STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL040009	A. BUILDING: _____ B. WING _____	01/09/2026

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SNOW HILL ASSISTED LIVING	1328 S. E. SECOND STREET SNOW HILL, NC 28580

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on January 6-9, 2026	D 000		
D 079	10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain an environment free of hazards including personal care items in residents' rooms that were accessible to residents and not properly securing oxygen canisters in a storage closet. 1. Review of the facility's policy Special Care Unit (for SCU) safety measures for accidental ingestion dated September 2021 revealed: -Assessment of the resident, on admission and periodically screening for; personal items that could be ingested are maintained by staff (all liquid personal items, aerosols, hearing aids, pins, buttons, clips, etc.). -Resident and responsible party are notified of	D 079		

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policy on admission.
-Resident rooms/care areas are inspected regularly for unsafe items that could be accidentally ingested or harmful (glass items, pictures with glass covers, vases, etc.).
-Staff routinely monitor residents for possible hoarding of substances that could be ingested.
-Staff training includes assessing residents for possible ingestion, initiating necessary emergency procedures calling the poison control center if necessary, monitoring the facility and resident rooms for substances that could be accidentally ingested, notifying the residents physician, responsible party and other required parties as necessary and per policy.

Review of the facility's census report on 01/06/26 revealed there were 23 residents living in facility.

Observation of room 105 on 01/06/26 at 8:58am revealed:
-There was a 4.5 ounce (oz) creamy petroleum jelly vitamin sitting on top of a table in the bedroom.
-There was a warning label on the back of the creamy petroleum jelly vitamin E product reading external use only, do not get into eyes, and stop uses and ask a doctor if a condition worsens.
-There were two 8 oz bottles of shampoo and body wash sitting on top of a table in the bedroom.
-One bottle did not have a cap on top, and the contents could be seen.
-There was a warning label on the back of the shampoo and body wash product reading for external use only, to avoid contact with eyes, and discontinue use if irritation occurs.

Observation of room 204 on 01/06/26 at 9:02am revealed:

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D 079	Continued From page 2 -There was a 1.5 oz bottle of aloe & vitamin E powder sitting on top of a table in the bedroom. -There was a warning label on the back of the aloe & vitamin E powder product reading to keep out of reach of children, keep power away from face to avoid inhalation, which can cause breathing problems, and avoid contact with open flame. Observation of resident room 106 on 01/06/26 at 9:03am revealed there was a jar of petroleum jelly sitting on the side table at the window with a warning label reading keep out of reach of children, for external use only, and if ingested get medical help or contact a poison control center. Observation of room 209 on 01/06/26 at 9:05am revealed: -There was a 4.0 oz container of deodorant sitting on top of a dresser drawer in the bedroom. -There was a warning label on the back of the deodorant reading for external use only, do not use on broken skin, and stop use if rash or irritation occurs. -There was a 12.0 oz of 2-in-1 shampoo and conditioner sitting on top of a dresser drawer in the bedroom. -There was a warning label on the back of the 2-in-1 shampoo and conditioner reading to avoid contact with eyes. Observation of resident room 108 on 01/06/26 at 9:05am revealed: -There were 2 disposable razors hanging on a black wire rack in the bathroom. -There was an uncovered stick deodorant sitting on a black wire rack in the bathroom with a warning label reading to keep out of reach of children and if swallowed to contact a poison control center.	D 079		

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-There was a pump bottle of body wash sitting on the tank of the toilet with a warning label reading to keep out of reach of children, do not ingest, and avoid eye contact.
-There were 3 bottles of nail polish sitting on her side table with a warning label reading keep out of reach of children, flammable, and avoid breathing vapors.
-There was an opened bottle of nail polish remover on her side table with a warning label reading extremely flammable, keep out of reach of children, and harmful if ingested.

Interview with the resident in room 108 on 01/06/26 at 9:05am revealed:
-She polished her fingernails the other day, not sure of the date.
-She kept her polish and remover on her side table or in her drawer.
-She washed her hands and applied deodorant every day.
-She shaved her underarms when needed.

Interview with a personal care aide (PCA) on 01/06/26 at 10:00am revealed:
-She was responsible for checking for personal care products in resident's rooms.
-Round checks were daily at the beginning of each shift and throughout the day and she looked for personal care products in residents' rooms.
-When she walked through on 01/06/26, she did not notice any items in anyone's room.
-Some residents would ask for their personal products on their non-shower day and the PCAs gave the products to them but forgot to remove them and place them back in the shower room.
-If she saw products in residents' rooms, she would remove them and place them in the shower room.
-There were bins with residents' names on them

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for the residents to keep their personal belongings.

Interview with a medication aide (MA) on 01/06/26 at 9:43am revealed:
-There were bins with residents' names on them for the residents to keep their personal belongings.
-She did her rounds at the beginning of the shift, after medication pass, and again at 2:00pm.
-She did rounds on 01/06/26 at 6:45am with the night shift MA and saw personal products in residents' rooms but did not remove them because she did not have time.
-She had not reported to management about items being in resident's rooms.

Interview with a second MA on 01/06/26 at 9:43am revealed:
-Residents were not allowed to keep personal care products in their rooms.
-Resident's personal care products were kept in the shower rooms in labeled bins.
-She made rounds in the morning at 7:00am and around 2:00pm each day.
-She made rounds this morning at 6:45am with the night shift MA and found some personal care products but had not removed them.
-She did not have time this morning to remove the personal care products because she needed to administer medications.
-She did see the personal care products this morning in room 108 but did not have time to remove the products.
-The resident's family could have brought the personal care products.
-The resident was supposed to let staff know when she was done using her personal care products.
-Personal care aides (PCA) were supposed to

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round and remove personal care products if found.

Interview with the Resident Care Coordinator (RCC) on 01/07/26 at 5:56pm revealed:
-She made rounds weekly looking for personal care products in residents' rooms.
-The staff should make daily rounds in residents' rooms looking for personal care products.
-She was concerned that a resident could ingest products or hurt themselves or others with razors.
-The MAs were responsible for ensuring the residents' personal care products were stored in the showers.
-She was ultimately responsible for ensuring the residents' personal care products were stored in the showers.

