

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL017054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 02/09/2026
NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379		
(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 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation from 02/04/26 to 02/06/26 and 02/09/26 with a telephone exit on 02/09/26.	D 000		
D 076	10A NCAC 13F .0306 (a)(3) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (3) have furniture that is clean, safe, and functional; 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 ensure the furniture in the facility was safe and functional as evidenced by a door that had broken off the hinges of a wardrobe in a resident room in the special care unit (SCU). The findings are: Observation of resident room #313 in the SCU on 02/04/26 at 9:25am revealed: -There was a wardrobe with double doors and two drawers in the resident room that served as a closet. -The left door had broken away from the hinges. -The first drawer under the doors was open and the left door was catty corner in the drawer.	D 076		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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D 076	Continued From page 1 -The bottom right corner of the door was resting inside the open drawer, and the top right corner was behind the closed door on the right side. -The right door on the wardrobe could not be opened because the left door would fall over. Based on observations and interviews it was determined the resident who resided in room #313 was not interviewable. Interview with the Maintenance Director on 02/06/26 at 8:15am revealed: -The facility purchased new wardrobes a few months ago. -He did a residents' room inspection in the SCU about a week ago. -He made a list of things that needed to be repaired when he did the inspections. -He prioritized items on the list and got to them as quickly as he could. -He looked at the doors on the wardrobe as part of the inspection. -He saw the door on the wardrobe in resident room #313 last week when he did his inspection. -He wanted to repair the door, but he had some emergency repairs that needed to be done elsewhere in the facility, and he had not had the chance. -He would have to use wood glue and repair the wood around the hinges for the broken wardrobe door. Interview with the Special Care Unit Coordinator (SCC) on 02/06/26 at 11:55am revealed: -She walked around the rooms and the SCU every day and checked to make sure everything was okay and nothing was leaking or broken. -If she found anything that needed repairing, she would notify the Maintenance Director. -She saw the wardrobe door in resident room	D 076		

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D 076	Continued From page 2 #313 about one or two days ago. -She had not had a chance to report it to the Maintenance Director yet. Interview with the Administrator on 02/06/26 at 1:45pm revealed: -The wardrobe door in resident room #313 was repaired. -She was not aware it was broken again. -The Maintenance Director would repair the broken door as soon as he was aware of it. -If he knew the repair was a safety issue or concern he would repair the door right then and there.	D 076		
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 ensure the facility was free from hazards including cracked and jagged shower floors in the	D 079		

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D 079	Continued From page 3 Special Care Unit (SCU) and a broken paper towel dispenser and a broken soap dispenser in a resident bathroom in the SCU. The findings are: 1. Observation of resident room #304 in the SCU on 02/04/26 at 9:11am revealed: -There were two patched areas on the floor of the shower in the bathroom. -Both patches were eight inches wide and had a rough finish and were not sanded smooth. -The patch on the left had three cracks that started from the center of the patch and went to the edge. -The patch on the right had a two-inch and a one inch circular depression within the patch. Based on observations and interviews it was determined the resident who resided in resident room #304 was not interviewable. Observation of resident room #605 on the AL on 02/05/26 at 9:00am revealed the -The shower floor was made of fiberglass material. -There was a large crack that had smaller cracks branching off. -The area at the largest crack had separated, exposing a jagged edge. -The damage was approximately a ten-inch by twelve-inch area. Interview with the resident who resided in resident room #605 at 9:00am revealed: -The shower had been broken since he moved into the room; he did not recall how long he had been in the room. -The Maintenance Director knew about the broken shower.	D 079			

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D 079	Continued From page 4 -He used the shower 2-3 weeks ago. -He made sure he did not step on the area that was broken. Interview with the Maintenance Director on 02/06/26 at 8:15am revealed: -The facility had the broken floors in the shower hours repaired in November 2025 by an outside company. -He thought all the floors in the showers and the residents' rooms had been repaired at that time. -The fiberglass had cracked in some of the showers and the outside company patched and sanded them when they did the repairs. -He inspected the showers for cracks and damage about every other week. -When there was a crack in the shower or a split, he contacted the repair company right away before the damage had a chance to get too bad. -He was not aware of the damage to the shower floor in resident room #605 in the AL or in resident room #304 in the SCU. Interview with the Administrator on 02/06/26 at 1:45pm revealed: -She did not do inspections of the showers. -The Maintenance Director was responsible for doing inspections daily of the showers looking for damage. -The Maintenance Director had been addressing repairs on a daily basis, and he was keeping her informed. -He gave her a daily list of things that he had repaired. -He had been dealing with some emergency repairs in the facility over the past week. -She was not aware that there were two showers that were damaged and needed repairs. 2. Observation of resident room #305 in the SCU	D 079		

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D 079	Continued From page 5 on 02/04/26 at 9:16am revealed: -There was a missing paper towel dispenser in the bathroom; the bracket was mounted on the wall, but the dispenser was missing. -The bracket for the paper towel dispenser had sharp edges that were exposed. -There was a missing soap dispenser in the bathroom; the bracket was mounted on the wall, but the dispenser was missing. -The bracket for the soap dispenser had a broken corner and had sharp edges that were exposed. Interview with the Maintenance Director on 02/06/26 at 8:15am revealed: -He did a residents' room inspections in the SCU about a week ago. -He made a list of things that needed to be repaired when he did the inspections. -He prioritized items on the list and got to them as quickly as he could. -He was aware the soap and paper towel dispensers were missing in the bathroom of resident room #305. -He had extra dispensers for both the soap and the paper towels. -He wanted to replace the missing dispensers, but he had some emergency repairs that needed to be done elsewhere in the facility, and he had not had the chance. Interview with the Special Care Unit Coordinator (SCC) on 02/06/26 at 11:55am revealed: -She saw the missing paper towel dispenser and broken soap dispenser in resident room #305 almost a week ago. -The Maintenance Director knew about the soap and paper towel dispenser because he checked the residence rooms every day. -The Maintenance Director Usually fixed things like the dispensers the same day but he must be	D 079		

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D 079	Continued From page 6 waiting on some parts because it had not been replaced yet. Interview with the Administrator on 02/06/26 at 1:45pm revealed: -She was not aware the dispensers were broken in resident room #305. -The resident who resided in room #305 had removed the dispensers before; it was part of his behaviors. -The Maintenance Director would replace the soap and paper towel dispensers in resident room #305 every time the resident removed them. -Over the last week the Maintenance Director had been dealing with other repairs in the facility that took priority over the dispensers. Based on observations and interviews it was determined the resident who resided in room #305 was not interviewable.	D 079			
D 105	10A NCAC 13F .0311 (a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: FOLLOW UP TO TYPE B VIOLATION.	D 105			

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D 105	Continued From page 7 Based on these findings, the previous Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to ensure the smoke detectors were maintained in a safe and operating condition, as evidenced by a beeping smoke detector. The findings are: Observation of resident room #506 on the Assisted Living on 02/04/26 at 9:22am revealed: -There was a battery-operated smoke detector in the room. -The smoke detector was beeping, indicating the battery needed to be changed. Confidential interview with a staff member revealed the smoke detector in resident room #506 had been beeping for a month. Observation of the 500-hallway on 02/05/26 between 8:45am-1:00pm revealed the Maintenance Director and other staff were standing in the hallway near resident room #506. Interview with the Maintenance Director on 02/06/26 at 9:25am revealed: -He was not aware that the smoke detector in resident room #506 was beeping and needed to have the battery changed. -He checked the smoke detectors in the facility at least every two weeks to make sure they were not beeping. -No one had told him the smoke detector was beeping. Observation of the hallway on 02/06/25 at 9:30am	D 105		

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D 105	Continued From page 8 revealed there was a medication aide (MA) in the hallway with her medication cart; the beeping from the smoke alarm could be heard while standing at the medication cart. Interview with the MA on 02/06/26 at 9:30am revealed: -She was not aware that the smoke detector in resident room #506 was beeping. -She did not hear the smoke detector beeping. Interview with a personal care aide (PCA) on 02/06/26 at 9:38am revealed: -She had not heard the smoke detector in resident room #506 beeping. -If she heard a smoke detector beeping, she would tell the MA, who would let someone in management know. Interview with the Administrator on 02/06/26 at 10:43am revealed: -The Maintenance Director was responsible for changing the batteries in the smoke detectors. -She expected staff to let the Maintenance Director know when they heard a smoke detector beeping so the battery could be changed. -She was concerned no one had notified the Maintenance Director, so the battery could have been changed sooner. Attempted interview with the resident who resided in resident room #506 on 02/04/26 at 9:22am and 12:35pm, and on 02/06/26 at 9:28am was unsuccessful.	D 105		
D 226	10A NCAC 13F .0702 (d) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents	D 226		

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D 226	Continued From page 9 (d) The notices of discharge and appeal rights as required in Paragraph (c) of this Rule shall be made by the facility administrator or their designee, at least 30 days before the resident is discharged except that notices may be made as soon as practicable when: (1) the discharge is necessary to protect the welfare of the resident and the facility cannot meet the needs of the resident under Subparagraph (b)(1) of this Rule; or (2) reasons under Subparagraphs (b)(3) and (b)(4) of this Rule exist. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the requirements for a notice of discharge and appeal rights were met by providing a discharge notice to 1 of 1 sampled residents (#4) who was discharged for the safety of the residents in the facility. The findings are: Review of Resident #4's FL-2 dated 08/11/25 revealed: -Diagnosis included dementia, Wernicke's encephalopathy, history of cerebrovascular accident, hypertension, type two diabetes, and chronic heart failure. -He resided in the Special Care Unit (SCU). -Resident #4 was intermittently disoriented and his recommended level of care was documented as "memory care".	D 226			

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D 226	Continued From page 10 Review of Resident #4's Resident Register revealed: -He was admitted to the facility on 08/01/25. -He had a Power of Attorney (POA). -The POA signed the admission section on 08/01/25. -Under the discharge section the notice of discharge was documented as 10/16/25. -The discharge was initiated by the Business Office Manager (BOM). -The reason for discharge was documented as, "the resident was an immediate harm to self, other residents and staff". -The discharge was dated 10/16/25. -Resident #4 was documented as discharged to the local county sheriff's office. -The BOM signed the Resident Register discharge on 10/16/25. -The POA nor Resident #4 had signed the discharge section. Review of Resident #4's care plan dated 09/30/25 revealed: -Resident #4 was verbally and physically abusive. -He was sometimes disoriented. Review of Resident #4's mental health provider's (MHP) after visit note dated 10/06/25 revealed: -It was an initial visit. -Resident #4 had behavioral issues, and aggressive outbursts including hitting staff with a shoe. -The severity of the behaviors and incidents were significant enough to warrant psychiatric intervention. Review of Resident #4's progress notes for October 2025 revealed: -On 10/12/25 at 10:22am, Resident #4 was arguing with staff, other residents, and was trying	D 226		

