STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092-323	A. BUILDING: _____ B. WING _____	R 02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTS OF GOLD FAMILY CARE	1004 EDENBURGHS KEEP DR KNIGHTDALE, NC 27545

(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
C 000	Initial Comments The Adult Care Licensure Section and the Wake County Department of Social Services conducted an annual, follow- up survey and complaint investigation from 02/05/26 to 02/06/26 and from 02/09/26 to 02/10/26. The complaint investigation was initiated by the Wake County Department of Social Services on 01/23/26.	C 000		
C 131	10A NCAC 13G .0403(a) Qualifications of Medication Staff 10A NCAC 13G .0403 QUALIFICATIONS OF MEDICATION STAFF (a) Family care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 2 sampled staff (the Administrator and Staff B) who administered medications to residents had completed the state approved 5-hour and 10-hour or 15-hour medication aide training courses (the Administrator and Staff B), completed the medication administration clinical skills validation checklist (Staff B), and passed the state written medication aide exam as required (Staff B). The findings are:	C 131		

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C 131	Continued From page 1 1. Review of the Administrator's personnel record revealed: -She was hired on 10/14/23 as a medication aide (MA). -She was the Administrator and co-owner/operator of the facility. -She completed the medication administration clinical skills validation checklist on 06/26/24. -She passed the state written MA examination on 12/02/22. -There was no documentation the Administrator completed the state approved 5-hour, 10-hour, and/or 15-hour MA training courses. Review of December 2025 medication administration records (MARs) revealed: -There was documentation the Administrator administered medications from 12/01/25 - 12/19/25. -Documentation for the administration of medications for 12/20/25 - 12/31/25 was blank. Review of the facility's MAR notebook revealed there were no January 2026 or February 2026 MARs for the residents. Observation of the Administrator on 02/06/26 revealed: -She prepared and administered medications to the residents from 8:58am - 9:23am, from 9:56am - 10:01am and from 10:24am - 10:29am. -She did not use MARs or controlled substance records (CSRs) when she prepared or administered the medications. -She did not document on the MARs or CSRs immediately after administering medications to a resident and prior to going to the next resident. -She did not observe a resident take her medication. -She did not prepare medications in advance in	C 131		

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C 131	Continued From page 2 accordance with the rules. -She did not administer insulin as ordered to a diabetic resident. -She did not sanitize or wash her hands when preparing or administering medications to the residents. -She did not keep the medications locked and secured when not under her direct supervision. -She refused to administer pain medication to a hospice resident who was exhibiting a pain level of 6 out of 10 and had to be instructed by the hospice nurse and surveyor to get her to administer the medication. Interview with the Administrator on 02/05/26 at 9:10am revealed: -She worked as a MA. -She was the only staff administering medications. -She was responsible for ensuring that staff completed required training. -She completed the state approved 5/10/15-hour MA training courses but could not access the online training portal to obtain documentation. -She had difficulty accessing the online training portal to retrieve training certificates for herself. -She attempted to contact the training provider in December 2025. [Refer to Tag 330, 10A NCAC 13G .1004(a) Medication Administration.] [Refer to Tag 334, 10A NCAC 13G .1004(e) Medication Administration.] [Refer to Tag 335, 10A NCAC 13G .1004(f) Medication Administration.] [Refer to Tag 341, 10A NCAC 13G .1004(i) Medication Administration.]	C 131		