Interview with the Administrator on 01/06/26 at 9:56am revealed:
-There was not a process for rounding to look for personal care because there should not be any personal care products in the residents' rooms.
-Residents personal care products were stored in the shower rooms.
-No personal care products should be stored in the residents' rooms.
-She was concerned that a resident could ingest the products.
-She had never had a resident ingest a personal care product.
-Razors should not be in the residents' rooms.
-Razors should not be in the residents' rooms because the residents could hurt themselves or others.
-It was the RCCs responsibility for ensuring there were no personal care products in the residents' rooms.

Attempted interview with the facility contracted

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primary care provider (PCP) on 01/09/26 at 9:15am was unsuccessful.

Attempted interview with the facility contracted mental health provider on 01/09/26 at 9:15am was unsuccessful.

2. Review of the facility's policy for oxygen handling and storage dated September 2021 revealed oxygen tanks shall be secured upright at all times to prevent falling over and secured in a manner to prevent tanks from being dropped or from striking violently against each other.

Observation of the medication room on 01/06/26 at 11:53am revealed there were 3 unsecured full oxygen (O2) tanks sitting in front of a rack holding 7 full O2 tanks and 5 empty O2 tanks.

Interview with a personal care aide (PCA) on 01/06/25 at 12:00pm revealed:
-Any staff member can change a residents O2 tank.
-The O2 tanks were stored in the medication room in a rack.

Interview with a medication aide (MA) on 01/06/26 at 11:55am revealed:
-An outside vendor delivered the O2 tanks.
-The O2 tanks were stored in the medication room.
-She did not know that the O2 tanks had to be stored in a rack.

Interview with the Resident Care Coordinator (RCC) on 01/06/25 at 4:16pm revealed:
-The O2 tanks should be stored in a rack for safety reasons.
-The O2 tanks could be a fire hazard if they fell over.

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D 079	Continued From page 7 -Staff members can change out a residents O2 tank. Interview with the Administrator on 01/07/26 at 2:30pm revealed: -O2 tanks were stored in the medication room. -O2 tanks should be stored in a crate. -She did not have any concerns related to full O2 tanks not being stored in a crate. -The RCC and the MAs were responsible for ensuring the O2 tanks were stored in crates. -The RCC was responsible for the proper storage of the O2 tanks.	D 079		
D 113	10A NCAC 13F .0311 (d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall supply hot water to the kitchen, bathrooms, laundry, housekeeping closets, and soiled utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F and shall not exceed 116 degrees F. Notwithstanding the requirements of Rule .0301 of this Section, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (°F) to a maximum of 116°F for nine fixtures sampled which ranged from 52.0 °F to 89.0 °F. The findings are:	D 113		

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D 113	Continued From page 8 Review of the facility's current license effective 01/01/26 revealed the facility was licensed as a Special Care Unit (SCU) facility with a capacity of 40 beds. Observation of the hot water temperature in the shared bathroom sink in room 101 and 103 on 01/06/26 at 8:55am revealed the hot water temperature was 52 °Fahrenheit (°F). Second observation of the hot water temperature in the shared bathroom sink in room 101 and 103 on 01/06/26 at 4:10pm revealed the hot water temperature was 69.5 °F. Observation of the hot water temperature in the shared bathroom sink in room 105 and 107 on 01/06/26 at 9:00am revealed the hot water temperature was 53 °F. Second observation of the hot water temperature in the shared bathroom sink in room 105 and 107 on 01/06/26 at 4:03pm revealed the hot water temperature was 75.6 °F. Observation of the hot water temperature in the bathroom sink in room 209 on 01/06/26 at 9:10am revealed the hot water temperature was 89 °F. Second observation of the hot water temperature in the bathroom sink in room 209 on 01/06/26 at 4:07pm revealed the hot water temperature was 95 °F. Third observation of the hot water temperature in the bathroom sink in room 209 on 01/07/26 at 2:30pm revealed the hot water temperature was 98.1°F.	D 113		

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D 113	Continued From page 9 Observation of the hot water temperature in the shared bathroom sink in room 202 and 204 on 01/06/26 at 9:15am revealed the hot water temperature was 88.5 °F. Second observation of the hot water temperature in the shared bathroom sink in room 202 and 204 on 01/06/26 at 4:11pm revealed the hot water temperature was 95 °F. Observation of hot water temperatures on 01/06/26 from 8:58am to 9:08am revealed: -The hot water temperature in the shared bathroom sink in room 102 and 104 was 84 degrees F. -The hot water temperature in the bathroom sink in room 106 was 70 degrees F. -The hot water temperature in the bathroom sink in room 108 was 72 degrees F. Observation of hot water temperatures on 01/06/26 from 11:37am to 11:50am revealed: -The hot water temperature in the men's spa sink was 70 degrees F. -The hot water temperature in the men's spa tub was 98 degrees F. Interview with a resident on 01/06/26 at 11:40am revealed: -The shower was always cool, barely warm. -She would like to have taken a hot shower. Interview with a second resident on 01/06/26 at 4:00pm revealed: -The water in the shower was warm when she took her shower. -The water in the sink was never warm when she washed her hands. -She would let the water run for a while, about 10	D 113		

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to 15 minutes and it still did not get warm.
-She told the medication aide (MA) that the water in her sink did not get hot.
-She told the Resident Care Coordinator (RCC) about a week ago, but she did not know if anyone followed up.
-She never saw Maintenance Director check the water.

Interview with a third resident on 01/07/26 at 12:50pm revealed:
-When he took a shower, the water would get warm and then cold again.
-He had to adjust the water temperature several times during his shower.
-He thought it would be great if the shower stayed warm.
-His sink took a long time to get warm.

Interview with a personal care aide (PCA) on 01/06/26 at 3:50pm revealed:
-The water had to run at least 10 to 15 minutes to warm up.
-She always turned the water on for at least 10 minutes to warm up before assisting a resident with a shower.
-The residents had not complained to her about cold water in the sink or shower.
-She had not reported the cold running water to any because she thought management knew because everyone knew to run the water for a while to get warm.
-She had not seen any staff checking the water temperature.

Interview with a second PCA on 01/06/26 at 3:55pm revealed:
-She was aware that the water in the residents' bathroom sink had to run at least 10 to 15 minutes to warm up.

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-She ran the water in the shower for at least 10 minutes to warm up before assisting a resident with a shower.