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D 226	Continued From page 11 to hit residents. -On 10/12/25 at 7:45pm, he was throwing chairs and turning tables over in the SCU. -On 10/16/25 at 2:03pm, he was throwing chairs, pushing tables across the room, and using foul language. -On 10/16/25 at 2:44pm, after Resident #4 became combative and after several uncontrolled behaviors the Administrator and the Resident Care Coordinator (RCC) decided to immediately discharge Resident #4. -The Primary Care Provider (PCP), and the MHP were notified of the immediate discharge. -At 4:54pm, the Resident Care Coordinator (RCC) notified Resident #4's POA of the immediate discharge. -The POA asked what she needed to do and she was told the resident would be involuntarily committed (IVC) and the social worker from another facility should be reaching out to her. Review of Resident #4's incident report dated 10/16/25 revealed: -The incident occurred at 12:30pm in the SCU dining room. -Resident #4 was combative with the staff. -He walked into the dining room and became combative, pushing tables, cursing and throwing chairs. -He was transported to the local emergency department (ED) at 7:30pm by the local sheriff's department. -Resident #4's PCP and his POA were notified via telephone. Review of Resident #4's record on 02/04/26 revealed: -There was a signed petition for an IVC for Resident #4 dated 10/16/25. -There was a facility admissions contract that	D 226		

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D 226	Continued From page 12 included a notice of transfer/discharge form and a hearing request form. -The only information on the notice of discharge form was Resident #4's name, the facility's address and the Administrator's name and telephone number; there was no other information on the form. -The hearing request form was blank. -The facility admissions contract was signed by Resident #4's POA on 08/01/25. -There were no completed notice of transfer/discharge or hearing request forms for Resident #4. -There was a sales receipt from the postal service for two certified first class letters dated 10/16/25. -There were two certified mail signature cards with signatures, the two addresses matched the two addresses on the postal services sales receipt. -Neither card was addressed to Resident #4's POA nor had her signature. -There was a postal tracking slip and tracking number for a single letter; the tracking number matched the tracking number on one of the two signature cards and a tracking number on the sales receipt. -There were no other postal sale receipts, tracking slips, or certified mail delivery signature cards in the record. Telephone interview with a social worker from the local hospital on 02/04/26 at 3:45pm revealed: -Resident #4 arrived at the hospital through the ED for dementia, mood swings, and aggressive behaviors. -Resident #4 was not admitted to the hospital but stayed in the ED until 11/13/25 because he did not require in-patient care. -On 10/23/25, the facility's Administrator told the	D 226		

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D 226	Continued From page 13 hospital social worker that Resident #4 had been discharged from the facility on 10/16/25 and could not be readmitted to the facility. -On 10/31/25, Resident #4's POA called the hospital social worker and told them she could not find placement for Resident #4. -The social worker made the POA aware Resident #4 could not stay in the hospital ED, so she took Resident #4 home with her on 11/13/25. Telephone interview with Resident #4's POA on 02/04/26 at 6:45pm revealed: -She was contacted by someone she thought was the Administrator at the facility to tell her Resident #4 was being sent to the hospital to be evaluated for behaviors. -She did not recall the date of the telephone call. -She was not told Resident #4 was being discharged from the facility during the telephone call. -A day or two after Resident #4 was sent to the ED, a social worker from the hospital called her and told her Resident #4 was being discharged from the hospital. -The social worker from the hospital told her the facility staff said they could not take Resident #4 back from the hospital. -She called the facility and was told by someone from the facility that Resident #4 could not return to the facility because they were afraid he would hurt someone there. -She attempted to find placement for Resident #4 at another facility but was unsuccessful. -After a few weeks had passed, she picked Resident #4 up from the hospital and brought him home with her. -She had not been asked by any staff at the facility to sign anything related to Resident #4's discharge from the facility. -She never received a 30 day written notification	D 226		

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NAME OF PROVIDER OR SUPPLIER CASWELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379		
(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 226	Continued From page 14 from the facility when Resident #4 was being discharged. -She did not receive a notice of transfer/discharge for Resident #4 from the facility or a hearing request form for an appeal to the discharge. Telephone interview with Resident #4's PCP on 02/05/26 at 4:10pm revealed: -Resident #4 a history of disruptive behaviors. -She was aware of Resident #4's disruptive behaviors because the facility would call her when he was having behaviors. -She could not recall the date, but the facility staff contacted her about Resident #4's behaviors and she recommended an IVC. -She could not recall if she was involved in the discharge of Resident #4 or if she completed a new FL-2 or care plan for him after he was IVC. Interview with the Special Care Unit Coordinator (SCC) on 02/05/26 at 10:40am revealed: -She did not recall what happened with Resident #4 on 10/16/25. -She did recall he had been having some behaviors. -He would yell, try to fight with other residents and she thought he hit a staff member. -The decision to discharge a resident went through the PCP first; the PCP made the decision to discharge a resident. -The facility would have the PCP update the resident's FL-2 so the next facility could review it when they did an assessment. -She did not know anything about discharge paperwork or forms; she thought the BOM completed discharge information. Interview with the BOM on 02/05/26 at 11:10am revealed: -When a resident had behaviors that put them at	D 226		

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D 226	Continued From page 15 risk to hurt themselves, another resident or staff, the facility could do an IVC for the resident. -The Administrator would get the necessary paperwork for an IVC, and the local sheriff would pick the resident up and take them to the hospital. -When the facility did an IVC for a resident, the resident could be discharged from the facility at that time or they could return from the hospital, it was up to the Administrator. -The RCC, the SCC or the Administrator would then notify the resident's family or POA by telephone that the resident was discharged from the facility. -Once the resident was at the hospital, the resident became the hospital's responsibility; the facility's responsibility was done at that point. -"Once the hospital had the resident, then it was out of the facility's hands." -The hospital or the family would find placement for the resident in another facility when the hospital discharged the resident. -The hospital tried to send Resident #4 back to the facility after he had been there for a couple of days. -She did not know anything else about Resident #4's discharge. -She did not send any information from the facility to the POA. Interview with the RCC on 02/05/26 at 11:00am revealed: -If the facility initiated the discharge of a resident they would speak to the family and the POA first. -The facility would then send a certified letter to the resident's POA. -The BOM and the Administrator completed the discharge paperwork. -If there was an emergency situation with a resident and they had to be sent out to the	D 226		

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D 226	Continued From page 16 hospital for unsafe behaviors, the discharge paperwork would be sent with them to the hospital. -If the resident could sign for themselves, they would sign the discharge papers from the contract. -She had not completed any discharge papers or hearing papers for appeals for Resident #4's discharge; she thought the BOM or the Administrator had completed them. Interview with the Administrator on 02/05/26 at 11:30am revealed: -The residents or their POA signed a contract with the facility at admission, and the contract had information about discharging residents for behaviors. -When a resident was sent to the hospital for an IVC the facility would call the POA. -The POA would be contacted by telephone and asked to come into the facility for a care plan meeting; the purpose of the care plan meeting would be to explain the reason for the IVC. -At the care plan meeting the POA would be told verbally and face to face or over the telephone that the resident was not allowed to return to the facility and was discharged. -Once a resident had an IVC due to behaviors they were considered discharged from the facility. -She was not sure of the timeline for a discharge notification, she thought it was thirty days; she would have to look at the contract. -The BOM or the Administrator would complete information on the Resident Register if the facility initiated the discharge. -Any resident who had an IVC would get discharge papers per the contract. -If the POA could not come to the facility to get the paperwork then the papers would be sent by certified mail so the receipt could be tracked.	D 226		

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D 226	Continued From page 17 -The decision to IVC Resident #4 was made after he pushed a table and then picked up a chair and threw it during a lunch meal; the chair narrowly missed another resident. -She contacted Resident #4's PCP and the suggestion from the PCP was to IVC Resident #4 because his behaviors had escalated and he was a danger to other residents. -Resident #4's POA was contacted by telephone after the local sheriff agreed to the IVC and the resident was picked up. -She and the RCC explained the incident with Resident #4 to the POA and discussed the reason for the IVC. -There was no discussion of discharging Resident #4 at that point. -When the hospital contacted her a few days later about Resident #4's return to the facility she informed them that he could not return to the facility after an IVC. -She sent Resident #4's POA the discharge part of the contract, and his IVC information by mail but did not request a delivery signature; she had a tracking number and information for the documents she sent to the POA. -She also sent the county Department of Social Services (DSS) where Resident #4 was from and the county Ombudsman for the area a copy of Resident #4's IVC documentation, the incident report and the contract with the discharge papers. -The information sent to the county Ombudsman and the county DSS were sent by certified mail and had delivery receipt signature cards. Interview with the Administrator on 02/06/26 at 2:20pm revealed: -She did not complete a notice of discharge for Resident #4, she thought the BOM completed one. -She was not aware she was responsible for	D 226		

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D 226	Continued From page 18 completing a portion of the hearing request form. -She did not send the completed notice for transfer/discharge, or the hearing request forms to Resident #4's POA.	D 226			
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: FOLLOW UP TO TYPE B VIOLATION. Based on these findings, the previous Type B Violation was abated. Non-compliance continues. Based on record reviews and interviews, the facility failed to ensure health care referral and follow-up for 1 of 5 sampled residents (#1) related to notifying the primary care provider (PCP) of fingerstick blood sugar (FSBS) values outside the ordered parameters. The findings are: Review of Resident #1's current FL2 dated 07/08/25 revealed diagnoses included diabetes mellitus type 2. Review of Resident #1's physician's order dated 11/11/25 revealed an order to check FSBS every morning before giving insulin and to notify the PCP if the value was less than 100 or greater than 400. Review of Resident #1's December 2025	D 273			

