 would not be able to get up from a fall without assistance because she was non-ambulatory. Review of Resident #1's facility progress note dated 10/27/25 at 7:24am revealed: -Resident #1's PCP was notified of swelling and bruising of Resident #1's left hand and arm as well as swelling of the resident's left lower leg. -The PCP stated Resident #1 was on blood thinners that could be the source of bruising. -The PCP recommended staff be cautious during personal care assistance to minimize bruising. Review of Resident #1's facility progress note dated 10/27/25 at 10:45am revealed: -Resident #1's PCP was notified that Resident #1's swelling and discoloration appeared to be spreading and worsening. -The PCP ordered an x-ray of Resident #1's left hand stat (immediately). Review of Resident #1's accident/incident report dated 10/27/25 at 7:15am revealed: -The type of incident was documented as medical - skin related. -Resident #1 had bruising of the left arm and hand and swelling of the left hand and leg. -The location of the incident was noted as the resident's room. -There was no documentation about how the	D 438		

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D 438	Continued From page 58 injuries occurred to Resident #1. -The PCP was notified. Review of Resident #1's home health care note dated 10/27/25 revealed: -Resident #1 was observed to have a swollen, bruised left hand. -Facility staff reported no falls. -It was unclear how the bruise occurred. -The resident was scheduled for an x-ray today. -The home health nurse (HHN) removed dressings from Resident #1's lower legs and performed wound care. Interview with a medication aide (MA) on 10/29/25 at 1:48pm revealed: -There was nothing reported by third shift staff when she came into work on 10/27/25 a little before 7:00am. -A personal care aide (PCA) was doing her walk through to check on residents around 6:48am. -The PCA asked her to look at Resident #1's hand. -Resident #1 was sitting up in her wheelchair in the hallway. -Resident #1's hand was "a little bit" swollen and had a dark purple bruise from the base of the resident's pointer finger that spread around and over to the resident's thumb. -Resident #1's fingers were not swollen or discolored initially. -Resident #1 reported she did not know what happened. -If Resident #1 had fallen, staff would have to help the resident get up because Resident #1 could not physically get up on her own. -No falls were reported for Resident #1. -She asked the third shift MA and PCA and both reported they were not aware of any injuries to Resident #1, and they reported they did not	D 438		

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D 438	Continued From page 59 observe the injuries during third shift. -She notified Resident #1's PCP on 10/27/25 and the PCP ordered an x-ray. Interview with Resident #1's HHN on 10/30/25 at 9:50am revealed: -Her first visit with Resident #1 was on 10/27/25. -She asked facility staff on 10/27/25 what happened to Resident #1's left hand but they did not know what happened to it. -No falls were reported by staff and Resident #1 would not be able to get up from a fall without assistance by staff. -Resident #1 had wounds that were documented as trauma wounds; the resident's skin was fragile, so it did not take much for the resident to get a skin tear. -She could not be sure what caused the skin tears, but it could be from the resident bumping her legs on something. Interview with Resident #1's PCP on 10/30/25 at 2:10pm revealed: -The facility staff contacted her on 10/27/25 about Resident #1's injuries to her left hand and leg. -The injuries were of unknown origin. -Resident #1 would not be able to get up by herself if she had fallen but there was no report of a fall on or around 10/27/25. Review of Resident #1's 24-hour initial report for the Heath Care Personnel Registry (HCPR) revealed: -The incident type was documented as injury of unknown source. -The incident date was documented as 10/27/25 and the facility became aware on 10/27/25 at 11:00am. -The facility staff initially completed an incident report and notified the PCP of bruising on	D 438		