Interview with the medication aide (MA) on 01/06/26 at 3:45pm revealed:
-She was aware that the water had to run for a while to heat up but could not specify how "long" was a while.
-The PCA must turn on water and let it run before a resident could take a shower.
-The residents had not complained to her about cold water in the sink or shower.
-She had not seen any staff checking the water temperatures.

Interview with the Resident Care Coordinator (RCC) on 01/07/25 at 6:50pm.
-She was not aware that the water had to run for a few minutes to warm up.
-No one reported to her that the hot water ran cold.
Interview with the Regional Maintenance Director on 01/07/26 at 2:15pm revealed:
-He was not aware that the hot water ran cold.
-The Administrator made him aware that the hot water ran cold, and to check it to see if it needed to be adjusted.
-He was the direct supervisor to the Maintenance Director in that facility.
-The Maintenance Director for that facility was out on leave.
-The Maintenance Director should be checking the water once a week in random bedrooms including the women's and men's spa bathrooms.
-The Maintenance Director kept a water temperature log of his recordings.
-He checked the water heater today and saw it registered at 110 °F and he turned the water heater up to 115 °F.

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D 113	Continued From page 12 -The water temperature should be checked even if the Maintenance Director was out on leave. Interview with the Administrator on 01/06/26 at 4:15pm revealed: -She was aware that the water had to run for a few minutes to warm up but could not say how long it took to warm up. -The Maintenance Director was responsible to check the water temperature at least once a week and he kept a log of the water temperature. -She had been checking the water temperatures and checked the water temperatures last Wednesday. -She randomly selected rooms to check water temperatures and the rooms she checked were between 100 to 116°F. -No residents had complained to her about the hot water running cold.	D 113		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure that 1 of 3 sampled staff	D 125		

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D 125	Continued From page 13 who administered medications to residents passed the medication aide (MA) test within 60 days of their completed medication administration skills validation form (Staff B). Review of Staff B's personnel record revealed: -Staff B was hired as a personal care aide (PCA) on 12/03/24. -Staff B completed the state approved 15-hour medication aide course on 06/10/25. -Staff B's medication administration skills validation form was dated 06/10/25. -Staff B began working as a medication aide (MA) in August 2025. -Staff B passed the MA test on 08/22/25. Interview with the Resident Care Coordinator (RCC) on 01/09/26 at 12:07pm revealed: -The Administrator was responsible for ensuring the staff qualifications were met. -The Administrator made the staffing schedule. -The Licensed Health Professional Support Nurse (LHPS) informed her when she performed the medication clinical skills with MAs. -She had never reviewed the staff records. Interview with the Administrator on 01/09/26 at 1:52pm revealed: -She informed the RCC once staff completed their training and were placed on the schedule. -She was aware that Staff B was required to take their MA test within 60 days of their medication administration skills validation. -She was aware that Staff B had taken her MA test after 60 days of their medication administration skills validation. .	D 125		

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D 253	Continued From page 14	D 253		
D 253	10A NCAC 13F .0801 (a) (b) Resident Assessment 10A NCAC 13F .0801 Resident Assessment (a) The facility shall complete an assessment of each resident within 30 days following admission and annually thereafter. (b) The facility shall use the assessment instrument and instructional manual established by the Department or an instrument developed by the facility that contains at least the same information as required on the instrument established by the Department. The assessment shall be completed by an individual who has met the requirements of Rule .0508 of this Subchapter. If the facility develops its own assessment instrument, the facility shall ensure that the individual responsible for completing the resident assessment has completed training on how to conduct the assessment using the facility's assessment instrument. The assessment shall be a functional assessment to determine the resident's level of functioning to include psychosocial well-being, cognitive status, and physical functioning in activities of daily living. The assessment instrument established by the Department shall include the following: (1) resident identification and demographic information; (2) current diagnoses; (3) current medications; (4) the resident's ability to self-administer medications; (5) the resident's ability to perform activities of daily living, including bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting, and eating; (6) mental health history;	D 253		

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D 253	Continued From page 15 (7) social history, to include family structure, previous employment and education, lifestyle habits and activities, interests related to community involvement, hobbies, religious practices, and cultural background; (8) mood and behaviors; (9) nutritional status, including specialized diet or dietary needs; (10) skin integrity; (11) memory, orientation and cognition; (12) vision and hearing; (13) speech and communication; (14) assistive devices needed; and (15) a list of and contact information for health care providers or services used by the resident. The assessment instrument established by the Department is available on the Division of Health Service Regulation website at https://policies.ncdhhs.gov/divisional/health-benefits-nc-medicaid/forms/dma-3050r-adult-care-home-personal-care-physician/@@display-file/form_file/dma-3050R.pdf at no cost. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure that a care plan was completed within 30 days of admission for 1 of 3 sampled residents (#1). The findings are:	D 253		

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 253	Continued From page 16 Review of Resident #1's current FL-2 dated 09/03/25 revealed diagnoses included Parkinson's bipolar, epilepsy, arteriovenous malformation, encephalopathy, prostatic hyperplasia, and bradycardia. Review of Resident #1's Resident Register revealed an admission date of 08/05/25. Review of Resident #1's record revealed there was not a care plan completed within 30 days of admission. Review of Resident #1's care plan dated 12/08/25 revealed: -Resident #1 was non-ambulatory and used a wheelchair. -Resident #1 was incontinent and needed assistance with toileting. -Resident #1 needed extensive assistance with bathing, dressing, grooming, hygiene, and transferring. Interview with the Resident Care Coordinator (RCC) on 01/07/26 at 6:43pm revealed she was responsible for completing the resident's care plans. Telephone interview with the Administrator on 01/09/26 at 12:07pm revealed: -The RCC was responsible for completing the residents' care plans. -She did not know that Resident #1's initial care plan was not in the record. -The residents' care plan should be in Resident #1's record. -It was the RCC's responsibility to complete the care plans and place them in the resident's record.	D 253		