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D 273	Continued From page 19 electronic medication administration record (eMAR) revealed: -There was an entry to check FSBS at 7:30am and to notify the PCP if the value was less than 100 or greater than 400. -Resident #1's FSBS was documented as less than 100 on 9 out of 31 opportunities. -There was no documentation the PCP was notified for FSBS less than 100 on 6 of the 9 opportunities. Review of Resident #1's January 2026 eMAR revealed: -There was an entry to check FSBS at 7:30am and notify the PCP if the value was less than 100 or greater than 400. -Resident #1's FSBS was documented as less than 100 on 16 of 31 opportunities. -There was no documentation the PCP was notified for FSBS less than 100 on 13 of the 16 opportunities. Review of Resident #3's February 2026 eMAR from 02/01/26 through 02/04/26 revealed: -There was an entry to check FSBS at 7:30am and notify the PCP if the value was less than 100 or greater than 400. -Resident #1's FSBS was documented as less than 100 on 3 of 3 opportunities. -There was no documentation the PCP was notified for FSBS less than 100 on 3 of the 3 opportunities. Review of Resident #1's progress notes for December 2025 through February 2026 revealed there was no other documentation the PCP was notified when Resident #1's FSBS value was less than 100 or greater than 400. Interview with Resident #1 on 02/05/26 at 3:48pm	D 273			

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D 273	Continued From page 20 revealed she sometimes felt dizzy in the mornings when her blood sugar was low. Interview with a medication aide (MA) on 02/06/26 at 11:57am revealed: -Resident #1 had orders to notify the PCP when her FSBS value was less than 100 or greater than 400. -She had the number to call or text message Resident #1's PCP when the FSBS value was outside the ordered parameters. -She knew that she should document notifications to the PCP in the eMAR or in the progress notes. -She thought she notified Resident #1's PCP of the FSBS of 90 on 01/29/26 at 7:30am and of the FSBS value of 97 on 02/03/26 at 7:30am. -Resident #1 did not complain of dizziness to her. Interview with a second MA on 02/06/26 at 2:27pm revealed: -She knew Resident #1 had orders to notify the PCP when her FSBS value was less than 100 or greater than 400. -She had the number to call or text message Resident #1's PCP when the FSBS value was outside the ordered parameters. -She could not remember if she notified the PCP when Resident #1's FSBS value was outside of the ordered parameters. Telephone interview with Resident #1's PCP on 02/06/26 at 10:48am revealed: -Resident #1 had an order to check FSBS in the morning and notify the PCP of FSBS values less than 100 or greater than 400. -The PCP's office always documented a note when the facility called. -She would ask the facility for Resident #1's FSBS readings during her weekly visits. -She expected the facility to call and notify her	D 273		

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D 273	Continued From page 21 when Resident #1's FSBS values were outside the ordered parameters and not wait until she made a visit so that other orders could be given such as giving juice and rechecking the FSBS if the FSBS was low. Interview with the Resident Care Coordinator (RCC) on 02/06/26 at 4:20pm revealed: -The MAs were responsible for notifying Resident #1's PCP when her FSBS values was less than 100 or greater than 400. -She was not aware the MAs did not notify Resident #1's PCP regarding some of Resident #1's FSBS values that were less than 100. -The MAs were supposed to document the notifications to Resident #1's PCP on the eMAR or in the progress notes. -She did not audit the eMAR to ensure the PCP was being notified when the FSBS values were less than 100 or greater than 400. -The MAs would usually tell her when Resident #1's FSBS values were below 100 and she would verbally tell them to make sure to notify the PCP and document in a progress note. -She expected the MAs to notify Resident #1's PCP every time the FSBS was below 100 or above 400 and to document the notification. Interview with the Administrator on 02/06/26 at 12:21pm. -Resident #1 had an order to notify the PCP when her FSBS values were below 100 or higher than 400. -The MAs should notify the PCP, document on the eMAR or progress notes that the PCP was notified, and then list any new orders given. -She expected the MAs to follow the parameters as ordered and document the PCP notification.	D 273			

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D 276	Continued From page 22	D 276		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: FOLLOW UP TO TYPE B VIOLATION. Based on these findings, the previous Type B Violation was abated. Noncompliance continues. Based on observations, interviews, and record reviews, the facility failed to ensure physicians' orders were implemented for 1 of 5 sampled residents (#1) related to an order to provide snacks before meals and at bedtime. The findings are: Review of Resident #1's current FL-2 dated 07/08/25 revealed diagnoses included type 2 diabetes mellitus (DM2), seizures, and hypertension. Review of Resident #1's physician's order dated 12/15/25 revealed an order to provide a snack before meals due to low fingerstick blood sugar (FSBS) readings in the morning. Review of Resident #1's primary care provider's	D 276		

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D 276	Continued From page 23 (PCP) after visit summary dated 12/16/25 revealed she documented that she instructed facility staff to write a verbal order for Resident #1 to have a snack before bedtime to reduce the risk of low FSBS in the mornings. Review of Resident #1's physician order dated 01/06/26 revealed an order with a start date of 11/11/25 to check FSBS every morning before giving insulin and call the PCP if FSBS was greater than 400 or less than 100. Review of Resident #1's physician's order dated 01/23/26 revealed an order for a bedtime snack between 8pm and 9pm daily. Review of Resident #1's December 2025 electronic medication administration record (eMAR) revealed: -There was no entry to provide snacks before meals or at bedtime. -Resident #1's FSBS ranged from 61 to 92 with examples as follows: -On 12/13/25 at 8:00am, the FSBS was documented as 61. -On 12/28/25 at 8:00am, the FSBS was documented as 68. Review of Resident #1's January 2026 eMAR revealed: -There was no entry to provide snacks before meals or at bedtime. -Resident #1's FSBS ranged from 52 to 144 with examples as follows: -On 01/27/26 at 8:00am, the FSBS was documented as 52. -On 01/28/26 at 8:00am, the FSBS was documented as 73. Review of Resident #1's February 2025 eMAR	D 276			

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D 276	Continued From page 24 from 02/01/26 through 02/05/26 revealed: -There was no entry to provide snacks before meals or at bedtime. -Resident #1's FSBS ranged from 79 to 100. Interview with Resident #1 on 02/05/26 at 3:48pm revealed: -She sometimes received snacks before meals and at bedtime. -She had to ask for snacks if she wanted one. -She would not always remember to ask for snacks. -She sometimes felt dizzy in the mornings and knew that her blood sugar was low. Interview with a medication aide (MA) on 02/05/26 at 2:55pm revealed: -She was not aware of an order to provide Resident #1 a snack before meals and at bedtime. -She was aware that Resident #1 had low blood sugar levels in the mornings. -It was the Resident Care Coordinator's (RCC) responsibility to review all orders. -She was not sure if the RCC or the pharmacy entered new orders onto the eMAR. Interview with another MA on 02/06/26 at 11:57am revealed: -She recalled the PCP mentioning giving Resident #1 snacks. -She was aware that Resident #1 had low blood sugar levels in the mornings. -The RCC was responsible for reviewing new orders and then sending them to the pharmacy to enter onto the eMAR. Interview with Resident #1's PCP on 02/06/26 at 10:48am revealed: -Resident #1 had low blood sugar readings in the	D 276		

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D 276	Continued From page 25 mornings. -She ordered snacks to be provided before meals and at bedtime to help level out Resident #1's blood sugar. -She was not aware the facility did not provide snacks before meals or at bedtime. -She verbally asked a MA and the RCC for the snack order to be entered on the eMAR so the staff would remember to give the snack and so she could see if the bedtime snack helped keep the resident's FSBS from dropping overnight. -She was concerned that without the snacks Resident #1's FSBS would continue to run low. -If Resident #1's FSBS became too low, she could have dizziness, increasing her risk for a fall. -She expected the staff to implement orders when she wrote them. Interview with the Kitchen Manager on 02/06/26 at 9:50am revealed: -None of the residents had an order from their physician for an evening snack. -She never had any residents with an order for a snack in the evening. Interview with the RCC on 02/06/26 at 12:45pm revealed: -All physician's orders were reviewed by her. -All new orders were faxed to the pharmacy to be placed onto the eMAR. -They had a new order tracking system but did not always use it. -She did not remember reviewing the snack order for Resident #1. Interview with the Administrator on 02/06/26 at 2:45pm revealed: -The RCC was responsible for reviewing the PCP's orders. -The new orders would be faxed to the pharmacy.	D 276			

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D 276	Continued From page 26 -She was aware of Resident #1's order to provide a snack at bedtime, but did not confirm that snacks were being provided. -She was not aware of the order for a snack before meals. -She was concerned that not implementing the new order was the cause for Resident #1's blood sugar continuing to be low. -She expected orders to be implemented as ordered.	D 276		
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages shall be offered in accordance with each residents' prescribed diet or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to offer or make available three snacks per day to residents in the assisted living (AL) unit. The findings are: Review of the facility's cycle week-at-glance menu for the current week revealed that snacks	D 298		

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D 298	Continued From page 27 were not listed on the menu. Review of the facility's resident census for 02/04/26 revealed 32 residents resided in the AL. Interview with a resident on 02/04/26 at 8:48am revealed: -Sometimes she was given snacks, but not three times a day. -Snacks were not offered every day. Interview with a second resident on 02/04/26 at 8:55am revealed: -He was not offered snacks. -He did not recall the last time he had a snack. -He got hungry between meals. Interview with a third resident on 02/04/26 at 9:00am revealed: -He was given a snack the day before yesterday. -He was never offered a snack three times a day. -He ate his own snacks when he had them. -He got hungry between meals. Interview with a fourth resident on 02/04/26 at 9:17am revealed: -He was offered snacks "every once in a while". -He was given a snack "the other day". -He was sometimes given a snack three times a day, but not often. Interview with a fifth resident on 02/04/26 at 9:33am revealed: -He was offered a snack "night before last". -He was never offered a snack in the morning or after lunch. -Sometimes at night, he was offered a snack. -He got hungry and would like to have snacks. Interview with a sixth resident on 02/04/26 at	D 298			

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D 298	Continued From page 28 9:45am revealed: -She was not offered a snack every day. -She was not offered a snack very often. -She got hungry between meals. -She would like to have snacks more often. Interview with two other residents on 02/04/26 at 9:48am revealed they were offered snacks once a day, "every once in a while". Observations of the AL on 02/05/26 from 9:45am to 11:33am and 1:42pm to 2:38pm to revealed that snacks were not offered in the AL. Interview with a ninth resident on 02/05/26 at 11:29am revealed: -He had not been offered a snack today, 02/05/26. -He had a snack last night, 02/04/26, but he had to go to the nurse's station to get it. Interview with a tenth resident on 02/05/26 at 3:48pm revealed -She was not offered a snack every day. -She often had to ask for a snack. -She did not always remember that she had to ask for a snack. -Sometimes snacks were not available when she asked for one. Interview with two other residents on 02/05/26 from 11:32am-11:34am revealed they had not been offered a snack last night or today, "so far". Telephone interview with the facility's contracted primary care provider (PCP) on 02/06/26 at 12:35pm revealed: -Snacks were beneficial to the residents when they were given three times a day. -Snacks were important for the elderly population	D 298		