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D 438	Continued From page 60 Resident #1's hand. -The resident was sent to the hospital on 10/27/25 for an x-ray but the facility requested a mobile x-ray for quicker results. -There was no documentation on the 24-hour report regarding injury to the resident's leg. -The resident reported the injury happened from a fall. -The mobile x-ray report from 10/29/25 noted no acute fracture; bruising was noted to the entire hand. -The 24-hour report was completed and signed and dated 10/29/25, more than 24 hours after the facility became aware of Resident #1's injuries. Interview with the Administrator on 10/31/25 at 4:35pm revealed: -She was responsible for doing 24-hour and 5-day reports for the HCPR. -She did not know she had to report injuries of unknown origin to the HCPR. -She did not report Resident #1's injuries of unknown origin on 10/27/25 within 24 hours to the HCPR because she did not know they had to be reported. -The Divisional Vice President of Operations (DVPO) educated her on the process of requirements for reporting to the HCPR on 10/29/25 so that was the date she did the initial 24-hour report for Resident #1's injuries discovered on 10/27/25. -She still did not know what caused Resident #1's injuries on 10/27/25. -She was in the process of completing the 5-day working report to send to the HCPR.	D 438		
D 453	10A NCAC 13F .1212(d) Reporting of Accidents and Incidents	D 453	**10A NCAC 13F .1212(d) Reporting of Accidents and Incidents**	

Division of Health Service Regulation

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D 453	Continued From page 61 10A NCAC 13F .1212 Reporting of Accidents and Incidents (d) The facility shall immediately notify the county department of social services in accordance with G.S. 108A-102 and the local law enforcement authority as required by law of any mental or physical abuse, neglect or exploitation of a resident. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to immediately notify local law enforcement (LE) of alleged abuse for 1 of 1 sampled resident (#3) who was forcibly removed from a chair and placed on the floor by a medication aide (Staff A). The findings are: Review of the facility's policy titled N.C. Policy & Procedures-Resident Abuse, Neglect and Exploitation and dated September 2021 revealed: -In the event of physical and/or verbal abuse, neglect, fraud, or exploitation of the resident or resident property or allegations of physical or verbal abuse, neglect, fraud or exploitation of the resident or community property by community staff, the community would complete the Health Care Personnel Registry (HCPR) 24-hour report now referred to as the Initial Report. -Upon notification of any of the above allegations as indicated in 10A NCAC 13 F .1205 as well as	D 453	All staff were inservice on Incident Reporting. All staff are encouraged to report any form of abuse, or neglect to management at the time of the event. Any staff that demonstrate any form of abuse or neglect should be instructed to leave the facility premises immediately and suspended pending an investigation to ensure all residents remain safe of preventative action for future mishaps. Management should thoroughly reviewed Policies and procedures to ensure appropriate steps are taken. Any witness or speculation of abuse should be immediately reported to the local sheriff's office.	12/8/25 12/8/25 12/8/25 12/8/25

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D 453	Continued From page 62 10A NCAC 13 F 0101, .0102, the community would begin an investigation and document findings on the HCPR 5-day report now referred to as the Investigation Report and submit to the HCPR. -In the event of any accusation of abuse; of a resident by staff, visitors, or other resident(s), Community management would direct staff to ensure the immediate safety of the resident. -If there was resident on resident altercation/abuse residents would be separated or relocated to another room as needed. -The physician would be notified for any additional orders which may include referral to outside resources for further medical evaluation, and the family, responsible party and or guardian would be notified and advised of their right to request notification of local authorities. -In the event of any accusation of abuse; of a resident by staff, visitors, or other residents, Community management would direct staff to ensure the immediate safety of the resident. -If there was any physical harm or injury present, the residents would be sent out to the hospital for further evaluation unless the resident or responsible party declined further evaluation. -The DVPO, DDCS (no definitions given for these titles) would be notified immediately, and all required reporting would be completed as required not limited to local law enforcement and Department of Social Services (DSS). -The community would complete the Health Care Personnel Registry (HCPR) 24-hour report and begin an immediate investigation. -Investigation Process was as follows: -Immediate suspension of the accused individual (staff) if named or suspected parties pending investigation. -Complete the Health Care Personnel Registry (HCPR) 24-hour report within 24 hours of	D 453		