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 253	Continued From page 17 -The residents' care plans should be completed and available for review. Attempted telephone interview with the PCP on 01/09/26 at 9:15am was unsuccessful.	D 253		
D 259	10A NCAC 13F .0802 (a) (c) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (a) The facility shall develop and implement a care plan for each resident based on the resident's assessment completed in accordance with Rule .0801 of this Section. The care plan shall be resident-centered and include the resident's preferences related to the provision of care and services. A copy of each resident's current care plan shall be maintained in a location in the facility where it can be accessed by facility staff who are responsible for the implementation of the care plan. (c) The care plan shall include the following: (1) a description of services, supervision, tasks, and level of assistance to be provided to address the resident's needs identified in the resident's assessment in Rule .0801 of this Section; (2) frequency of the services or tasks to be performed; (3) revisions of tasks and frequency based on reassessments in accordance with Rule .0801 of this Section; (4) licensed health professional tasks required according to Rule .0903 of this Subchapter; (5) a dated signature of the assessor upon completion; and (6) a dated signature of the resident's physician or physician extender as defined in Rule .0102 of this Subchapter within 15 days of completion of the care plan certifying the resident is under this	D 259		

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D 259	Continued From page 18 physician's care and has a medical diagnosis with associated physical or mental limitations warranting the provision of the personal care services in the above care plan in accordance with G.S. 131D-2.15. This shall not apply to residents assessed through the Medicaid State Plan Personal Care Services Assessment for the portion of the assessment covering tasks needed for each activity of daily living of this Rule for which care planning and signing are directed by Medicaid. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that 3 of 3 sampled residents (#1, #2, and #3) had a care plan signed by the residents' primary care provider (PCP). The findings are: 1. Review of Resident #2's current FL2 dated 04/14/25 revealed diagnoses included dementia, post-traumatic stress disorder, and gastroesophageal reflux disease. Review of Resident #2's Resident Register revealed an admission date of 02/18/25. Review of Resident #2's current care plan dated 03/17/25 revealed: -The care plan was not signed and dated by the staff who completed the care plan. -The primary care provider (PCP) had not signed the care plan.	D 259		

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 259	Continued From page 19 -Resident #2 was semi-ambulatory and needed assistance. -Resident #2 was incontinent and needed assistance with toileting. -Resident #2 needed extensive assistance with bathing, dressing, grooming, hygiene, and transferring. Refer to the interview with the Resident Care Coordinator (RCC) on 01/07/25 at 6:43pm. Refer to the interview with the Administrator on 01/08/25 at 12:50pm. Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable. 2. Review of Resident #3's current FL2 dated 10/27/25 revealed: -Diagnoses included type 2 diabetes, dementia, hypertension dysphagia, major depressive disorder, cognitive communication deficit, and gastro-esophageal reflux disease. Review of Resident #3's Resident Register revealed an admission date of 10/20/25. Review of Resident #3's current care plan dated 12/08/25 revealed: -The care plan was not signed and dated by the staff who completed the care plan. -The primary care provider (PCP) had not signed the care plan. -Resident #3 was semi-ambulatory and needed extensive assistance. -Resident #3 was incontinent and needed extensive assistance with toileting. -Resident #3 needed extensive assistance with bathing, dressing, grooming, hygiene, and	D 259		

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 259	Continued From page 20 transferring. Refer to the interview with the Resident Care Coordinator (RCC) on 01/07/25 at 6:43pm. Refer to the interview with the Administrator on 01/08/25 at 12:50pm. Based on observations, interviews and record reviews, it was determined Resident #3 was not interviewable. 3. Review of Resident #1's current FL-2 dated 09/03/25 revealed diagnoses included Parkinson's bipolar, epilepsy, arteriovenous malformation, encephalopathy, prostatic hyperplasia, and bradycardia. Review of Resident #1's Resident Record revealed an admission date of 08/05/25. Review of Resident #1's current care plan dated 12/08/25 revealed: -The care plan was not signed and dated by the staff who completed the care plan. -The primary care provider (PCP) had not signed the care plan. -Resident #1 was non-ambulatory and used a wheelchair. -Resident #1 was incontinent and needed assistance with toileting. -Resident #1 needed extensive assistance with bathing, dressing, grooming, hygiene, and transferring. Refer to the interview with the Resident Care Coordinator (RCC) on 01/07/25 at 6:43pm. Refer to the interview with the Administrator on 01/08/25 at 12:50pm.	D 259		

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D 259	Continued From page 21 Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable. _____ Interview with the Resident Care Coordinator (RCC) on 01/07/25 at 6:43pm revealed: -She was aware the care plan assessment was due annually. -She had not sent the care plan assessment to the primary care provider (PCP). -She was not aware that the PCP was to sign the care plan assessment. -She had noticed the signature lines on the care plan but there was not a line for the PCP. -She put the care plan information into the computer system, and the system validated it and that was all she thought she had to do. -She had not had any training on how to complete care plans by the previous Administrator. -She was responsible for completing care plan assessments for residents in the facility. -She used the tickler system which told her when FL-2s, care plans, and other important papers were due to review. Interview with the Administrator on 01/08/25 at 12:50pm revealed: -She was not aware that the PCP did not review or sign residents' care plans. -She was aware that the care plan should be reviewed and signed by the PCP. -The RCC was responsible for ensuring resident care plans were completed and signed annually.	D 259		
D 278	10A NCAC 13F .0903(a) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support	D 278		

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D 278	Continued From page 22 (a) An adult care home shall assure that an appropriate licensed health professional participates in the on-site review and evaluation of the residents' health status, care plan and care provided for residents requiring one or more of the following personal care tasks: (1) applying and removing ace bandages, ted hose, binders, and braces and splints; (2) feeding techniques for residents with swallowing problems; (3) bowel or bladder training programs to regain continence; (4) enemas, suppositories, break-up and removal of fecal impactions, and vaginal douches; (5) positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter; (6) chest physiotherapy or postural drainage; (7) clean dressing changes, excluding packing wounds and application of prescribed enzymatic debriding agents; (8) collecting and testing of fingerstick blood samples; (9) care of well-established colostomy or ileostomy (having a healed surgical site without sutures or drainage); (10) care for pressure ulcers up to and including a Stage II pressure ulcer which is a superficial ulcer presenting as an abrasion, blister or shallow crater; (11) inhalation medication by machine; (12) forcing and restricting fluids; (13) maintaining accurate intake and output data; (14) medication administration through a well-established gastrostomy feeding tube (having a healed surgical site without sutures or drainage and through which a feeding regimen has been successfully established);	D 278		