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D 298	Continued From page 29 because if they did not eat their whole meal at mealtimes, they would eat a snack. -Without the snacks some of the residents would experience weight loss, less energy, decreased endurance, and their blood sugars would not be stable. Interview with a personal care aide (PCA) on 02/05/26 at 2:38pm revealed: -The PCAs were responsible for snacks. -Snacks were not offered this morning, 02/05/26, because the kitchen did not bring snacks to the office. -Yesterday, 02/04/26, she told residents they could go to the office and get a snack. -She also went to the residents' rooms and told them snacks were available. -She did not provide snacks for the residents yesterday morning 02/04/26, because the kitchen did not bring the snacks out until right before lunch was to be served. Interview with a second PCA on 02/06/26 at 10:30am revealed: -Snacks were served to the residents at 10:00am, 2:00pm and 7:00pm. -The snacks were passed to the residents. -The PCAs would take turns going down the hallway to pass snacks in the AL. -If there was only one PCA the PCA passed snacks on both hallways in the AL. -They did not skip passing snacks because the residents would ask for them. Interview with a dietary aide on 02/06/26 at 10:30am revealed: -Snacks were passed by the PCAs 3 times a day at 10:00am, 2:00pm and 7:00pm. -He set up the snack cart three times a day with snacks, a drink made from a mix, ice water, ice	D 298		

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D 298	Continued From page 30 and cups. -He made sure the cart was picked up by a PCA. -If a PCA did not come pick it up, he would deliver it to the nurses' station. -He left the snack cart in the nurses' station before he left at night so the PCAs had it for the evening snack time. -He could tell when the snacks had been passed to the residents because the cart would be empty. -He was not aware of any time snacks were not passed to the residents. Interview with the Kitchen Manager on 02/06/26 at 9:30am revealed: -Snacks were offered to the residents 3 times a day at 10:00am, 2:00pm and 7:00pm. -The kitchen staff set up the snacks on a cart and the PCAs came and got the cart. -When there were two PCAs working they pushed the cart down the hallways offering the snacks to the residents. -If there were not enough PCAs working, the dietary staff put the snack cart in the nurse's station and the residents would come ask for the snacks. -The dietary staff put a variety of snacks including cookies, chips, popcorn, and applesauce on the cart along with water and a fruit punch from a drink mix. -She would look at the snack cart twice a day after snacks were passed to see what was left; that was how she monitored if snacks were passed. -She also asked the residents at resident council if they got their snacks and they said "yes". -She did not think snacks had been missed being passed since October 2025. Interview with the Resident Care Coordinator (RCC) on 02/06/26 at 10:50am revealed:	D 298		

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D 298	Continued From page 31 The kitchen staff set up the snack cart and parked it in the nurses' station. -Snacks were offered to the residents 3 times a day at 10:00am, 2:00pm and 7:00pm. -The PCA was responsible for passing snacks to the residents. -There was not a certain PCA assigned to pass snacks; it was whoever was not doing resident care at that moment. -The PCAs passed snacks up and down the hall; some of the residents came to the nurses' station and some stayed in their rooms. -She and the Administrator had passed snacks to the residents when the PCAs were busy. -She would ask the residents if they got their snacks to make sure snacks had been passed. -She knew one day this week that snacks were not passed out. -One of the staff told her that the residents did not get snacks at 10:00am but it was too close to lunch when they realized it, so she told them not to pass snacks until the 2:00pm time. -That was the only time she was aware of residents not getting snacks in a long time. Interview with the Administrator on 02/06/26 at 1:45pm revealed: -The residents were given snacks three times a day every day at 10:00am, 2:00pm and 8:00pm. -The dietary department prepared the snack cart with cups, ice, beverages, water, and assorted snacks. -The dietary department took the snack cart to the nurse's station prior to snack times. -The PCAs passed the snacks three times a day. -There was no particular PCA assignment for passing snacks. -Whoever was not providing care could pass snacks; even she and the RCC could pass snacks.	D 298		

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D 298	Continued From page 32 -The PCAs were supposed to go to each and every resident's room and ask them if they wanted a snack. -When the PCA knocked on the door and the resident did not answer, they did not get a snack and the PCA went on to the next room. -If there were any leftover snacks the PCAs put the snack cart back in the nurse's station until the dietary staff picked up the snack cart to refill for the next snack time. -Residents could come down to the nurses' station and request snacks any time of the day -She was not sure who was responsible for making sure the snacks were done every day and passed. -She put her faith in the staff that it was done. -She had not had any complaints from residents in the AL about not getting snacks -She was not aware the 10:00 AM snacks had not been passed one day this week; she had passed the 2:00 PM snacks herself on Wednesday, 02/04/26.	D 298			
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure therapeutic diets were served as ordered for 1 of 2 sampled residents (#6), who had an order for a	D 310			

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D 310	Continued From page 33 mechanical soft (MS) diet. The findings are: Review of Resident #6's current FL-2 dated 11/11/25 revealed: -Diagnoses included hypertension, stroke with weakness, and right hemiplegia. -There was an order for a mechanical soft diet entire meal. Review of the diet list dated 01/16/26 revealed Resident #6 was listed as ordered a MS diet-entire meal. Review of the facility's regular menu for 02/04/26 and 02/05/26 revealed: -On 02/04/26, lunch included a bologna sandwich, vegetable macaroni soup, and pears. -On 02/05/26, lunch included shepherd's pie, peas and carrots, and a chocolate chip cookie. -On 02/05/26, dinner included crispy fried chicken, macaroni and cheese, stir fried broccoli, green salad, a dinner roll, and apple slices. Review of the facility's therapeutic diet menu for 02/04/26 revealed the MS diet meal for lunch included a minced and moistened cheese sandwich, minced and moistened tater tots, extremely thick tomato soup, and strawberry ice cream. Review of the facility's therapeutic diet menu for 02/05/26 revealed: -The MS diet meal for lunch included a minced and moistened hot ham and cheese sandwich, mashed potatoes and gravy, garden vegetable soup and vanilla ice cream. -The MS diet meal for dinner included soft and bite sized fried chicken, mashed macaroni and	D 310			

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D 310	Continued From page 34 cheese, mashable carrots, mashed collard greens, bite sized and moistened dinner roll. Observation of Resident #6's lunch meal service on 02/04/26 from 12:11PM-12:30pm revealed: -Resident #6 was served a bologna sandwich cut into 1 inch by 1.5 inch pieces, a bowl of pasta with cooked vegetables, and a bowl of diced canned pears. -Resident #6 took pieces of the bread and dipped the bread into a small container of mayonnaise. -Resident #6 ate less than 25% of his sandwich; he did not eat anything else he was served. Observation of Resident #6's lunch meal service on 02/05/26 at 12:11pm revealed: -Resident #6 was served a plate of a mixture of ground meat, creamed potatoes, green peas, and 5 large slices of carrots. -Resident #6 ate less than 25% of the plate that was served. -He did not eat any of the carrots served. Observation of Resident #6's dinner meal service on 02/05/26 from 6:06pm-6:32pm revealed: -Resident #6 was served fried chicken cut off the bone, brussels sprouts, macaroni and cheese, and 2 biscuits. -Resident #6 did not eat the fried chicken skin. -He ate 75% of the brussels sprouts and macaroni and cheese. -He did not eat the biscuits. Interview with Resident #6 on 02/06/26 at 8:55am revealed: -He thought he was served a MS diet because he did not have any teeth. -Sometimes his food was soft enough that he could chew with no problem. -Sometimes the pieces of food were too big so he	D 310		

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D 310	Continued From page 35 would just chew on it the best he could. -He would chew and chew on his food until it was gone. -The bread, dinner rolls, and biscuits were always dry and never moistened. Telephone interview with Resident #6 primary care provider (PCP) on 02/05/26 at 4:10pm revealed: -Resident #6 had an order for a MS diet with ground food because he had undergone chemotherapy treatments and his mouth was sore and he also did not have any teeth. -The MS diet was for the entire meal, meaning softer foods and ground meats. -She expected for the order to be followed for Resident #6's MS diet. Interview with a cook on 02/06/26 at 9:00am revealed: -She used the week at a glance menu to prepare meals. -She only used the therapeutic diet menus to look at portion sizes. -She did not reference the therapeutic diet menus for the MS diets. -She ground the meats for the MS diets. -She knew how to prepare food for the MS diets from a previous job. -She knew residents on a MS diet either did not have teeth to chew or had issues swallowing. -She gave all the residents on a MS diet the same vegetables as the regular diet menu. -She did not cut up or moisten the bread, dinner rolls, or biscuits for the residents on a MS diet. -If the therapeutic menu did not match the weekly menu she would let the Kitchen Manager know so it could be fixed. Interview with the Kitchen Manager on 02/06/26	D 310			

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D 310	Continued From page 36 at 9:30am revealed: -She trained the kitchen staff on how to prepare food for the MS diet. -The MS diet was just chopped meat. -The MS meals were not the whole meal. -The vegetables for a MS diet were the same vegetables as a regular diet except for some items like coleslaw. -The biscuits or bread on a MS diet were not cut up or moistened. -She told the cook to put the baloney on the sandwich and then the whole sandwich was cut up because she thought that was better; the chopped baloney would fall off the sandwich when the resident picked it up. -She printed the weekly and therapeutic menus every week; no one told her they did not match this week. Interview with the Resident Care Coordinator (RCC) on 02/06/26 at 10:50am revealed: -She monitored the dining room 3 times a week. -She would look at the different meals and look at the food on the plate. -She was not sure what should be on the plates for MS meal. -She did not look at the therapeutic diet menu to compare what was on the plate for a MS diet meal. -The Kitchen Manager and the Administrator were responsible for making sure the MS diet meals were served correctly. Interview with the Administrator on 02/06/26 at 1:45pm revealed: -She thought the MS diet was soft foods like mashed potatoes, macaroni and cheese and ground meats. -When food was cut into bite sized pieces it was not a MS diet but a chopped diet.	D 310		

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D 310	Continued From page 37 -The Kitchen Manager informed her about the regular menu and the therapeutic diet menus not matching that week. -She had not checked the plated food against the therapeutic diet menu. -The cook was responsible for following the therapeutic diet menu and serving the correct food per the diet menu. -The Kitchen Manager was responsible for ensuring the cook was following the therapeutic diet menu.	D 310		
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 B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 6 residents (#6) observed during the medication pass including errors with a medication to treat pain and a medication to treat low blood pressure; and for 2 of 3 residents (#3, #5) sampled for record review including errors with medication for	D 358		