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C 131	Continued From page 3 [Refer to Tag 342, 10A NCAC 13G .1004(j) Medication Administration.] [Refer to Tag 346, 10A NCAC 13G .1004(n) Medication Administration.] [Refer to Tag 353, 10A NCAC 13G .1006(b) Medication Storage.] [Refer to Tag 367, 10A NCAC 13G .1008(a) Controlled Substances.] 2. Review of Staff B's personnel record revealed: -Staff B was hired on 04/22/25 as a personal care aide (PCA). -There was no documentation of Staff B being hired as a medication aide (MA). -There was no documentation of Staff B completing the medication administration clinical skills validation checklist. -There was no documentation of Staff B passing the state written MA examination. -There was no documentation of Staff B completing the state approved 5-hour, 10-hour, and/or 15-hour MA training courses. Interview with Staff B on 02/05/26 at 11:12am revealed: -She usually worked at the facility as a PCA on Thursdays from 3:00pm - 7:00pm and on Fridays, Saturdays, and Sundays from 8:00am - 8:00pm. -The Administrator called her into work this morning (Thursday, 02/05/26) because the only other staff member, another PCA, quit yesterday, 02/04/26. -The facility had no other staff now except for her and the Administrator. -The Administrator would leave her at the facility alone with the four residents about every other	C 131		

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C 131	Continued From page 4	C 131		

day that she was on duty if they needed groceries.
-The Administrator "occasionally" prepared medications for the residents and handed to her to take and administer to the residents without the Administrator observing her.
-She did not recall the last time the Administrator had prepared and handed medications to her to administer to the residents.
-She was not a MA, had no training to be a MA, and she was not interested in becoming a MA.
-The Administrator was aware she was not a MA, did not have training to be a MA, and did not want to become a MA.

Observation of Staff B on 02/06/26 at 8:00am revealed:
-Staff B went into a resident's room to provide personal care and get the resident up for the day.
-There was a scattered red rash in the middle of the resident's lower back.
-There was a quarter-sized reddened area on her sacrum with the edges on the left side noted to have open areas of pink tissue.
-Staff B got a tube of Nystatin cream from the resident's nightstand drawer and applied Nystatin cream to the rash on the resident's lower back and the excoriated skin on her sacral area after cleaning the resident's skin. (Nystatin cream in a topical prescription medication used to treat fungal infections of the skin.)

Second interview with Staff B on 02/06/26 from 8:00am - 8:19am revealed:
-The rash and the excoriated area on the resident had been there for about a week or two.
-She usually applied the Nystatin cream to both areas and the areas would go away.
-When she left on Sundays, the resident's skin would be clear, but when she returned to work on

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C 131	Continued From page 5 Thursdays, the resident's skin on her back and bottom would be red again. Third interview with Staff B on 02/06/26 at 10:45am revealed: -The Administrator sometimes left the resident's medications prepared for administration on the kitchen counter when she left the facility. -The medications were left in the pill crushers with the residents' initials and a white cup for a resident who took medication that was not crushed. -The Administrator told her what time to administer the medications to the residents, and she would administer the prepared medications to the residents at that time while the Administrator was away. -The last time she administered medications to the residents when the Administrator was not at the facility was on Saturday, 01/31/26. -She administered medications prepared and left by the Administrator about once a week. -The Administrator was aware that she had no medication administration training. -The Administrator would leave the facility 2 or 3 days out of the 4 days she worked each week. -The Administrator would leave the facility for an hour and up to 3 to 4 hours at a time. Interview with the Administrator on 02/10/26 at 11:04am revealed: -She was the only MA at the facility and the only one who administered medications. -A resident had an order to put Nystatin cream on reddened skin, and she usually applied the resident's Nystatin cream. -The PCAs could apply skin barrier cream, not Nystatin cream. -She denied preparing and leaving medications for Staff B or any other staff to administer to the	C 131		

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C 131	Continued From page 6 residents. _____ The facility failed to ensure staff who administer medications to the residents met the requirements to administer medications. The Administrator reported she was the only medication aide (MA) employed at the facility. She did not have documentation of completing the state approved 5-hour, 10-hour, and/or 15-hour MA training courses. The Administrator made multiple errors including errors with controlled substances for pain for hospice residents and errors with long-acting and rapid-acting insulin for a diabetic resident. She failed to maintain and document the administration of medications on the medication administration records (MARs) and controlled substance records (CSRs). The Administrator prepared and left medications for Staff B, who was a personal care aide (PCA), to administer to residents on a routine basis, aware that Staff B had no MA training. There were no staff employed by the facility who met the qualifications to administer medications to the residents. This failure put the residents at substantial risk of serious physical harm and this constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/06/26 for this violation. THIS FACILITY WAS ISSUED A SUMMARY SUSPENSION ON 02/12/26.	C 131		
C 140	10A NCAC 13G .0405(a)(b) Test For Tuberculosis 10A NCAC 13G .0405 Test For Tuberculosis	C 140		