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D 278	Continued From page 23 (15) medication administration through injection; Note: Unlicensed staff may only administer subcutaneous injections, excluding anticoagulants such as heparin. (16) oxygen administration and monitoring; (17) the care of residents who are physically restrained and the use of care practices as alternatives to restraints; (18) oral suctioning; (19) care of well-established tracheostomy, not to include indo-tracheal suctioning; (20) administering and monitoring of tube feedings through a well-established gastrostomy tube (see description in Subparagraph(a)(14) of this Rule); (21) the monitoring of continuous positive air pressure devices (CPAP and BiPAP); (22) application of prescribed heat therapy; (23) application and removal of prosthetic devices except as used in early post-operative treatment for shaping of the extremity; (24) ambulation using assistive devices that requires physical assistance; (25) range of motion exercises; (26) any other prescribed physical or occupational therapy; (27) transferring semi-ambulatory or non-ambulatory residents; or (28) nurse aide II tasks according to the scope of practice as established in the Nursing Practice Act and rules promulgated under that act in 21 NCAC 36. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure licensed	D 278		

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D 278	Continued From page 24	D 278		

health professional support (LHPS) evaluations were completed quarterly for 2 of 3 sampled residents (Residents #1, #2) who required assistance with tasks including ambulation with assistive device and transferring (#1), and ambulation with assistive device and transferring (#2).

The findings are:

1. Review of Resident #2's current FL2 dated 04/14/25 revealed diagnoses included dementia, post-traumatic stress disorder, and gastroesophageal reflux disease.

Review of Resident #2's Resident Register revealed an admission date of 02/18/25.

Review of Resident #2's current care plan dated 03/17/25 revealed Resident #2 needed extensive assistance with bathing, dressing, toileting, grooming, hygiene, and transferring.

Observation of Resident #2 on 01/06/26 at 12:20pm revealed staff propelling Resident #2 in a Geri chair to the dining hall for lunch.

Review of Resident #2's Licensed Health Professional Support (LHPS) evaluation dated 08/26/25 revealed:
-There was documentation for an LHPS review for transferring and ambulation using assistive devise that require physical assistance.
-There was documentation for an LHPS review for applying and removing ace bandages, ted hose, binders, and braces and splints.

Review of Resident #2's record revealed there were no subsequent or quarterly LHPS reviews completed for Resident #2.

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D 278	Continued From page 25 Refer to the interview with the Resident Care Coordinator (RCC) on 01/07/25 at 6:35pm. Refer to the interview with the Administrator on 01/08/25 at 12:50pm. Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable. 2. Review of Resident #1's current FL-2 dated 09/03/25 revealed diagnoses included Parkinson's bipolar, epilepsy, arteriovenous malformation, encephalopathy, prostatic hyperplasia, and bradycardia. Review of Resident #1's Resident Register revealed an admission date of 08/05/25. Observation of Resident #1 on 01/06/26 at 12:00pm revealed staff propelling Resident #1 in a Geri chair to the dining hall for lunch. Review of Resident #1's record revealed there was no Licensed Health Professional Support (LHPS) for Resident #1 since 09/02/25. Refer to the interview with the Resident Care Coordinator (RCC) on 01/07/25 at 6:35pm. Refer to the interview with the Administrator on 01/08/25 at 12:50pm. Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable. _____ Interview with the Resident Care Coordinator (RCC) on 01/07/25 at 6:35pm revealed:	D 278		

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D 278	Continued From page 26 -She was aware the contracted registered nurse (RN) came every two weeks to do LHPS. -The contracted nurse entered the LHPS information for residents into the computer system. -She was not aware that she was to follow up on the residents' LHPS assessments. -She did not know LHPS assessments were to be completed quarterly. -She did not know she was responsible for following up on quarterly LHPS assessments. Interview with the Administrator on 01/08/25 at 12:50pm revealed: -She was not aware that the residents' LHPS assessments were not completed quarterly. -The RCC was responsible for ensuring residents' LHPS were completed and signed by the RN quarterly. -The RCC was responsible for making sure the RN knew which residents needed quarterly reviews. -The RCC was responsible for following up on the LHPS recommendations.	D 278		
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:	D 358		

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D 358	Continued From page 27 Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 3 sampled residents (#1) related to a medication to treat extrapyramidal disease and (#3) related to a medication supplement. The findings are: 1. Review of Resident #1's current FL-2 dated 09/03/25 revealed: -Diagnoses included Parkinson's bipolar, epilepsy, arteriovenous malformation, encephalopathy, prostatic hyperplasia, and bradycardia. -There was an order for Benztropine 2mg twice daily (Benztropine is used to treat extrapyramidal disease). Review of Resident #1's Resident Register revealed an admission date of 08/05/25. Review of the mental health provider's (MHP) progress note dated 11/13/25 revealed: -There was an order to discontinue Benztropine 2mg twice daily. -There was an order to start Benztropine 1mg twice daily for 7 days and then decrease to ½ (0.5mg) twice daily for 7 days if resident is tolerating taper well (tapering off-notify provider with any concerns). Review of Resident #1's MHP progress note dated 11/20/25 revealed: -There was an order to continue Benztropine taper. -There was an order to discontinue Benztropine 1mg and start Benztropine 0.5 mg twice daily for 7 days and then discontinue.	D 358		

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D 358	Continued From page 28 Review of Resident #1's medication order detail entered by the Resident Care Coordinator (RCC) dated 11/13/25 revealed to discontinue Benztropine 1mg on 11/21/25 at 3:00pm. Review of Resident #1's MHP order dated 12/17/25 revealed to start Benztropine 0.5mg twice daily. Observation of Resident #1's medications on hand on 01/07/26 at 2:47 pm revealed there were Benztropine 0.5mg tablets in a multi-medication pak with a seven-day supply. Review of Resident #1's October 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Benztropine 2mg twice daily. -There was documentation that Benztropine 2mg twice daily was administered at 8:00am and 8:00pm from 10/01/25 to 10/31/25. Review of Resident #1's November 2025 eMAR revealed: -There was an entry for Benztropine 2mg twice daily. -There was documentation that Benztropine 2mg twice daily was administered at 8:00am from 11/01/25 to 11/1325 and at 8:00pm from 11/01/25 through 11/12/25. -There was documentation that Benztropine 2mg had been discontinued at 8:00pm from 11/13/25 to 11/30/25 and at 8:00am from 11/14/25 to 11/30/25. -There was an entry for Benztropine 1mg twice daily. -There were dashes documented at 8:00am from 11/14/25 to 11/17/25 and at 8:00pm from 11/14/25 to 11/16/25.	D 358		