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D 358	Continued From page 38 seizures (#3); and eye drops (#5). The findings are: Review of the facility's undated medication administration policy revealed: -The Executive Director, Resident Care Coordinator (RCC), or designee would ensure that medication administration services required for each resident were provided. -Medications may be given up to one hour before or up to one hour after the prescribed time unless the physician ordered an exact time. 1. The medication error rate was 7% as evidenced by the observation of 2 errors out of 28 opportunities during the morning medication pass on 02/05/26. Review of Resident #6's current FL-2 dated 11/11/25 revealed diagnoses included stroke with weakness, and hypertension. a. Review of Resident #6's signed physician order dated 01/06/26 revealed there was an order for morphine 15mg extended release (a medication used to treat pain) take 1 tablet twice daily. Observation of the morning medication pass on 02/05/26 from 9:24am to 9:44am revealed: -The medication aide (MA) removed a blister pack labeled morphine 15mg extended release from a second locked drawer in the medication cart. -The MA compared the morphine to the electronic medication record (eMAR). -She removed the morphine from the blister pack and placed it in a medication cup. -The MA administered morphine to Resident #6 at 9:40am.	D 358		

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D 358	Continued From page 39 Review of Resident #6's February 2026 eMAR on 02/05/26 revealed there was an entry for morphine 15mg extended release take 1 tablet twice daily scheduled at 8:00am and 8:00pm. Interview with Resident #6 on 02/05/26 at 10:40am revealed: -He took morphine to control pain associated with his lung cancer diagnosis. -He did not keep track of what time his medication was administered. -He did not currently complain of increased pain. Interview with the MA on 02/05/26 at 02:55pm revealed: -She knew Resident #6's medication had an administration time of 8:00am. -She knew that Resident #6's medication should be administered at least 1 hour before 8:00am or 1 hour after 8:00am. -She was behind administering medications due to answering the front door and assisting other residents. -She did not want to administer any medication during breakfast, so she decided to wait until Resident #6 was finished with breakfast. Telephone interview with a representative from the facility's contracted pharmacy on 02/06/26 at 09:29am revealed: -Resident #6 had a current order for morphine 15mg extended release take 1 tablet twice daily. -Morphine was used to treat pain. -Extended-release morphine should be administered 12 hours apart. -If morphine was administered late, it could cause a lower concentration in the blood stream. -If Resident #6 had a lower concentration of the medication, it could result in him experiencing	D 358		

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D 358	Continued From page 40 more pain. Telephone Interview with Resident #6's primary care provider (PCP) on 02/06/26 at 2:27pm revealed: -Morphine was used to treat pain associated with Resident #6's lung cancer diagnosis. -She was concerned that Resident #6 could have increased pain if the morphine was administered late. -She expected the MA to administer the medication on time. b. Review of Resident #6's signed physician order dated 01/06/26 revealed there was an order for midodrine 10mg (a medication used to treat low blood pressure) take 1 tablet three times daily with meals. Observation of the morning medication pass on 02/05/26 from 9:24am to 9:44am revealed: -The MA removed a blister pack containing midodrine 10mg. -The MA compared the blister pack to the eMAR. -She removed midodrine from the blister pack and placed it in a medication cup. -The MA administered midodrine to Resident #6 at 9:40am. Review of Resident #6's February 2026 eMAR on 02/05/26 revealed there was an entry for midodrine 10mg take 1 tablet three times daily with meals at 8:00am, 12:00pm, and 5:00pm. Telephone interview with a representative from the facility's contracted pharmacy on 02/06/26 at 09:29am revealed: -Resident #6 had a current order for midodrine 10mg take 1 tablet three times daily with meals. -Midodrine was used to treat low blood pressure.	D 358		

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D 358	Continued From page 41 -Midodrine was to be given with meals because of the blood flow going to the stomach to aid in digestion which could cause lower blood pressure. -Resident #6's blood pressure may become too low if midodrine was administered late. Interview with the MA on 02/05/26 at 02:55pm revealed: -She knew Resident #6's medication had an administration time of 8:00am. -She knew that Resident #6's medication should be administered at least 1 hour before 8:00am or 1 hour after 8:00am. -She was behind administering medications due to answering the front door and assisting other residents. -She did not want to administer any medication during breakfast, so she decided to wait until Resident #6 was finished with breakfast. Telephone interview with Resident #6's PCP on 02/06/26 at 2:27pm revealed: -Midodrine was prescribed to treat low blood pressure. -She was concerned that the Resident #6's blood pressure may be lower if midodrine was administered late. -If Resident #6's blood pressure became too low he may have dizziness, increasing his risk for a fall. -She expected the MA to administer the medication on time. _____ Interview with Resident #6 on 02/05/26 at 10:40am revealed: -He did not keep track of what time his medication was administered. -He did not currently complain of dizziness.	D 358			

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D 358	Continued From page 42 Interview with the RCC on 02/05/26 at 4:20pm revealed: -All medication should be administered within the 1 hour before and 1 hour after timeframe. -The medication administration times were split between 8:00am and 9:00am depending on which hall the resident resided on. -Resident #6 recently moved from the hall that had the 8:00am medication administration to a hall that had a 9:00am medication administration time. -Resident #6's medications were mistakenly not changed to 9:00am. -She was responsible for ensuring the medication administration times were changed. -She expected all medication to be administered on time. Interview with the Administrator on 02/05/26 at 5:00pm revealed she expected the medications to be administered on time. 2. Review of Resident #3's current FL2 dated 07/11/25 and 09/01/25 revealed: -Diagnoses senile dementia, hallucinations, and transient ischemic attack (TIA). -There was an order for levetiracetam (used to control seizures) 250mg twice a day. Review of Resident #3's Resident Register revealed: -She was admitted on 08/28/25. -She was discharged on 10/05/25. Review of Resident #3's primary care provider's (PCP) after-visit summary dated 08/20/25 revealed: -Resident #3 was being seen for a physical examination; the resident was moving into an assisted living facility (ALF) on 08/28/25.	D 358		

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D 358	Continued From page 43 -Resident #3 had a diagnosis of new-onset seizures. -Resident #3's current medication list included levetiracetam 250mg twice daily, started on 07/18/25, and was current. Review of Resident #3's progress notes revealed: -Resident #3 was admitted on 08/28/25. -Resident #3 had a fall on 08/28/25 at 3:40pm and was sent to the hospital. -Resident #3 returned on 08/29/25 with staples in her head. -Resident #3 had a fall on 09/06/25 and was transported to the emergency department (ED) by emergency medical services (EMS) at 9:35pm. Review of Resident #3's incident report dated 09/06/25 revealed: -Resident #3 was lying on the floor in the living room with a red substance on the floor. -EMS was called, and the resident was transported to the ED. Telephone interview with a personal care aide (PCA) on 02/05/26 at 3:49pm revealed: -Resident #3 had a seizure. -She heard a loud noise, like someone hollering, "oh", and when she looked, Resident #3 was on the floor, and her head and shoulders were shaking. -There was a second staff member in the room who saw the resident on the floor, too. Telephone interview on 02/05/26 at 3:58pm with the medication aide (MA) who completed the incident report on 09/06/25 revealed: -She did not recall anything about the incident. -She did not recall if she had administered medication to Resident #3 or not. -She could not recall "back that far".	D 358		

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D 358	Continued From page 44 Telephone interview with a second PCA on 02/05/26 at 4:02pm revealed: -She heard a loud "yell out," and when she looked, the resident was falling out of a straight back chair; it happened so fast. -Resident #3 appeared to be having a seizure; she had jerking going on like a seizure. -She immediately went and got the MA. Review of Resident #3's EMS report dated 09/06/25 revealed: -She fell from a chair in the living room area of the assisted living facility. -She hit her head on the floor and had a deep laceration on the left side of her forehead. -She was transported to the local ED. Review of Resident #3's ED visit summary dated 09/06/25-09/07/25 revealed: -Her medical history included hypertension, hyperlipidemia, dementia, seizures, and recurrent urinary tract infections (UTI). -At bedside, the resident was unable to provide history, possibly due to being somnolent, though arousable, but quickly went back to sleep. -Her history was obtained from the ED medical record. -Per report, the resident fell out of the chair and landed face-first onto the floor, and sustained a laceration on the right-side of her forehead. -Apparently, the resident was recently admitted to the facility about 2 weeks ago, and it was unknown to the staff that the resident had home medication, so she had not received any medication since she arrived at this facility. -She had a seizure disorder and was evidently not on any medication at this time; therefore, would be loaded with levetiracetam. -She had a 4-inch by 2-inch laceration that	D 358			

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D 358	Continued From page 45 required 5 sutures. -Computed Tomography (CT) results showed she had a trace traumatic subarachnoid hemorrhage (bleeding into the fluid-filled space surrounding the brain, most commonly caused by a head trauma from falls). Review of Resident #3's medication administration records (MAR) revealed there were no MARs available to be reviewed. Interview with a medication aide (MA) on 02/04/26 at 2:31pm revealed: -She did not recall being given Resident #3's medications she brought to the facility from home when she was admitted. -The medications would have been given to the Resident Care Coordinator (RCC) or Special Care Unit Coordinator (SCC) at admission. -Resident #3's medications were not profiled, meaning they were not on the MAR. -She could only administer medication that was on the MAR. -If Resident #3 had a paper MAR, she did not remember. Interview with the SCC on 02/04/26 at 2:47pm revealed: -When a resident was admitted to the facility, their medication list was faxed to the pharmacy by the MA or the RCC/SCC. -Medications brought from home would be matched to the medication list. -If there was a discrepancy in the medications on hand and the medication list, the RCC/SCC would be responsible for getting clarification on what the resident's current medications were. -She did not recall anything about Resident #3 and her medications because she had been out on medical leave and had just returned to work	D 358		