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C 140	Continued From page 7 (a) Upon employment or moving into a family care home, the administrator, all other staff, and any persons living in the family care home shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205, which is hereby incorporated by reference, including subsequent amendments. (b) There shall be documentation on file in the family care home that the administrator, all other staff, and any persons living in the family care home are free of tuberculosis disease. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 2 sampled staff (the Administrator) was tested for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Public Health. The findings are : Review of the Administrator's personnel file on 02/05/26 at 10:40am revealed: -She was hired as the Administrator on 10/14/23. -There was documentation of an Interferon Gamma Release Assay (IGRA) tuberculosis (TB) test with a positive result dated October 2022. -There was no date specified on the TB test from October 2022. -There was no documentation a chest x-ray had been completed after October 2022. Interview with the Administrator on 02/10/26 at 10:45am revealed: -She reported a history of positive TB test results with chest x-rays showing no active TB disease.	C 140		

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C 140	Continued From page 8 -She was unable to recall where the TB screening documentation was placed.	C 140		
C 153	10A NCAC 13G .0501 (a and b)) Personal Care Training And Competency 10A NCAC 13G .0501 Personal Care Training And Competency (a) The facility shall assure that staff who provide or directly supervise staff who provide personal care to residents complete an 80-hour personal care training and competency evaluation program established by the Department. For the purpose of this Rule, "directly supervise" means being on duty in the facility to oversee or direct the performance of staff duties. A copy of the 80-hour training and competency evaluation program is available online at https://info.ncdhhs.gov/dhsr/acls/training/index.html#80hr, at no cost. The 80-hour personal care training and competency evaluation program curriculum shall include: (1) observation and documentation skills; (2) basic nursing skills, including special health-related tasks; (3) activities of daily living and personal care skills; (4) cognitive, behavioral, and social care; (5) basic restorative services; and (6) residents' rights as established by G.S. 131D-21. (b) The facility shall assure that training specified in Paragraph (a) of this Rule is completed within six months after hiring for staff hired after September 30, 2022. Documentation of the successful completion of the 80-hour training and competency evaluation program shall be maintained in the facility and available for review	C 153		

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C 153	Continued From page 9 by the Division of Health Service Regulation and the county department of social services. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure that 2 of 3 staff (Administrator and Staff B) who provide personal care to residents completed the required 80-hour personal care aide (PCA) training and competency evaluation program within six months of hire. The findings are: 1. Review of the Administrator's personnel record on 02/06/25 at 9:30am revealed: -She was hired on 10/14/23 as a personal care aide (PCA). -She was the Administrator and owner of the facility. -There was no documentation verifying completion of the required 80-hour personal care aide training within six months of hire. Interview with the Administrator on 02/05/26 at 9:10am revealed she worked as a PCA. Refer to interview with the Administrator on 02/05/26 at 9:10am. 2. Review of Staff B's personnel record revealed: -Staff B was hired on 04/22/25 as a personal care aide (PCA). -There was no documentation verifying completion of the required 80-hour personal care aide training within six months of hire.	C 153		