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D 453	Continued From page 64 -There was a history of mental illness, and the resident was receiving medications for the mental illness/behavior. -Resident #3 was documented as ambulatory with aide or device which was listed as a wheelchair. -Resident #3 was documented as sometimes disoriented and forgetful needing reminders. Review of Staff A's staff record revealed Staff A was hired as a medication aide (MA) on 04/16/24. Review of Resident #3's Accident/Incident (A/I) report dated 10/24/25 revealed: -The incident occurred on 10/22/25 at 8:00am in the dining room. -The type of incident was documented as other (not related to a fall)-misappropriate behavior between resident and staff. -It was witnessed by a staff member. -It was reported by staff members with 4 staff members named. -It was described as the staff observed that a MA grabbed Resident #3 and placed her on the floor. -There were no complaints or negative outcomes to the resident related to the incident. -First aid was not administered. -The Administrator and Special Care Coordinator (SCC) met with the primary care provider (PCP) and the PCP ordered bilateral shoulders, hips, and pelvis x-rays to be done for Resident #3 on 10/23/25. -Resident #3 was not sent out to the emergency room (ER). -The resident was seen by the PCP on 10/23/2025 at 6:49am. -The additional follow up documented that there was no symptoms or negative outcome noted. -The Administrator and county Department of Social Services (DSS) were notified.	D 453		

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D 453	Continued From page 65 -The resident's status was monitored for 72 hours and charted in the progress notes daily from 10/23/25 -10/27/25. Review of Resident #3's progress notes dated 10/23/2025 at 6:49am revealed: -She was seen by the PCP for a follow up from an incident that occurred on 10/22/25. -Resident #3 was involved in an incident where she was physically handled by a staff member in a manner that could be considered abusive. -While in the dining room, the patient threw a cup at a staff member. -In response, the staff member picked Resident #3 up by her arms and placed her on the floor. -The incident was witnessed, and it was confirmed that the resident did not hit her head. -No x-rays were ordered at the time, and she did not go to the emergency room. -She denied any pain. -There were no complaints of pain reported, but due to the incident there was a concern for potential injuries. -The PCP ordered x-rays of bilateral hips, shoulders, and pelvis to assess for any injuries. -The treatment plan was dependent upon x-ray results. -There was documentation that the resident had been involved in an incident where she was physically handled by a staff member in a manner that could be considered abusive. -The diagnosis code T74.11XA adult physical abuse, confirmed, initial encounter was documented. Review of Resident #3's progress notes revealed: -Staff documented every shift from 10/23/25-10/28/25. -There were no complaints of pain or discomfort noted.	D 453		

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D 453	Continued From page 66 -There were no injuries noted and no mental status changes noted. Review of Resident #3's x-ray reports dated 10/23/25 revealed: -Bilateral hips with pelvis x-rays had been done with normal x-ray examination of the bilateral hip with pelvis. -Bilateral shoulders x-rays had been done with no acute bone abnormality noted. Review of Resident #3's accident and incident 24-hour report revealed: -It was faxed to Health Care Personnel Registry (HCPR) on 10/23/25 at 4:41pm and 4:52pm. -There was no notification of law enforcement documented on the report. Review of Resident #3's accident and incident report revealed -It was faxed to the county Department of Social Services (DSS) on 10/24/25 at 12:56pm. -There was no notification of law enforcement documented on the report. Review of Resident #3's accident and incident 5-day report revealed: -It was faxed to HCPR on 10/29/25 at 5:25pm. -There was no notification of law enforcement documented on the report. Telephone interview with Staff A on 10/31/25 at 3:15pm revealed: -She worked on 10/22/25 when the incident with Resident #3 occurred. -She had been checking another resident's blood pressure, when Resident #3 started saying "that's mine, no that's mine," referring to the blood pressure cuff. -Resident #3 was known to approach other	D 453		