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D 358	Continued From page 46 when the resident had a fall and did not return to the facility. Interview with the Business Office Manager (BOM) on 02/04/26 at 2:56pm revealed she gave all of Resident #3's paperwork and medications brought from home to one of the care managers (RCC/SCC) on the day of admission. Telephone interviews with a pharmacist at the facility's contracted pharmacy on 02/04/26 at 3:06pm and 3:54pm revealed: -Resident #3's FL2 was received at the pharmacy on 08/28/25, but the provider's signature was not clear, and it was dated as what appeared to be 09/01/25 and 07/11/25. -There was a care note attached to the FL2, but it was not dated. -The care note had current medications listed, which included levetiracetam 250mg twice daily. -Resident #3's medication was not profiled, which meant a MAR was not created, because the pharmacy did not receive clarification on the FL2 dates. -FL2's had to be dated within 30 days to be considered orders. -The facility was called, and a fax was sent requesting clarification, but no response was received prior to the resident being discharged. -Levetiracetam was used to treat seizures. -It took about 44 hours for the medication levetiracetam to be fully eliminated from the body. -There were other factors that could affect the absorption, including age. -Seizure medications had a low threshold, so any missed doses increased the risk of seizures. Interview with the RCC on 02/05/26 at 9:37am revealed: -Generally, when medications were brought from	D 358			

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D 358	Continued From page 47 home, the medications would be matched to the FL2, and if there was any discrepancy, they would call the provider for clarification. -She did not recall if there was any discrepancy with Resident #3's medications brought in from home and her orders. -She recalled there being a problem with a MAR populating to administer the medications. -She could not recall if a paper MAR was used to administer Resident #3's medications. -They were not supposed to use paper MARs and had to wait until the medication was put into the system by the pharmacy. -She remembered talking to the pharmacy staff about Resident #3's medications, but she did not recall any details. -She thought Resident #3 had medications administered, but she could not be sure. -Resident #3 did not see the facility's PCP after her fall on 08/28/25 but was scheduled to see the PCP the next week, but went to the hospital before she was seen. Telephone interview with the facility's PCP on 02/05/26 at 2:16pm revealed: -When a new resident was admitted, and she was going to be the PCP, the facility usually faxed all the paperwork to her. -She had never seen Resident #3, and the resident was not in their system. -Resident #3 was not scheduled to be seen at any time. -If Resident #3 had a fall on 08/28/25, the resident should have been scheduled to be seen on her weekly visit, which would have been 09/02/25. -She would have expected Resident #3 to have been put on her list to be seen on 09/02/25. -If Resident #3 was not getting the levetiracetam as ordered, it would increase the resident's risk of	D 358		

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D 358	Continued From page 48 seizures. -Levetiracetam levels were not always therapeutic, but as long as some medication was in the system, it would have helped prevent a seizure. Interview with another MA on 02/05/26 at 5:18pm and 5:42pm revealed: -Resident #3's medication was not profiled, and they did not normally do a paper MAR. -She recalled Resident #3 having medications that were brought in from home. -Medications were usually verified by the pharmacy and profiled. -She did not recall getting called from the pharmacy for clarification. -She recalled doing an admission progress note. -She recalled there being an issue with Resident #3's medications being profiled. -She did not recall if she did or did not administer Resident #3 any medications. Interview with the Administrator on 02/05/26 at 5:28pm revealed: -She had not been able to locate any MARs for Resident #3. -From her understanding, Resident #3's medication was not profiled. -She did not know if it was the facility's mistake or the pharmacy's mistake. -The RCC/SCC were responsible for documenting all medications that came in with the resident and ensuring the medications matched the FL2. -As soon as a newly admitted resident needed medication, when it was scheduled, it should have been administered; a resident should not go without medication for 24 hours. -Her concern was the staff did not provide adequate care to Resident #3 related to her	D 358			

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D 358	Continued From page 49 medications, and the resident was without medication for at least 5 days. -The medications should have been clarified by the RCC/SCC or a MA. Telephone interview with Resident #3's family member on 02/09/26 at 9:46am revealed: -She was told by the BOM that Resident #3 could use her medications from home, so she brought them with her the day of admission. -She did not know Resident #3 was not getting her medications until she visited on 09/06/25. -She asked Resident #3 if she had her medications that morning, and she responded no. -Resident #3 remembered her medications when she lived at home and would, at times, remind the family member she needed her medications. -She asked a MA about the medications on the morning of 09/06/25, and the MA told her the resident had to be evaluated by the PCP before they could administer medications. -The MA told her she had given Resident #3 a little green pill, which was sertraline, but she did not see anything about the levetiracetam in the system. -She did not understand why she would get one medication and not another medication if they were waiting for her to be evaluated by the PCP. -It scared her that Resident #3 was not getting her medication. -The contract she signed for Resident #3 stated that after a fall, a resident would be seen within 3 days by the PCP, so she did not understand why Resident #3 was not seen after her fall on 08/28/25, and then her medications could have been given if she needed to be evaluated first. -When she was called by the MA on 09/06/25, the MA told her the "ladies" in the room said it looked like Resident #3 had a seizure. -When she asked if Resident #3 had taken her	D 358		

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D 358	Continued From page 50 medications, the MA said she had not administered her any medication. -She did not know who the ladies were, whether they were staff or other residents. -She received a call from the hospital on Sunday, 09/07/25, and asked about the medications Resident #3 was supposed to be taking. -Resident #3 had stitches, was bruised on her head, and had a black eye when she saw her after the fall. -Resident #3 did not return to the facility after her hospitalization. 3. Review of Resident #5's current FL2 dated 08/11/25 revealed diagnoses included hypertension and glaucoma. a. Review of Resident #5's physician's orders dated 08/11/25 revealed an order for prednisolone acetate drops (a steroid used to treat swelling in the eye), instill two drops in both eyes twice a day. Review of Resident #5's December 2025 electronic medication administration record (eMAR) revealed: -There was an entry for prednisolone acetate drops, instill two drops in both eyes twice a day with a scheduled administration time at 8:30am and 8:00pm. -Prednisolone acetate drops were documented as administered at 8:30am and 8:00pm from 12/01/25-12/31/25, with exceptions documented as refused on 12/20/25, 12/21/25, and 12/29/25 at 8:30am and on 12/29/25 and 12/31/25 at 8:00pm. Review of Resident #5's January 2025 eMAR revealed: -There was an entry for prednisolone acetate	D 358		

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D 358	Continued From page 51 drops, instill two drops in both eyes twice a day with a scheduled administration time at 8:30am and 8:00pm. -Prednisolone acetate drops were documented as administered at 8:30am and 8:00pm from 01/01/26-01/31/26 with exceptions documented as discontinued on 01/07/26 at 8:30am, and refused on 01/15/26 at 8:00pm and on 01/17/26, 01/30/26, and 01/31/26 at 8:30am. Review of Resident #5's February 2025 eMAR from 02/01/26-02/06/26 revealed: -There was an entry for prednisolone acetate drops, instill two drops in both eyes twice a day with a scheduled administration time at 8:30am and 8:00pm. -Prednisolone acetate drops were documented as administered at 8:30am and 8:00pm from 02/01/26-02/06/26, with exceptions documented as refused on 02/04/26 at 8:00pm and the resident would not wake up on 02/05/26 at 8:30am. Observation of Resident #5's medication on hand on 02/06/26 at 12:25pm revealed: -There was a bottle of prednisolone acetate dispensed on 01/07/26 with the direction to instill 2 drops in each eye twice daily. -There was documentation on the label that the medication was opened on 01/08/26. -The bottle was opaque, so the amount of solution could not be visualized, but the bottle felt full. Interview with the medication aide (MA) on 02/06/26 at 12:36pm revealed she thought the prednisolone eye drop bottle felt "almost full". Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/06/26 at	D 358		

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D 358	Continued From page 52 1:20pm revealed: -Resident #5's prednisolone acetate eye drops were dispensed on 10/07/25, 12/08/25, and 01/07/26. -The directions for each dispensing were to instill two drops in each eye twice daily. -Each bottle dispensed would last for 12.5 days based on that order. -Prednisolone acetate was a steroid eye drop and was used to stop inflammation. Interview with another MA on 02/06/26 at 1:59pm revealed: -She administered Resident #5's prednisolone when she worked. -If Resident #5's prednisolone bottle was almost full, it could mean other MAs were not administering the eye drops. Telephone interview with a third MA 02/06/26 at 2:39pm revealed: -She administered Resident #5's prednisolone eye drops. -She thought Resident #5 got one drop in each eye, but she could not be sure because she was not looking at the MAR. b. Review of Resident #5's physician's orders dated 08/11/25 revealed an order for timolol maleate eye drops (used to treat high pressure in the eye caused by glaucoma), instill one drop in both eyes twice a day. Review of Resident #5's December 2025 eMAR revealed: -There was an entry for timolol maleate eye drops, instill one drop in both eyes twice a day with a scheduled administration time at 8:30am and 8:00pm. -Timolol maleate eye drops were documented as	D 358		

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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 358	Continued From page 53 administered at 8:30am and 8:00pm from 12/01/25-12/31/25, with exceptions documented as refused on 12/20/25, 12/21/25, and 12/29/25 at 8:30am and on 12/29/25 and 12/31/25 at 8:00pm. Review of Resident #5's January 2025 eMAR revealed: -There was an entry for timolol maleate eye drops, instill one drop in both eyes twice a day with a scheduled administration time at 8:30am and 8:00pm. -Timolol maleate eye drops were documented as administered at 8:30am and 8:00pm from 01/01/26-01/31/26 with exceptions documented as discontinued on 01/07/26 at 8:30am, and refused on 01/15/26 at 8:00pm and on 01/17/26, 01/30/26, and 01/31/26 at 8:30am. Review of Resident #5's February 2025 eMAR from 02/01/26-02/06/26 revealed: -There was an entry for timolol maleate eye drops, instill one drop in both eyes twice a day with a scheduled administration time at 8:30am and 8:00pm. -Timolol maleate eye drops were documented as administered at 8:30am and 8:00pm from 02/01/26-02/06/26, with exceptions documented as refused on 02/04/26 at 8:00pm and the resident would not wake up on 02/05/26 at 8:30am. Observation of Resident #5's medication on hand on 02/06/26 at 12:25pm revealed: -There was a bottle of timolol maleate eye drops dispensed on 01/07/26 with the direction to instill 2 drops in each eye twice daily. -There was documentation on the label that the medication was opened on 01/08/26. -The bottle was opaque, so the amount of	D 358			

