| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| HEATH HOUSE | 919 WILMA SIGMON ROAD LINCOLNTON, NC 28092 |

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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted an annual survey, follow-up survey and complaint investigation from January 13, 2026 through January 15, 2026.<br><br>The compliant investigation was initiated by the Lincoln County Department of Social Services on November 5, 2025. | D 000 | | |
| D 125 | 10A NCAC 13F .0403(a) Qualifications Of Medication Staff<br><br>10A NCAC 13F .0403 Qualifications Of Medication Staff<br>(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.<br><br>This Rule is not met as evidenced by:<br>Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff B) had completed all required training including the 5, 10, or 15-hour Medication Aide (MA) training and MA Clinical Skills Competency Validation prior to administering medications to residents.<br><br>The findings are:<br><br>Review of Staff B's personnel record on 01/14/25 revealed:<br>-Staff B was hired as a personal care aide (PCA) | D 125 | | |

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| D 125 | Continued From page 1 | D 125 | | |

on 12/01/21.
-There was no documentation that Staff B completed the MA Clinical Skills Competency Validation.
-There was no documentation that Staff B completed the MA 5, 10, or 15-hour training course.

Telephone interview with Staff B on 01/14/26 at 9:45am and on 01/15/26 at 2:35pm revealed:
-Staff B trained for a MA position about eight months ago.
-Staff B did not complete the MA training because she did not like all the paperwork involved.
-Staff B believes she completed online MA training but could not recall when.
-Staff B shadowed a MA on third shift and the Resident Care Coordinator (RCC) who also observed her administering medications to residents.
-Staff B did not have any documentation of when she shadowed other staff.

Interview with the MA Supervisor on 01/15/26 at 10:00am revealed:
-Staff B trained for a MA position about six to eight months ago but did not finish.
-She did not train Staff B and did not know if Staff B administered medications.
-MAs who were in training and shadowing another MA were to complete the required 15-hour MA training course of MA training.

Interview with the RCC on 01/13/26 at 3:11pm revealed:
-Staff B had trained to become a MA but never took the MA test.
-Staff B had shadowed another MA several months ago but did not wish to pursue a MA position.

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| D 125 | Continued From page 2<br><br>Interview with the RCC on 01/15/25 at 2:46pm revealed:<br>-Any staff training for a MA position must complete the facility MA training and MA Clinical Skills Competency Validation prior to administering medications.<br>-Staff B did not shadow her.<br>-She does not know if Staff B shadowed another MA.<br>-To her knowledge, Staff B did not administer any medications.<br><br>Interview with the Licensed Health Professional Support (LHPS) Registered Nurse (RN) on 01/15/26 at 2:03pm revealed she had no documentation for Staff B completing MA Clinical Skill Competency Validation.<br><br>Interview with the Administrator on 01/15/26 at 3:51pm revealed:<br>-He did not know Staff B had trained or shadowed other MAs for a MA position.<br>-Potential MAs were to complete the online MA training prior to shadowing another MA and prior to administrating medications to residents. | D 125 | | |
| D 273 | 10A NCAC 13F .0902(b) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.<br><br>This Rule is not met as evidenced by:<br>Based on interviews, record reviews and observations, the facility failed to ensure referral and follow-up to meet the healthcare needs for 2 | D 273 | | |

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| D 273 | Continued From page 3 | D 273 | | |

of 5 sampled residents (#2 and #3) related to not obtaining medications used to treat pain (#1) and a medication used to lower cholesterol and triglycerides (#3).

The findings are:

1.Review of Resident #1's current FL2 dated 11/25/25 revealed diagnoses included diabetes mellitus type 2, chronic kidney disease stage 4, hypertension (high blood pressure), vascular dementia, and history of stroke.

Review of Resident #1's record revealed there was a signed physician's order dated 12/09/25 for diclofenac (used to relieve mild-to-moderate pain) 1% topical gel every eight hours as needed for knee pain.

Review of Resident #1's December 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for diclofenac gel 1% apply topically every 8 hours as needed to bilateral (both) knees for pain.
-There was no documentation diclofenac gel 1% had been administered for knee pain.