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D 453	Continued From page 68 the dining room on 10/22/25 when the incident with Resident #3 occurred. -She heard a noise and looked over and Resident #3 was on the floor. -Another MA came into the dining room and helped Resident #3 off the floor after assessing her for injuries. Interview with a second MA on 10/31/25 at 10:50am revealed: -She had been in the hallway after finishing administering medications. -She had nutritional supplements that needed to be administered to residents with their meals, so she entered the dining room with the supplements. -She saw Resident #3 on the floor. -Staff A had told her that Resident #3 had thrown a cup at her. -Staff A had tried to escort Resident #3 out of the dining room and told her that Resident #3 'threw herself' on the floor. -She had never seen Staff A be disrespectful towards the residents. -Staff received training regarding dementia residents "every so often", she had just completed a training in September 2025. Interview with the Dietary Manager on 10/31/25 at 11:15am revealed: -On 10/22/25 she was in the dining room and was feeding a resident at a table. -She heard a sound when a hard plastic cup hit the floor, and she realized Resident #3 had thrown the cup. -She observed a Staff A "manhandle" Resident #3. -She physically provided an example by standing in front of a state surveyor and placed her arms under the surveyor's arms and imitated throwing	D 453		

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D 453	Continued From page 69 the state surveyor down to the floor. -She described the Staff A as "body slamming" the resident to the floor. -She observed two other staff that were in the dining room assist Resident #3 to get up from the floor. -Staff A's facial expression looked like she was mad, but Staff A was usually sweet and kind to the residents. -She heard Resident #3 yell at Staff A "you stupid". -She had never observed Staff A to be disrespectful, verbally abusive or physically abusive to any residents at the facility prior to this incident. Interview with the Special Care Coordinator (SCC) on 10/31/25 at 11:34am revealed: -She was not at the facility when the incident occurred with Staff A and Resident #3. -It was around shift change close to 7:00pm when she heard two staff that she did not identify talking about the incident that occurred earlier in the day between Staff A and Resident #3. -She heard two staff members discussing that Staff A removed Resident #3 from her chair in the dining room and put her on the floor after the resident threw her cup in the dining room. -She contacted the Administrator by telephone and reported what she overheard to the Administrator. -She reported to the Administrator that she overheard two staff members discussing that Resident #3 threw her plastic cup at Staff A who then picked the resident up out of her chair and put the resident on the floor. -She had never observed Staff A speaking disrespectfully to residents or being physically aggressive with residents. -Residents had never reported any complaints or	D 453		

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D 453	Continued From page 70 concerns to her about Staff A. -Staff A was suspended for five days so a 24-hour report could be made and a 5-day investigation completed for the Health Care Personnel Registry (HCPR). -She called the Adult Home Specialist Supervisor at the local Department of Social Services (DSS) to inform her of the incident. -She did not notify local law enforcement because the resident did not "seem to be hurt or anything." Interview with the Administrator on 10/31/25 at 12:19pm revealed: -She was notified by the SCC by telephone shortly after 7:00pm during shift change on 10/22/25 that the SCC overheard two staff members talking about the incident that occurred between Resident #3 and Staff A earlier in the day. -Staff A's shift ended at 7:00pm and she wanted to interview Staff A the next morning so she could obtain her side of the story. -Staff A reported that Resident #3 threw a cup at her and reported she picked the resident up from her chair from behind and tried to place the resident on the floor because the resident let her weight go onto Staff A. -Staff A reported that she was attempting to remove Resident #3 from the dining room and the resident flopped to the floor. -Staff A was suspended for 5 days pending an investigation and was then terminated. -There were no past issues or concerns with Staff A verbally or physically abusing residents. -The PCP ordered x-rays for Resident #3 to ensure she had no injuries. -She did not notify local law enforcement because she did not feel the resident was in danger. -She realized after the interview, the incident needed to be reported.	D 453		

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D 453	Continued From page 72 -She ordered x-rays which revealed no injuries. Based on observations, interviews, and record reviews it was determined that Resident #3 was not interviewable. Attempted telephone interview with Resident #3's guardian on 10/31/25 at 3:51pm was unsuccessful. The facility failed to ensure that local law enforcement (LE) was immediately notified of alleged abuse of a special care unit resident (Resident #3) by Staff A that occurred on 10/22/25 but was not reported until 10/31/25 while state surveyors were investigating. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/31/25 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 15, 2025.	D 453		