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D 358	Continued From page 54 solution could not be visualized, but the bottle felt full. Interview with the MA on 02/06/26 at 12:36pm revealed she thought the timolol maleate eye drop bottle felt "almost full". Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/06/26 at 1:20pm revealed: -Resident #5's timolol maleate eye drops were dispensed on 10/07/25, 12/08/25, and 01/07/26. -The directions for each dispensing were to instill one drop in each eye twice daily. -Each bottle dispensed would last for more than 30 days based on the order, but all eye drops should be disposed of after 30 days because of the risk of infection. -Timolol maleate eye drops were used to bring down pressure in the eyes. Interview with a second MA on 02/06/26 at 1:59pm revealed: -She administered Resident #5's timolol eye drops when she worked. -If Resident #5's timolol bottle was almost full, it could mean other MAs were not administering the eye drops. Interview with the Special Care Unit Coordinator (SCC) on 02/06/26 at 11:55am revealed: -Resident #5 was progressively losing his sight. -He was becoming more frustrated with his sight loss and it was hard for him to understand with his dementia so he was having increased behaviors. Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/06/26 at 1:20pm revealed if the two eye drops were not	D 358			

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D 358	Continued From page 55 used as ordered, the resident could experience inflammation and increased pressure in the eyes, which could also cause hypertension and worsening of his vision. Telephone interview with the facility's contracted primary care provider (PCP) on 02/06/26 at 1:45pm revealed: -She did not order Resident #5's eye drops, but she did sign the physician's orders for the medication to be ongoing. -If Resident #5's eye drops were not administered as ordered, the resident could experience vision impairment, including loss of eye sight, because of increased pressure. Interview with the Resident Care Coordinator (RCC) on 02/06/26 at 3:05pm revealed: -She did not know why Resident #5's eye drop bottles were almost full unless someone clicked off the eye drops were administered, and the resident actually refused and did not document that the drops were refused. -The MA should not have documented until the eye drops were completed. -If the MA had documented that the eye drops were refused multiple times, the PCP would have been contacted. -If Resident #5's eye drops were administered as ordered, it could have saved some of his eye sight. Interview with the assistant of the ophthalmologist for Resident #5 on 02/26/26 at 3:08pm revealed: -Resident #5 was last seen on 06/03/25. -Resident #5 needed the eye drops to keep the pressure in his eyes low due to glaucoma. -Resident #5's last eye pressure was 20 in the right eye and 21 in the left eye. -The normal pressure in the eyes should be in the	D 358		

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D 358	Continued From page 56 teens. -She was not aware that Resident #5 was not getting the eye drops as ordered. -She has not received any notification from the facility Resident #5 refused the eye drops. -She expected Resident #5's eye drops to be administered as ordered. Second interview with the SCC on 02/06/26 at 3:52pm revealed: -Cart audits were completed earlier this week. -The cart audits were to make sure the medication was on the cart, and everything was in date. -If Resident #5's eye drop bottles were full, it was because he had extra bottles or because he was refusing, and the MAs were not documenting the refusals. -Bottles of eye drops were not opened until the previous bottle was completed. -Maybe the MAs tried to administer the eye drops, and he refused. Interview with the Administrator on 02/06/26 at 4:16pm revealed: -She expected Resident #5's eye drops to be administered as ordered. -If there were more eye drops on hand than there should be, it appeared the eye drops were not being administered as ordered. -Glaucoma was a serious condition, so it was concerning that the eye drops had not been administered as ordered. Telephone interview with Resident #5's family member on 02/09/26 at 9:30am revealed: -Resident #5 had glaucoma. -Resident #5 was able to see shadows but she did not know if that had worsened. -Resident #5 was nonverbal.	D 358		

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D 358	Continued From page 57 Based on interviews, observations, and record reviews it was determined Resident #5 was not interviewable. The facility failed to administer medications as ordered for 2 of 3 residents, including a resident (#3) who had a history of seizures, and the resident missed 18 doses of her seizure medication. The resident fell out of her chair, hit her face, and suffered a laceration that required sutures; the resident appeared to have a seizure, as evidenced by her head and shoulders shaking. The failure of the facility to administer medications as ordered was detrimental to the health, safety, and welfare of the residents and constitutes an Unabated Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/05/26 for this violation.	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;	D 367			

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D 367	Continued From page 58 (7) documentation of any omission of medications or treatments and the reason for the 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 observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 1 of 3 sampled residents (#5) for an antipsychotic medication. The findings are: Review of the facility's Medication Services and Medication Administration Record (MAR) policies (undated) revealed: -All medications that staff members administered would be documented on the MAR. -MARs should include the reason why the as needed (PRN) medication was administered, document the effectiveness of the medication and the initials of the staff who administered the medication. Review of Resident #5's current FL2 dated 08/11/25 revealed diagnoses included hypertension and glaucoma. Review of Resident #5's mental health provider's after-visit summary dated 01/30/26 revealed to continue haloperidol (an antipsychotic medication) 1mg up to twice daily PRN for	D 367		

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D 367	Continued From page 59 agitation/aggression as the resident was a danger to himself and others. Review of Resident #5's physician's orders revealed no other order for haloperidol. Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/06/26 at 1:20pm revealed: -An order was received on 12/02/25 for haloperidol 1mg, up to twice daily as needed for agitation/aggression. -Resident #5's haloperidol was dispensed on 12/02/25, and there had been no other dispensing. -The purpose of documentation was for the provider to see how often the resident was agitated and if the medication was used a lot, the medication may need to be scheduled to keep the resident's mood consistent. -If the administered doses were not documented, the provider would not know the medication had been administered as often as it had been. Review of Resident #5's progress notes for December 2025-February 2026 revealed: -On 12/23/25, Resident #5 ate a bar of soap. -On 12/29/25, Resident #5 damaged his room, was tearing blinds off the window, pulling the cord out of the call bell in his room, flipping the mattress off his bed, and pinching staff; he was sent to the hospital. -There were no other behaviors documented. Review of Resident #5's December 2025 electronic medication administration record (eMAR) revealed: -There was an entry for haloperidol 1mg, take 1 tablet twice a day as needed for agitation and for dementia with a start date of 12/03/25.	D 367		

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D 367	Continued From page 60 -Haloperidol was documented as administered on 12/05/25 at 8:12am, 12/12/25 at 1:04am, 12/10/25 at 10:32pm, and 12/28/25 at 11:10pm. Review of Resident #5's January 2025 eMAR revealed: -There was an entry for haloperidol 1mg, take 1 tablet twice a day as needed for agitation and for dementia with a start date of 12/03/25. -Haloperidol was documented as administered on 01/05/26 at 7:36pm. Review of Resident #5's February 2025 eMAR from 02/01/26-02/06/26 revealed: -There was an entry for haloperidol 1mg, take 1 tablet twice a day as needed for agitation and for dementia with a start date of 12/03/25. -Haloperidol was not documented as administered from 02/01/26-02/06/26. Observation of Resident #5's medication on hand on 02/06/26 at 12:25pm revealed: -There was a punch card of haloperidol 1mg with the directions to take one tablet twice daily as needed for agitation and dementia dispensed on 12/02/25. -There were 11 of 30 tablets remaining on the punch card. -There were 14 tablets unaccounted for. Interview with a medication aide (MA) on 02/06/26 at 12:26pm revealed that she had not administered Resident #5's haloperidol. Interview with a second MA on 02/06/26 at 2:39pm revealed she had not administered Resident #5's haloperidol. Interview with the Special Care Unit Coordinator (SCC) on 02/06/26 at 3:52pm revealed:	D 367		

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D 367	Continued From page 61 -If a PRN medication was administered, the MAs were to document that the medication was administered and why the medication was administered. -All PRN medication administered should be documented. -If the resident was administered the medication but spit it out, the MA should have documented what occurred. -Even if the medication was dropped, it should have been documented and let management know. Interview with the Administrator on 02/06/26 at 4:16pm revealed: -She expected the administered medications to be documented. -If Resident #5's haloperidol was not documented, the provider would not know if the medication had been administered, and the provider would not know whether to increase, decrease, or even discontinue the medication. Attempted telephone interview with a third MA on 02/06/26 at 2:47pm was unsuccessful. Attempted telephone interview with Resident #5's mental health provider on 02/06/26 at 3:35pm was unsuccessful.	D 367			
D 510	10A NCAC 13F .0309 (q) Fire Safety and Emergency Preparedness Plans 10A NCAC 13F .0309 Fire Safety and Emergency Preparedness Plans (q) Where a fire alarm or automatic sprinkler system is out of service, the facility shall immediately notify the fire department, the fire	D 510			

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D 510	Continued From page 62 marshal, and the Division of Health Service Regulation Construction Section and, where required by the fire marshal, a fire watch shall be conducted until the impaired system has been returned to service as approved by the fire marshal. The facility will adhere to the instructions provided by the fire marshal related to the duties of staff performing the fire watch. The facility will maintain documentation of fire watch activities which shall be made available upon request to the DHSR Construction Section and fire marshal. The facility shall notify the DHSR Construction Section when the facility is no longer conducting a fire watch as directed by the fire marshal. 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: FOLLOW UP TO TYPE A2 VIOLATION. Based on these findings, the previous Type A2 Violation was abated. Non-compliance continues. Based on observations, record reviews, and interviews, the facility failed to conduct a fire watch as instructed by the fire marshal until it had been approved by the county to ensure the sprinkler system was functioning correctly. The findings are: Review of the facility's undated policy titled Fire Watch Guideline revealed: -Assigned staff were to conduct fire watch rounds throughout the facility. -Staff selected shall be solely dedicated to the fire watch and have no other facility-related activities	D 510		

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D 510	Continued From page 63 or events assigned while on patrol. -Fire watch personnel would monitor the facility through direct observation of all rooms, including resident rooms, mechanical and electrical rooms, kitchen, laundry, etc., for possible signs of fire. -Fire watch personnel would make rounds every half hour and document findings by noting date, time, and initials in the fire watch log. -Additional staff would be necessary to staff the fire watches. Review of a fire inspection report dated 03/28/25 revealed: -Next to the entry "fire resistant construction not compromised" was marked "fail". -There was an additional note in the report dated 04/01/25 that read "sprinkler system is still not functioning properly, causing alarms". Review of the fire watch log notebook revealed: -There was a fire watch log completed daily. -There was an entry every 30 minutes for a different location in the facility. -A staff member signed their name and documented the location in the facility, with examples as follows: -On 02/01/26, at 7:00am and 5:00pm, the special care unit (SCU) was documented as the location of the fire watch. -At 7:30am and 8:30pm, the front entrance was documented at the location. -At 8:00am and 9:00pm, the library was documented as the location. -At 8:30am and 9:30pm, the living room was documented as the location. -At 12:00pm and 11:30pm, the oxygen room was documented as the location. -At 4:00pm and 3:30am, the 100-400 hall was documented as the location. -At 4:30pm and 4:00am, the 500-600 hall was	D 510		