Review of Resident #1's January 2026 eMAR revealed:
-There was an entry for diclofenac gel 1% apply topically every 8 hours as needed to bilateral knees for pain.
-There was no documentation diclofenac gel 1% had been administered for knee pain on 01/01/26- 01/14/26.

Observation of Resident #1's medications on hand on 01/14/26 revealed there was no diclofenac 1% gel available for administration.

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| D 273 | Continued From page 4<br><br>Telephone interview with the facility's contracted pharmacist on 01/15/26 at 11:40am revealed:<br>-The pharmacy had received the order for diclofenac gel 1% on 12/09/25 but had not received a request to fill the medication.<br>-She was not sure why the medication had not been filled but believed it was possible that price was an issue and that the medication required prior authorization from Resident #1's insurance company before being filled.<br>-If Resident #1 did not receive diclofenac gel 1% as needed, he could have continued knee pain.<br><br>Interview with Resident #1 on 01/15/26 at 3:15pm revealed:<br>-His knees "hurt sometimes, and sometimes all the time."<br>-He had not had or asked for any medication for his knee pain and was not aware there was a prescription for topical pain medication.<br><br>Interview with a Medication Aide (MA) on 01/15/26 at 12:45pm revealed:<br>-She was not aware Resident #1's diclofenac gel 1% was not on the medication cart.<br>-She did not recall Resident #1 ever requesting medication for knee pain.<br>-She did not know how often medication cart audits were completed.<br><br>Interview with the Resident Care Coordinator (RCC) on 01/14/26 at 3:45pm revealed:<br>-She was responsible for approving and declining medication orders.<br>-She was responsible for completing medication cart audits but had not done medication cart audits since November 2025 when she started temporarily working on third shift.<br>-She was not aware that Resident #1's diclofenac | D 273 | | |

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| D 273 | Continued From page 5<br>gel 1% was not on the medication cart.<br><br>Telephone interview with Resident #1's Primary Care Practitioner (PCP) on 01/14/26 at 11:46am revealed:<br>-She was not aware that Resident #1's prescription for diclofenac gel 1% had not been filled.<br>-It was not unusual that prescriptions that needed insurance prior authorization "took some time to get approved."<br><br>Interview with the Administrator on 01/15/26 at 3:51pm revealed:<br>-He did not know that Resident #1 had not received the diclofenac gel.<br>-The RCC was responsible for ensuring medication orders were completed and accurate.<br>-He expected the MAs to notify the RCC and contact the pharmacy if medications were not available on the medication cart for administration.<br>2. Review of Resident #3's current FL2 dated 10/25/25 revealed diagnoses included osteoarthritis, unspecified injury of head, and hypertension.<br><br>Review of Resident #3's hospital discharge summary dated 01/05/26 revealed:<br>-Resident #3's admission diagnosis was altered mental status (AMS).<br>-Under section titled hospital course, there was documentation Resident #3's AMS was attributed to her underlying Alzheimer's dementia with remote consideration of cerebrovascular accident.<br>-Under section titled discharge medications, there was an order for atorvastatin (used to lower cholesterol and triglycerides)10mg by mouth at bedtime. | D 273 | | |

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| D 273 | Continued From page 6<br><br>Review of Resident #3's January 2026 eMAR revealed:<br>-There was an entry for atorvastatin 10mg by mouth at bedtime starting on 01/06/26.<br>-Atorvastatin was documented as administered from 01/06/26 though 01/12/26.<br><br>Observation of Resident #3's medications on hand on 01/14/26 revealed there was no atorvastatin available for administration.<br><br>Telephone interview with a Pharmacist at Resident #3's pharmacy of choice on 01/14/26 at 2:14pm and on 01/15/26 at 9:30am revealed:<br>-The pharmacy did not receive an order for atorvastatin 10mg by mouth at bedtime until 01/14/26.<br>-Resident #3 could experience increased risk of cardiovascular events from atorvastatin being delayed.<br><br>Telephone interview with the facilities contracted Pharmacist on 01/15/26 at 9:24am revealed:<br>-Resident #3 did not get her medications filled at this pharmacy.<br>-The pharmacy received an order for Resident #3's atorvastatin 10mg by mouth at bedtime on 01/05/26 and added the medication to the facility eMAR system.<br>-The pharmacy was responsible for placing and/or removing all medication orders onto the facility's eMAR system.<br>-Once the pharmacy completed any medications orders, staff at the facility had to approve or decline the order.<br>-The facility staff did approve Resident #3's atorvastatin to be added to the eMAR system on 01/06/26. | D 273 | | |