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C 153	Continued From page 10 Interview with Staff B on 02/05/26 at 11:40am revealed: -She completed PCA training. -She had difficulty accessing the online training portal. -She attempted to access the training portal on 02/04/26 but was unsuccessful. -She did not recall the date she completed the 80-hour PCA training. Refer to interview with the Administrator on 02/05/26 at 9:10am. _____ Interview with Administrator on 02/05/26 at 9:10am revealed: -She had difficulty accessing the online training portal to retrieve training certificates for herself and Staff B. -She attempted to contact the training provider in December 2025. -She was responsible for ensuring staff complete required training.	C 153		
C 185	10A NCAC 13G .0601(a) Management and Other Staff 10A NCAC 13G .0601 Mangement and Other Staff (a) A family care home administrator who is approved in accordance with Rule .1501 of this Subchapter shall be responsible for the total operation and management of the facility to assure that all care and services are provided to maintain the health, safety, and welfare of the residents in accordance with all applicable local, state, and federal regulations and codes. The administrator shall also be responsible to the Division of Health Service Regulation and the	C 185		

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C 185	Continued From page 11 county department of social services for complying with the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the facility and for meeting and maintaining the rules of this Subchapter. The term "administrator" also refers to co-administrator where it is used in this Subchapter. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to ensure the total operation and management of the facility to ensure care and services were provided to maintain the health, safety, and welfare of the residents as related to personal care and supervision; qualifications of medication staff; management and other staff; licensed health professional support (LHPS); resident rights; health care; medication storage; medication administration; and controlled substances. The findings are: Review of the facility's current 2026 license revealed the facility was licensed with a capacity of 6 residents. Review of the facility's current census February 2026 revealed there were 4 residents residing in	C 185		

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C 185	Continued From page 12 the facility. Observation of the facility on 02/06/26 between 7:21am and 7:40am revealed: -The surveyor began knocking at the front door at 7:21am. -The Administrator answered the door at 7:30am. -Upon entrance of the facility, the surveyor observed the Administrator grimacing. -The Administrator stated she had been up all night, was not feeling well and planned to go the emergency department when the other staff arrived. -There were no lights on in the facility. -Two residents were lying in bed but were wide awake. -Two residents were in bed sleeping. -There was a urine odor in two resident rooms. -There was no other staff in the facility except the Administrator. Observation of the Administrator on 02/06/26 revealed: -She prepared and administered medications to the residents from 8:58am - 9:23am, from 9:56am - 10:01am and from 10:24am - 10:29am. -She did not use MARs or controlled substance records (CSRs) when she prepared or administered the medications. -She did not document on the MARs or CSRs immediately after administering medications to a resident and prior to going to the next resident. -She did not observe a resident take her medication. -She did not prepare medications in advance in accordance with the rules. -She did not administer insulin as ordered to a diabetic resident. -She did not sanitize or wash her hands when preparing or administering medications to the	C 185		

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C 185	Continued From page 13 residents. -She did not keep the medications locked and secured when not under her direct supervision. -She refused to administer pain medication to a hospice resident who was exhibiting a pain level of 6 out of 10 and had to be instructed by the hospice nurse and surveyor to get her to administer the medication. Observation of the facility on 02/06/26 at 10:18am revealed: -The Administrator was outside, ready to leave. -The surveyor went outside to inform the Administrator the hospice nurse and a resident's family member were looking for her. -The Administrator came back inside the facility. -The Administrator left the facility at 10:32am. Interview with the Administrator on 02/05/26 at 9:10am revealed: -She worked as a medication aide (MA). -She was the only staff administering medications. -She completed the 5,10 or 15-hour medication training but could not access the online training portal to obtain documentation. -She was responsible for ensuring staff complete required training. Interview with the Administrator on 02/09/26 at 3:41pm revealed: -She was not feeling well on Friday, 02/06/26. -When scheduled staff left the facility at 8:00pm. -She was on duty after 8:00pm daily. -She checked the residents for incontinence at midnight and 4:00am. -She slept on and off during the night. -She was awake every 2 hours to provide water to a resident to prevent him from being dehydrated.	C 185		

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HEARTS OF GOLD FAMILY CARE	1004 EDENBURGHS KEEP DR KNIGHTDALE, NC 27545