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D 358	Continued From page 29 -There was documentation that Benztropine 1mg was administered at 8:00pm from 11/17/25 to 11/20/25 and at 8:00am from 11/18/25 to 11/20/25. Review of Resident #1's December 2025 eMAR revealed: -There was an entry for Benztropine 0.5mg twice daily. -There was documentation that Benztropine 0.5mg was administered at 8:00pm from 12/18/25 to 12/31/25 and at 8:00am from 12/19/25 to 12/31/25. Review of Resident #1's January 2026 eMAR revealed: -There was an entry for Benztropine 0.5mg twice daily. -There was documentation that Benztropine 0.5mg was administered at 8:00am from 01/01/26 to 01/06/26 and at 8:00pm from 01/01/26 to 01/05/26. Telephone interview with the facility's contracted pharmacist on 11/09/26 at 10:55am revealed: -Benztropine 2mg twice daily was dispensed for a 7 day supply on 10/31/25 and 11/7/25. -There was an order to discontinue Benztropine 2mg dated 11/13/25. -There was an order to start Benztropine 1mg twice daily for 7 days then decrease Benztropine to 0.5mg twice daily for 7 days and then discontinue the medication. -The pharmacy dispensed Benztropine 1mg 14 tablets on 11/13/25. -The pharmacy dispensed Benztropine 0.5 mg 14 (1/2) tablets on 11/13/25. -There was a new order for Benztropine 0.5mg twice daily on 12/17/25, 12 (1/2) tablets for a 6-day supply and then the cycle would begin.	D 358		

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-The pharmacy entered the orders into the eMAR system and the facility had to accept the order once it was entered or decline the order.
-Benztropine suddenly stopped could increase stiffness, decrease movement, cause nausea and vomiting, headache, sleep disturbances and irritability.
-Benztropine was used to treat Parkinson's disease and extrapyramidal disease.

Interview with a medication aide (MA) on 01/07/26 at 2:47pm revealed:
-The medication cycle for this week started on 01/06/26.
-Dashes on the eMAR meant that the medication was not administered.
-The RCC was the only staff that could enter new orders and verify orders in the eMAR system.

Interview with a second MA on 01/07/26 at 5:45pm revealed:
-She did not know what a dash meant on the eMAR.
-She did not know why Resident #1 missed 7 doses (3.5 days) of Benztropine 1mg in November 2025.

Interview with the RCC on 01/07/26 at 3:34pm revealed:
-The MPH let her know about Resident #1's Benztropine taper order when she was at the facility on 11/13/25 and she faxed the order to pharmacy.
-The pharmacy entered orders into the eMAR.
-She did not identify that the Benztropine order was not profiled on the eMAR.
-She performed cart audits once a week by matching the eMAR to the medications, removed expired medications, ensured medications that needed an open date were dated, removed

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discontinued medications, and removed medications if a resident was no longer at the facility.
-MAs performed medication cart audits twice a week on night shift.
-MAs reported if there were any issues found on the medication cart.
-Dashes on the eMAR meant that the medication was not administered.
-She was responsible for ensuring the staff administered medications as ordered.

Interview with the Administrator on 01/09/26 at 12:07pm revealed:
-She did not know that Resident #1 had missed any doses of his Benztropine.
-The RCC was responsible for ensuring that the staff administered residents medications as ordered.
-She did not know what a dash meant on the eMAR.
-She did not know the process for approving medications in eMAR.

Attempted telephone interview with the MHP on 01/09/26 at 9:15am was unsuccessful.

Attempted telephone interview with Resident #1's primary care provider (PCP) on 01/09/26 at 9:15am was unsuccessful.

Based on observations, record reviews and interviews, it was determined that Resident #1 was not interviewable.

2. Review of Resident #3's current FL2 dated 10/27/25 revealed:
-Diagnoses included type 2 diabetes, dementia, hypertension dysphagia, major depressive disorder, cognitive communication deficit, and

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gastro-esophageal reflux disease.
-There was an order for multivitamin, 1 tablet daily (used for immune support).

Review of Resident #3's Resident Register revealed an admission date of 10/20/25.

Review of Resident #3's primary care provider (PCP) progress note dated 11/21/25 revealed there was an order to discontinue the use of multivitamin.

Review of Resident #3's PCP progress note dated 12/22/25 revealed there was an order to discontinue the use of multivitamin.

Observation of Resident #3's medications on hand on 01/07/26 at 3:04pm revealed there was no multivitamin on the medication cart.

Review of Resident #3's November 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for multivitamin, 1 tablet daily.
-There was documentation that multivitamin, 1 tablet daily was administered at 8:00am from 11/22/25 to 11/30/25.

Review of Resident #3's December 2025 eMAR revealed:
-There was an entry for multivitamin, 1 tablet daily.
-There was documentation that multivitamin, 1 tablet daily was administered at 8:00am from 12/01/25 to 12/22/25.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 01/08/26 at 3:55pm revealed:

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D 358	Continued From page 33 -There was a discontinue order for Resident #3's multivitamin, 1 tablet daily on 11/21/25, but the facility did not fax over the discontinue order until 12/22/25 at 1:29pm. -The multivitamin was removed from the cycle fill starting 12/27/25. Interview with a medication aide (MA) on 01/07/26 at 4:00pm revealed: -Resident #3's multivitamin was showing on the electronic medication administration record (eMAR) as an active order duirng November 2025 and December 2025. -She continued to administer Resident #3's multivitamin because she did not know the multivitamin was discontinued. -The Resident Care Coordinator (RCC) was responsible for notifying the MAs that the medication had been discontinued. Interview with the RCC on 01/07/26 at 6.:00pm revealed: -She was unaware that the MAs administered the discontinued multivitamin to Resident #3. -She verified new medications orders and discontinued medications orders daily. -The PCP's progress notes came to her by email daily and she would print them out to see if she needed to follow up on any orders. -She was responsible for reviewing all medication orders for clarification. -She was responsible for making the MAs aware of any medication changes. Interview with the Administrator on 01/08/26 at 1:30pm revealed: -The RCC was responsible for medication order clarification. -The RCC was with the PCP when making rounds at the facility to communicate about	D 358		