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| D 273 | Continued From page 7<br><br>Interview with the RCC on 01/14/25 at 3:45pm revealed:<br>-She was responsible for approving and/or declining medication orders.<br>-She did not review Resident #3's hospital discharge summary upon residents return to the facility.<br>-She thought the pharmacy had received all medication orders from the hospital.<br>-She did not know Resident #3 did not have atorvastatin available for administrator until today (01/14/26).<br>-She documented administering Resident #3's atorvastatin, "by accident" on 01/10/26 and 01/11/26.<br><br>Interview with the Administrator on 001/15/26 at 3:51pm revealed:<br>-He did not know Resident #3 had not received her ordered atorvastatin.<br>-The RCC was responsible for ensuring medication orders were completed and accurate.<br>-He expected all MAs to accurately document administration of medications.<br>-He expected the MAs to notify the RCC and contact the pharmacy if medications were not available on the medication cart for administration.<br><br>Attempted telephone interview with a third shift MA on 01/15/26 at 11:52am was unsuccessful.<br><br>Attempted telephone interview with Resident #3's PCP on 01/14/25 at 4:18pm was unsuccessful. | D 273 | | |
| D 280 | 10A NCAC 13F .0903(c) Licensed Health Professional Support<br><br>10A NCAC 13F .0903 Licensed Health | D 280 | | |

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| D 280 | Continued From page 8<br><br>Professional Support<br>(c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following:<br>(1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule;<br>(2) evaluating the resident's progress to care being provided;<br>(3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and<br>(4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 5 sampled residents (#3 & #5) had quarterly licensed health professional services (LHPS) assessments for tasks listed for ambulation using assistive devices that requires physical assistance, transferring semi-ambulatory or non-ambulatory residents (#3 & #5), inhalation medication by machine and oxygen administration and monitoring (#5).<br><br>The findings are:<br><br>1. Review of Resident #3's current FL2 dated | D 280 | | |

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| D 280 | Continued From page 9<br>10/25/25 revealed diagnoses included osteoarthritis, unspecified injury of head, and hypertension.<br><br>Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 01/14/22.<br><br>Review of Resident #3's LHPS dated 09/19/25 revealed tasks listed for ambulation using assistive devices that required physical assistance and transferring semi-ambulatory or non-ambulatory residents.<br><br>Review of Resident #3's record revealed there was no quarterly LHPS completed for December 2025.<br><br>Review of Resident #3's care plan dated 09/25/25 revealed she required limited staff assistance for eating, toileting, ambulation, bathing, dressing, grooming and transfers.<br><br>Refer to the telephone interview with the facility's prior contracted LHPS nurse on 01/15/26 at 2:03pm.<br><br>Refer to the interview with the Administrator on 01/15/25 at 3:51pm.<br><br>2. Review of Resident #5's current FL2 dated 07/31/25 revealed diagnoses included chronic obstructive pulmonary disease and hyperlipidemia.<br><br>Review of Resident #5's Resident Register revealed the resident was admitted to the facility on 03/17/23.<br><br>Review of Resident #5's LHPS dated 09/25/25 | D 280 | | |

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revealed tasks listed for ambulation using assistive devices that required physical assistance, transferring semi-ambulatory or non-ambulatory residents, inhalation medication by machine and oxygen administration and monitoring.

Review of Resident #5's record revealed there was no quarterly LHPS completed for December 2025.

Review of Resident #5's care plan dated 02/26/25 revealed:
-She required staff supervision or set-up with toileting and limited staff assistance with eating, bathing and dressing. -She was independent with ambulation, grooming/personal hygiene and transferring.

Attempted telephone interview on 01/15/26 at 12:05pm with the current LHPS nurse was unsuccessful.

Refer to the telephone interview with the facility's prior contracted LHPS nurse on 01/15/26 at 2:03pm.

Refer to the interview with the Administrator on 01/15/25 at 3:51pm.

_____
Telephone interview with the facility's prior contracted LHPS nurse on 01/15/26 at 2:03pm revealed:
-She completed the quarterly LHPS for residents at the facility through September or October 2025.
-She was no longer contracted to complete LHPS for the facility after October 2025.