(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
C 185	Continued From page 14 -She did not check the residents for incontinence every 2 hours. -While she slept at night there was no other staff on duty to monitor the residents. -Facility staff came on duty at 8:00am. Interview with a personal care aide (PCA) on 02/05/26 at 11:12am revealed: -She usually worked at the facility as a PCA on Thursdays from 3:00pm - 7:00pm and on Fridays, Saturdays, and Sundays from 8:00am - 8:00pm. -The facility had no other staff now except for her and the Administrator. -There were no staff in the facility at night except for the Administrator. -The Administrator was always the night staff person on duty. -When she came in on her workdays at 8:00am in the morning, the residents were usually still in bed. -The residents were "always wet" and sometimes soiled with feces when she arrived in the mornings. -One resident was always wet and sometimes soiled when she arrived at 8:00am on her workdays. -The Administrator would leave her at the facility alone with the four residents about every other day that she was on duty if they needed groceries. Interview with Staff B on 02/05/26 at 11:12am revealed: -She was not a medication aide, had no training to be a medication aide, and she was not interested in becoming a medication aide. -The Administrator was aware she was not a medication aide, did not have training to be a medication aide, and did not want to become a medication aide.	C 185		

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C 185	Continued From page 15 Interview with the PCA on 02/06/26 at 8:26am revealed: -The Administrator did not help her with providing personal care to the residents. -The Administrator just watched her on the cameras in the residents' rooms. Telephone interview with a former PCA on 02/09/26 at 10:45am revealed: -She provided cooked meals and provided personal care to residents when she worked at the facility. -When she arrived to the facility each morning at 9:00am, all residents were still in bed. -She was responsible for getting up all residents except for one resident who got herself up. -Sometimes when she arrived in the mornings, the residents would be wet and the urine would be soaked through the incontinence brief down to the incontinence pad. -Sometimes the residents would be soiled with feces as well. Interview with home health nurse on 01/23/26 at 9:05am revealed: -Her nursing specialty was wound care. -She addressed concerns with the Administrator, who stated she would "do what she wanted to do." -She made several attempts to educate the Administrator regarding appropriate wound care, but the Administrator refused to follow recommendations. Interview with the Administrator on 02/06/26 at 9:21am revealed she was going to leave the facility to go to the hospital since she was not feeling well.	C 185		

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C 185	Continued From page 16 Interview with the Administrator on 02/06/26 at 9:55am revealed she was about to leave the facility to take herself to the hospital. Interview with a resident's hospice nurse on 02/06/26 at 10:20am revealed: -She had to find the Administrator today to get the supplies to do a dressing change on a resident's pressure ulcer. -The supplies were locked in the medication closet. Interview with a resident's hospice nurse on 02/06/26 at 10:08am revealed: -Her hospice agency started providing hospice services to a resident on 01/24/46. -When she came to the facility on Wednesday, 02/04/26, the resident was soaked in heavy urine and it was soaked through the hoyer lift pad and the incontinence pad. Interview with a resident's hospice nurse on 02/06/26 at 11:07am revealed: -She planned to transfer a resident to emergency respite. -This resident was exhibiting acting pain. -The Administrator left the facility with one personal care aide (PCA) on duty and no medication aide (MA). -She was concerned because there were no staff in the facility that was able to administer PRN for pain medications to a resident. Observation of a resident on 02/06/26 at 10:30am revealed: -The resident's incontinence brief was saturated with urine as well as the incontinence pad and the bed sheets. -The back of the resident's blue shirt was soaked in urine from the bottom of the shirt up to the	C 185		

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C 185	Continued From page 17	C 185		

resident's shoulder blades.
-The resident grimaced multiple times as the hospice nurse and PCA changed his clothing.