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D 358	Continued From page 34 residents' medication orders. -The RCC does not receive the progress notes for a few weeks, but the RCC should reach out to the PCP to clarify medications. -The RCC was responsible for following up with the pharmacy on a discontinued order to ensure the medication was not on the eMAR. Attempted telephone interview with Resident #3's PCP on 01/08/26 at 3:30pm was unsuccessful. Attempted telephone interview with Resident #3's family member on 01/08/26 at 4:09pm was unsuccessful. Based on observations, record reviews and interviews, it was determined that Resident #3 was not interviewable.	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 omission, including refusals; and,	D 367		

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D 367	Continued From page 35 (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medication administration records were accurate for 1 of 3 sampled residents (#2) including a medication used to treat anxiety. The findings are: Review of Resident #2's current FL2 dated 04/14/25 revealed: -Diagnoses included dementia, post-traumatic stress disorder, and gastroesophageal reflux disease. -Three was an order for lorazepam 0.5mg, 1 tablet to be administered three times daily (used to treat anxiety). Review of Resident #2's physician orders dated 11/18/25 revealed: -Lorazepam 0.5mg, 1 tablet to be administered three times daily was discontinued and the reason was duplicate order. -There was a new order starting 11/18/25 for lorazepam 0.5mg, 1 tablet three times daily to be administered three times daily for agitation, take with Risperdal (Risperdal is a medication used to treat mental health disorders), hold if sedated or asleep. Review of Resident #2's Resident Register	D 367		

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D 367	Continued From page 36 revealed an admission date of 02/18/25. Review of Resident #2's November 2025 electronic medication administration record (eMAR) revealed: -There was an entry for lorazepam 0.5mg, take 1 tablet three times daily (8:00am, 2:00pm, and 8:00pm). -There was documentation lorazepam 0.5mg was administered at 8:00am from 11/21/25 to 11/30/25. -There was documentation lorazepam was administered at 2:00pm from 11/21/25 to 11/30/25. -There was documentation lorazepam was administered at 8:00pm from 11/20/25 to 11/30/25. -There was no documentation from 11/01/25 to 11/20/25 at 8:00am and 2:00pm, and from 11/01/25 to 11/19/25 at 8:00pm to indicate lorazepam had been administered, the blocks for documentation of administration were shaded in black, and there were no exception notes for those dates. -There was a second entry for lorazepam 0.5mg, take 1 tablet three times daily (8:00am, 2:00pm, and 8:00pm). -There was documentation lorazepam 0.5mg was administered at 8:00am on 11/19/25 and 11/20/25. -There was documentation lorazepam was administered at 2:00pm on 11/19/25 and 11/20/25. -There was documentation lorazepam was administered at 8:00pm on 11/18/25 and 11/19/25. -There was no documentation from 11/01/25 to 11/18/25 at 8:00am and 2:00pm, and from 11/01/25 to 11/17/25 at 8:00pm to indicate lorazepam had been administered, the blocks for	D 367		

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D 367	Continued From page 37 documentation of administration were shaded in black, and there were no exception notes for those dates. -There was documentation from 11/21/25 to11/30/25 lorazepam was discontinued at 8:00am, 2:00pm, and 8:00pm. -There was a third entry for lorazepam 0.5mg, take 1 tablet three times daily (8:00am, 2:00pm, and 8:00pm). -There was documentation lorazepam 0.5mg was administered at 8:00am on 11/01/25 and 11/18/25. -There was documentation lorazepam was administered at 2:00pm on 11/01/25 and 11/18/25. -There was documentation lorazepam was administered at 8:00pm on 11/01/25 and 11/17/25. -There was documentation on 11/18/25 lorazepam was discontinued at 8:00pm. Telephone interview with a pharmacist at the facility's contracted pharmacy on 01/08/26 at 3:32pm revealed: -Resident #2 had medications filled by their pharmacy. -He had not seen a duplicate order of the medication Lorazepam on Resident #2's medication order in their systems. -He knew the facility had issues with medication duplicates on the eMAR, but it was an issue with the computer system in the facility. Interview with the medication aide (MA) on 01/07 at 4:00pm revealed: -She did not remember receiving an order to discontinue lorazepam. -The RCC informed the MAs verbally or by text when a medication was discontinued for a resident.	D 367		

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-The lorazepam was showing up as a duplicate in the eMAR system, and she reported it to the RCC and was waiting on verification from the RCC that she was able to delete the duplicates.
-Some MAs were clicking on one lorazepam entry while another MA was clicking on the duplicate.
-Third shift was responsible for cart audits every Wednesday and their task was to make sure the physician orders matched the medication in the cart.

Interview with the Resident Care Coordinator (RCC) on 01/07/25 at 6:00pm revealed:
-If the MA saw a duplicate order on the eMAR, they were to report that to her.
-She had manually removed Resident #2's duplicate medication order from the eMAR, but the pharmacy added it back to the eMAR.
-She was responsible to notify the MAs of any mediation changes.
-The primary care provider (PCP) progress notes with electronic signed medication orders came to her through email and she reviewed them daily.

Interview with the Administrator on 01/08/25 at 1:15pm revealed:
-She was not aware that Resident #2 had duplicate medication on the eMAR.
-She had no explanation for why the eMAR was shaded black on 11/01/25 through the 11/20/25 on the eMAR.
-The MAs were to report anything on the eMAR out of the ordinary to the RCC.
-The RCC was responsible to follow up with pharmacy about discontinued orders and to ensure duplicate medication orders were not on the eMAR.