Interview with the Administrator on 01/15/25 at

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| D 280 | Continued From page 11<br><br>3:51pm revealed:<br>-The facility's contracted LHPS nurse was responsible for completing the quarterly LHPS assessment for residents.<br>-Quarterly LHPS assessments for December 2025 were overdue due to the previous LHPS nurse leaving.<br>-The new LHPS nurse started three to four weeks ago but had not yet came to the facility to complete any LHPS assessments.<br>-He expected LHPS assessments to be completed quarterly and timely by the LHPS nurse. | D 280 | | |
| D 367 | 10A NCAC 13F .1004 (j) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(j) The resident's medication administration record (MAR) shall be accurate and include the following:<br>(1) resident's name;<br>(2) name of the medication or treatment order;<br>(3) strength and dosage or quantity of medication administered;<br>(4) instructions for administering the medication or treatment;<br>(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;<br>(6) date and time of administration;<br>(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,<br>(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). | D 367 | | |

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This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure the electronic medication administration record (eMAR) was accurate for 1 of 5 residents (#3) related to inaccurate documentation of a medication used to lower cholesterol and triglycerides.

The findings are:

Review of Resident #3's current FL2 dated 10/25/25 revealed diagnoses included osteoarthritis, unspecified injury of head, and hypertension.

Review of Resident #3's hospital discharge summary dated 01/05/26 revealed:
-Resident #3's admission diagnosis was altered mental status (AMS).
-Under section titled hospital course, there was documentation Resident #3's AMS was attributed to her underlying Alzheimer's dementia with remote consideration of cerebrovascular accident.
-Under section titled discharge medications, there was an order for atorvastatin (used to lower cholesterol and triglycerides)10mg by mouth at bedtime.

Review of Resident #3's January 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for atorvastatin 10mg by mouth at bedtime starting on 01/06/26.
-Atorvastatin was documented as administered from 01/06/26 though 01/12/26.

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HEATH HOUSE | 919 WILMA SIGMON ROAD LINCOLNTON, NC 28092 |

| (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 13<br><br>Observation of Resident #3's medications on hand on 01/14/26 at 12:12pm revealed there was no atorvastatin available for administration.<br><br>Telephone interview with a Pharmacist at Resident #3's pharmacy of choice on 01/14/26 at 2:14pm and on 01/15/26 at 9:30am revealed the pharmacy did not receive an order for atorvastatin 10mg by mouth at bedtime.<br><br>Telephone interview with the facilities contracted Pharmacist on 01/15/26 at 9:24am revealed:<br>-The pharmacy was responsible for placing and/or removing all medication orders onto the facility's eMAR system.<br>-Once the pharmacy completed any medications orders, the facility had to approve or decline the order.<br>-The pharmacy received an order for Resident #3's atorvastatin 10mg by mouth at bedtime and added the medication to the facility eMAR system.<br>-The facility did approve Resident #3's atorvastatin to be added to the eMAR system.<br><br>Interview with the Resident Care Coordinator (RCC) on 01/14/25 at 3:45pm revealed:<br>-She was responsible for approving and/or declining medication orders.<br>-She did not clarify Resident #3's hospital discharge summary upon residents return to the facility.<br>-She thought the pharmacy had received all medication orders from the hospital.<br>-She documented administering Resident #3's atorvastatin, "by accident" on 01/10/26 and 01/11/26.<br><br>Interview with the Administrator on 001/15/26 at | D 367 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL055013 | A. BUILDING: _____ B. WING _____ | R 01/15/2026 |

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|---|---|---|---|---|
| D 367 | Continued From page 14<br><br>3:51pm revealed:<br>-He did not know Medication Aides (MAs) had documented administering Resident #3's atorvastatin on the eMAR when the medication was not in the building to administer.<br>-The RCC was responsible for ensuring medication orders were completed and accurate.<br>-He expected all MAs to accurately document administration of medications.<br>-He expected the MAs to notify the RCC and contact the pharmacy if medications were not available on the medication cart for administration.<br><br>Attempted telephone interview with a third shift MA on 01/15/26 at 11:52am was unsuccessful. | D 367 | | |