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D 510	Continued From page 64 documented as the location. Observation of the fire panel on 02/05/26 at 10:00am revealed: -The system was listed as normal. -There was a green light beside of AC power. -There were no red lights observed to indicate there were any issues with the system. Observation of the 500 and 600 halls on 02/04/26 between 10:25am-12:45pm revealed: -Residents were going up and down the hallways. -At 10:56am, a personal care aide (PCA) was in the living room while residents were outside the facility smoking. -At 11:16am, the Administrator called the PCA out into the hallway; the PCA came right back into the room. -At 11:30am, the PCA went down the 500-hallway after a resident asked her to come to his room. -At 11:47am, there was no staff in the hallway, and residents started heading to the dining room for lunch. -From 12:19pm-12:42pm, the medication aide (MA), PCA, Resident Care Coordinator (RCC), and the Administrator were in the dining room with the residents. -There were no staff in the hallway at the front entrance, 100-400 hallway, 500-600 hallway, or the hallway at the laundry room and management offices. -There was no dedicated staff member conducting a fire watch. Observations of the SCU on 02/04/26 at various times from 8:45am to 11:45am and from 2:35pm to 3:10pm revealed: -At 8:45am, there were 6 residents in the television room with no staff. -There were two PCAs in the hallway who were	D 510			

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D 510	Continued From page 65 providing personal care to residents. -There was a housekeeper cleaning resident rooms and a MA administering medications. -At 9:55am, there was a MA and a PCA in the television room with the residents. -There was a second PCA providing personal care to residents in their rooms. -At 11:00am, there was an Activity Director in the television room with the residents. -There was a MA and a PCA in the television room with the residents. -There was a second PCA providing personal care to residents. -The Maintenance Director was in a resident room replacing a towel bar. -At 11:15am, the housekeeper went into the staff breakroom. -At 11:20am, the SCU Coordinator (SCC) came out of her office and walked to the door of the television room. -The SCC asked the MA if everything was okay and then returned to her office. -At 11:35am, the Maintenance Director came out of the resident room he was working in and left the SCU. -At 11:45am, the SCC came to the television room, spoke to the MA and left the SCU. -At 2:35pm, there were 8 residents, and a PCA in the television room. -The MA was in the staff breakroom and a second PCA was providing personal care to residents in their rooms. -At 2:50pm, the MA walked from the breakroom to the television room and took a resident to the bathroom. -At 2:58pm, another PCA brought snacks to the television room and passed them to the residents. -At 3:00pm, the SCC walked to the television room, spoke to a PCA, went into the medication	D 510		

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D 510	Continued From page 66 room and then left the SCU. -The second PCA returned the snack cart to the medication room and stayed in the medication room. -At 3:10pm, the second PCA went from resident room to resident room with the snack cart. -There was a PCA and a MA in the television room with the residents. -The housekeeper came into the SCU with the housekeeping cart and parked it in the cleaning closet and left the SCU. -A second housekeeper came into the SCU, she spoke to the MA in the television room and then left the SCU. -There were no additional staff in the SCU, and no staff were observed walking the hallways with a clipboard. Review of the fire watch log notebook revealed: -The fire watch log dated 02/04/26 at 3:37pm was completed from 7:30am-3:30pm by a PCA. -At 7:30am, the nurses' station was documented at the location. -At 8:00am, the 100-400 hall was documented as the location. -At 8:30am, the oxygen room was documented as the location. -At 9:00am, the living room was documented as the location. -Every 30 minutes until 3:00pm, an area in the facility was documented as observed. Interview with a PCA on 02/04/26 at 4:23pm revealed: -She was the PCA who signed off on the fire watch log dated 02/04/26 from 7:30am-3:00pm. -She did not know she had to do fire watch until after lunch today, 02/04/26. -The RCC told her to complete the fire watch log. -She had been trained to do fire watch, but today	D 510		

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D 510	Continued From page 67 was her first day doing the fire watch. -Every 30 minutes, she was supposed to look somewhere different and document the location on the fire log. -If a resident let her in their room, she would look, but some residents did not want staff in their room. -When she was the only PCA working in AL, it was hard to "get to it" because she was busy doing rounds with the residents. -She did the fire watch when she had a break. -It was hard to do fire watch and do resident care. Telephone interview with the county building inspector on 02/04/26 at 10:17am revealed: -The facility failed its fire inspection in March 2025. -He had not received a call to do a fire inspection at the facility. -He had not been contacted for any work to be done at the facility on the sprinkler system, so he did not know if the sprinkler had been repaired or not. -Whoever was working on the sprinkler system would have had to "pull a permit" to do any work on the sprinkler system. -The facility was still under fire watch until it passed its fire inspection. Telephone interviews with the county fire marshal on 02/04/26 at 10:45am and 4:07pm revealed: -He did not know if the facility's sprinkler system was working or not; every time he asked, he was told they were working on it. -He did not recall the last time he was told they were working on the sprinkler. -He had asked the building inspector on 02/03/26 if the sprinkler had been fixed, and he was told a permit had not been pulled, so he did not know. -The facility was put on fire watch multiple times	D 510		

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D 510	Continued From page 68 and was told what a fire watch was. -He did not recall the last time the facility was put on a fire watch but as far as he knew they were still on fire watch. -The facility had been told they were on a fire watch and needed to provide 24/7 surveillance. -The staff member assigned to do fire watch should not have any other responsibilities. -The purpose of the fire watch was to catch quickly any issues that would warrant contacting the fire department in the event the sprinkler was not working and residents needed to be evacuated for their safety. Interview with the facility's Maintenance Director on 02/04/26 at 3:47pm revealed: -Every 30 minutes, a staff member should check the common areas where they were prone to catching fire. -Every 30 minutes, the assigned staff member should look in a different area. -There was no set routine; just look in a different area every 30 minutes. -If he was not busy, he did the fire watch, but if he was busy, another staff member would do it. -When checking the hallway, the rooms in the hallway should be checked. -The sprinkler system had been repaired in the fall of 2025. Interview with the SCC on 02/06/26 at 12:41pm revealed: -The fire watch was done all day every day. -There was a staff assigned to do the fire watch or a MA did it. -The fire watch included the AL and the SCU. -She saw staff conducting the fire watch in the SCU. -She was not sure, but she thought the fire watch was every half an hour.	D 510		

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D 510	Continued From page 69 -She had done a fire watch herself and she had seen staff doing fire watches in the facility. Interview with the RCC on 02/05/26 at 4:08pm revealed: -The Business Office Manager (BOM) was responsible for scheduling a staff member to do fire watch. -All staff knew the fire watch needed to be done. -Generally the fire watch was a PCA from the assisted living (AL) side of the facility. -She asked the PCA on 02/04/26 if she was doing the fire watch and the PCA responded no. -She thought she asked the PCA about doing the fire watch mid-morning. Interview with the BOM on 02/05/26 at 5:00pm revealed: -They did not have anyone who specifically did fire watch. -When the staff did resident checks every two hours, they were also doing fire watch because the staff were already walking through the halls and going into the resident rooms. -She put on the schedule who was supposed to do the fire watch by putting FW beside the staff member's name. -There had been times when staff were on light duty, and the fire watch would be all that staff member did during their shift. Interview with a MA on 02/05/26 at 5:18pm revealed: -If she was scheduled to do a fire watch she incorporated it into her medication pass and in between medication passes she would look around. -She had not done fire watch recently. Interview with another MA on 02/05/26 at 5:59pm	D 510			

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D 510	Continued From page 70 revealed: -She had been assigned to do a fire watch while also doing her other responsibilities. -She walked the facility all day anyway as part of her other responsibilities. -She did not think there was a designated staff member doing fire watch. -It would help to have a designated staff member doing the fire watch so she could focus on resident care, calling the pharmacy, and talking to families. -She did not go into resident rooms when doing the fire watch, only if she was going in for other reasons. Interview with a MA in the SCU on 02/04/26 at 5:50pm revealed: -One staff did the fire watch for the entire facility. -She was required to do the fire watch. -She went into each and every resident room including the vacant rooms. -She went into the electrical room, the kitchen, the linen room, and any other open rooms. -The fire watch included the outside of the facility. -She looked for smoke, flames and hot spots. -She filled out a clipboard that was kept in the AL. -She also went to the SCU when she did a fire watch even though there were no rooms from the SCU on the list. -She had not seen anyone else doing a fire watch in the SCU. -She felt like the fire watch was done on the AL. -Sometimes a PCA would come in just to do the fire watch. -If there were no staff assigned to do the fire watch, the MA was automatically required to conduct it. -It took her about 20 minutes to complete the fire watch. -She still had to perform her other MA	D 510			

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D 510	Continued From page 71 responsibilities when she conducted fire watches. -It was hard to perform the fire watch while she was also working as a MA. -If a fire watch was supposed to happen during or at a medication pass, she did not do the fire watch until after she administered medications, or she would skip the fire watch. -She did a fire watch about every hour. Interviews with the Administrator on 02/04/26 at 10:49am and 5:12pm revealed: -She knew the facility was on a fire watch until the fire marshal came back to the facility. -The Divisional Director of Maintenance was responsible for scheduling the fire marshal to do a re-inspection. -Staff should be monitoring for signs of anything that could spark a fire, smell of smoke, or anything that smelled out of the ordinary, because the residents had televisions, refrigerators, and telephone chargers in their rooms. -If anything sparked, the sprinkler system was working and would work as it was intended. -Staff were supposed to walk the entire facility every 30 minutes. -She thought the staff were walking the entire facility but only documenting a location on the form because the form did not have room to document everywhere they walked. -The RCC assigned a staff member to do the fire watch. -She knew it was mentioned that they were to have a designated staff member to do fire watch. -There were times a designated staff member was doing the fire watch, but the facility was short-staffed now and using what they had. -"I know we probably should not have used care staff." -Today, 02/04/26, there was supposed to be a designated staff member, but the person could	D 510		

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D 510	Continued From page 72 not come into work. -They had reached out to several staff, but no one was able to come in. -There were several staff members who were on light duty and were assigned to do the fire watch until they were able to return to a normal workload. -She did not feel she had been given adequate instructions on what a fire watch was. Telephone interview with the Divisional Director of Maintenance on 02/05/26 at 1:54pm revealed: -All deficiencies related to the sprinkler system were repaired in November 2025. -He had tried to call the local building inspector multiple times to coordinate a re-inspection of the sprinkler system. -No one had told him he needed to pull a permit until he talked to the building inspector on 02/04/26, and he was working on that now.	D 510		