Attempted telephone interview with Resident #2's primary care provider (PCP) on 01/08/26 at

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D 367	Continued From page 39 3:30pm was unsuccessful. Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable.	D 367		
D 400	10A NCAC 13F .1009 (a)(1) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (a) An adult care home shall obtain the services of a licensed pharmacist or a prescribing practitioner for the provision of pharmaceutical care at least quarterly. The Department may require more frequent visits if it documents during monitoring visits or other investigations that there are medication problems in which the safety of residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes the following: (1) an on-site medication review for each resident which includes the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and (C) documenting the results of the medication	D 400		

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D 400	Continued From page 40 review in the resident's record. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure the quarterly pharmaceutical reviews were completed for 2 of 3 sampled residents (#1, #2). The findings are: 1. Review of Resident #1's current FL-2 dated 09/03/25 revealed diagnoses included Parkinson's bipolar, epilepsy, arteriovenous malformation, encephalopathy, prostatic hyperplasia, and bradycardia. Review of Resident #1's Resident Register revealed an admission date of 08/05/25. Review of Resident #1's record revealed there were no quarterly pharmaceutical reviews. Refer to interview with the Resident Care Coordinator (RCC) on 01/07/26 at 11:55am. Refer to telephone interview with the Administrator on 01/09/26 12:07pm. 2. Review of Resident #2's current FL2 dated 04/14/25 revealed diagnoses included dementia, post-traumatic stress disorder, and gastroesophageal reflux disease.	D 400		

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	HAL040009	A. BUILDING: _____ B. WING _____	01/09/2026

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D 400	Continued From page 41 Review of Resident #2's Resident Register revealed an admission date of 02/18/25. Review of Resident #2's record revealed there were no quarterly pharmaceutical reviews. Refer to interview with the Resident Care Coordinator (RCC) on 01/07/26 at 11:55am. Refer to telephone interview with the Administrator on 01/09/26 12:07pm. _____ Interview with the Resident Care Coordinator (RCC) on 01/07/26 at 11:55am revealed she did not have any of the pharmaceutical reviews for Resident #1 and Resident #2. Telephone interview with the Administrator on 01/09/26 at 12:07pm revealed: -The RCC was responsible for ensuring the pharmacy completed the residents' pharmaceutical reviews quarterly. -She did not know that Resident #1 and Resident #2 did not have any pharmaceutical reviews available in their records. -The RCC was responsible for ensuring the residents' pharmaceutical reviews were available for review.	D 400		
D 433	10A NCAC 13F .1201(a) Resident Records 10A NCAC 13F .1201Resident Records (a) The following shall be maintained on each resident in an orderly manner in the resident's record in the adult care home and made available for review by representatives of the Division of Health Service Regulation and county	D 433		

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 433	Continued From page 42 departments of social services: (1) FL-2 or MR-2 forms and the patient transfer form or hospital discharge summary, when applicable; (2) Resident Register; (3) receipt for the following as required in Rule .0704 of this Subchapter: (A) contract for services, accommodations and rates; (B) house rules as specified in Rule .0704(a)(2) of this Subchapter; (C) Declaration of Residents' Rights (G.S. 131D-21); (D) the home's grievance procedures; and (E) civil rights statement; (4) resident assessment and care plan; (5) contacts with the resident's physician, physician service or other licensed health professional as required in Rule .0902 of this Subchapter; (6) orders or written treatments or procedures from a physician or other licensed health professional and their implementation; (7) documentation of immunizations against influenza virus and pneumococcal disease according to G.S. 131D-9 or the reason the resident did not receive the immunizations based on this law; and (8) the Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form if the resident is being or has been discharged. When a resident leaves the facility for a medical evaluation, records necessary for that medical evaluation such as Subparagraphs (1), (4), (5), (6) and (7) above may be sent with the resident. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to maintain records that were readily	D 433		

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D 433	Continued From page 43	D 433		

available for review for 3 of 3 sampled residents (Resident #1, # 2, #3).

The findings are:

Review of the facility's license dated 01/01/26 revealed:
-The facility was licensed for a capacity of 40.
-The facility was licensed as a special care unit for Alzheimer's and dementia residents.

Review of the facility's census report on 01/06/26 revealed there were 22 residents living in the facility.

Records for Resident #1, Resident #2, and Resident #3 were requested on 01/06/26 at 9:10am, 1:00pm, 2:50pm, and 3:26pm.

Interview with the Administrator on 01/06/26 at 1:00pm revealed she would have the documents in approximately one hour.

Interview with the Administrator on 01/06/26 at 2:30pm revealed she gathered some of the initial documents requested and the RCC was gathering the remaining items.

Interview with the Administrator on 01/06/26 at 2:50pm revealed she had called the Regional Vice President of Operations (RVPO) to request help obtaining the requested documents and she was assisting another facility.

Telephone interview with the RVPO on 01/06/26 at 3:32pm revealed:
-The Administrator had sent her text messages a couple of times today 01/06/26 that she and the RCC were unable to print documents from the facility's computer system.

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D 433	Continued From page 44	D 433		

-She had provided the Administrator with a contact and number for the new computer system.
-She would have the Administrator to send over the requested documents and the Clinical Nurse Consultant (CNC) could print the documents to the facility's printer.
-She would have the CNC come to the facility tomorrow, 01/07/26 to help facilitate printing the requested documents.

Review of resident record documents provided on 01/06/26 at 4:00pm revealed:
-The facility provided SCU profiles and the Resident Register for Resident #3.
-There were no documents provided for Resident #1 or Resident #2.

Interview with the Resident Care Coordinator (RCC) on 01/06/26 at 4:16pm revealed:
-She had started to look for Resident #2's documents.
-She had not received the electronic medication administration records (eMARs) for Resident #1, Resident #2, and Resident #3.
-She was unable to locate any additional records for Resident #1.

Interview with the Administrator on 01/06/26 at 5:06pm revealed she would have all of the requested resident documents by 8:00am on 01/07/26.

Records for Resident #1, Resident #2, and Resident #3 were requested on 01/07/26 at 8:00am.

Interview with the RCC on 01/07/26 at 11:55am revealed:
-She did not have any of the pharmacy reviews

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D 433	Continued From page 45 for Resident #1 and Resident #2. -She had called the pharmacy to request the pharmacy reviews and had to leave a message and no one had called her back. Interview with the RCC on 01/07/26 at 6:30pm revealed: -She was responsible for ensuring that the pharmacy reviews were in resident records. -She was responsible for ensuring the Licensed Health Professional Support (LHPS) evaluations were in the resident records. -She was responsible for all the documentation in the resident records. Attempted telephone interview with the facility's primary care provider (PCP) on 01/09/26 at 9:15am was unsuccessful.	D 433		