Telephone interview with a resident's previous hospice provider's case manager on 01/28/26 at 2:00pm revealed:
-Their agency was providing hospice services for a resident until 01/24/26 when he was transferred to a different hospice agency.
-The resident previously had a sacral wound that they were managing with wet to dry dressings.
-The wound to his sacrum had closed.
-On the last visit with the resident on 01/21/26 when the hospice nurse observed the resident's sacral area a Calcium Alginate dressing had been applied instead of the ordered wet to dry dressing. (Calcium Alginate is primarily used to treat stage 3-4 pressure ulcers and promote a moist wound environment. A stage 3 pressure ulcer involves full thickness skin loss and exposure of the fatty tissue beneath. A stage 4 pressure ulcer extends down to the muscle, bone, or joints.)
-On the resident's visit on 01/21/26 the area on his sacrum that was healed was now open and was a Stage 2 pressure ulcer and the healthy tissue around the wound had deteriorated. (A stage 2 pressure ulcer is partial thickness skin loss that looks like an abrasion or blister.)
-When staff asked the Administrator where the Calcium Alginate dressing came from and why she had applied it to Resident #2's sacral area she got "back and forth answers" about it.

Review of a resident's Licensed Health Professional Support (LHPS) review dated 09/22/25 revealed:
-The nurse documented the resident's LHPS task was as needed nebulizer.

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C 185	Continued From page 18 -The nurse documented the resident used nebulizer daily as needed. -There were no other LHPS tasks listed for this resident. -There was no physical assessment documented on the LHPS form for any LHPS tasks, including the nebulizer. -The LHPS review did not address this resident's LHPS tasks of ambulation requiring physical assistance, transferring, or care of a pressure ulcer. -There were no recommendations noted on the form. Interview with the Administrator on 02/10/26 at 11:04am revealed: -This resident's LHPS review was last completed on 09/22/25 because the resident was no longer using the nebulizer. -The resident required total assistance with activities of daily living including ambulation and transferring. -The resident was a 2-person assist but one staff person could transfer him. -The resident had a sore on his bottom that was healing better with no more drainage and it was now closed and dry to her knowledge. -The hospice nurse was doing dressing changes, and she would put on a new dressing if one fell off. -She was not aware all those tasks should be addressed on the LHPS quarterly reviews. Review of a second resident's record on 02/05/26 revealed: -There was documentation of a Licensed Health Professional Support (LHPS) completed on 09/09/25. -The personal care task currently present was catheter care.	C 185		

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C 185	Continued From page 19 -There was no documentation of the medication administration through injection and collecting and testing of fingerstick blood sugars. -There was no documentation of a LHPS completed quarterly after 09/09/25. Interview with the Administrator on 02/09/26 at 8:25am revealed: -This resident was never assessed for her fingerstick blood sugars and insulin injections. -She did not know the resident's fingerstick blood sugars and insulin injections were tasks. Interview with the landlord on 02/06/26 at 4:05pm revealed: -She was a Registered Nurse. -She had conducted LHPS tasks for the facility in the past. -Her signature appeared on LHPS task documentation for the facility. -She signed blank LHPS task forms at the request of the Administrator without conducting resident assessments. -She did not perform physical assessments prior to signing the LHPS documentation. Interview with the Administrator on 02/09/26 at 8:25am revealed: -The LHPS reviews were completed quarterly. -She completed the tasks information on the LHPS review forms. -She was responsible to ensure the residents' tasks were physically assessed and documented on the LHPS review form. Observation of the Administrator on 02/06/26 from 08:58am - 9:21am revealed: -She was in the kitchen preparing medications for the residents. -She punched all oral medications for a resident	C 185		

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C 185	Continued From page 20 into her bare, ungloved hands. -She did not wash or sanitize her hands after preparing medications for the residents. Second observation of the Administrator on 02/06/26 from 9:56am - 10:01am revealed at 10:01am, the Administrator walked out of the kitchen and reported she was going to the bathroom and then to the hospital because she was not feeling well. Interview with the Administrator on 02/10/26 at 11:04am revealed: -She usually washed her hands then pulled and prepared all residents' medications at the same time. -She prepared medications the same as usual on 02/06/26. -She usually punched the pills into her bare hands. -She usually washed her hands after she finished administering medications to all residents. Telephone interview with a resident's primary care provider (PCP) on 02/10/26 at 2:10pm revealed not washing or sanitizing hands between residents when administering medications could cause contamination and the transmission of communicable diseases. Observation of the facility on 02/06/26 between 7:21am and 7:40am revealed: -The Administrator answered the door at 7:30am. -There were no lights on in the facility. -The medication closet in the hallway was opened with the keys hanging on a keychain in the lock of the doorknob. Observation of the facility on 02/05/26 from 11:56am - 12:10pm revealed:	C 185		

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C 185	Continued From page 21 -The Administrator left the facility at 11:56am. -The personal care aide (PCA) was left at the facility with the four residents. -At 12:10pm, the medication closet was still unlocked with the keys hanging in the doorknob. -There was an ambulatory resident in her room with the door opened which was right beside the medication closet. Interview with the Administrator on 02/05/26 at 2:35pm revealed: -She was the only medication aide (MA) at the facility and the only staff with keys to the medication closet. -She had no explanation for the medication closet being unlocked with the keys hanging in the doorknob throughout the day on 02/05/26. -The controlled substances were now kept in the medication closet stored with each individual residents' medication bins. Non-compliance was identified at violation levels in the following areas: 1. Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 2 sampled staff (the Administrator and Staff B) who administered medications to residents had completed the state approved 5-hour and 10-hour or 15-hour medication aide training courses (the Administrator and Staff B), completed the medication administration clinical skills validation checklist (Staff B), and passed the state written medication aide exam as required (Staff B). [Refer to Tag 131 10A NCAC 13G .0403(a) Qualifications of Medication Staff (Type A2 Violation)]. 2. Based on observations, interviews, and record reviews, the Administrator failed to ensure the	C 185		

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C 185	Continued From page 22 total operation and management of the facility to ensure there were enough staff on duty at night to provide personal care and supervision to the residents. [Refer to Tag 188 10A NCAC 13G .0601(g) Management and Other Staff (Type A1 Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to provide personal care and to attend to personal care needs for 2 of 4 sampled residents (#2, #4) who were non-ambulatory including failure to provide incontinence care and the residents being saturated with urine (#2, #4) and soiled with feces (#4) including one resident with a stage 2 pressure ulcer (#2). [Refer to Tag 242 10A NCAC 13G .0901(a) Personal Care and Supervision (Type A1 Violation)]. 4. Based on observations, interviews, and record reviews, the facility failed to ensure the quarterly licensed health professional support (LHPS) reviews and evaluations for 2 of 3 sampled residents (#2, #3) with LHPS tasks were completed quarterly and included a physical assessment, evaluation of care provided, and recommendations based on the physical assessment and evaluation of the residents including tasks for assistance with ambulation and transferring (#2, #3), medication through injection (#3), medication through inhalation (#2), collecting and testing of fingerstick blood sugars (#3), clean dressing changes (#2), care for pressure ulcers (#2), and care of a urinary catheter (#3). [Refer to Tag 254 10A NCAC 13G .0903(c) Licensed Health Professional Support (Type B Violation)]. 5. Based on observations, interviews, and record reviews, the facility failed to ensure residents	C 185		

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C 185	Continued From page 23 were free from neglect as evidence by failure to attending to personal care needs for 2 of 4 sampled residents (#2, #4) who were non-ambulatory including failure to provide incontinence care and the residents being saturated with urine (#2, #4) and soiled with feces (#4) including one resident with a stage 2 pressure ulcer (#2); failure to administer a controlled substance pain medication to a hospice resident actively in pain requiring intervention by the hospice nurse and surveyor; and failed to provide residents with privacy as evidenced by an audio and video surveillance system being operational in all residents' rooms. [Refer to Tag 311 10A NCAC 13G .0909 Resident Rights (Type A1 Violation)]. 6. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 4 sampled residents (#2, #3, #4) including errors with two insulins (#3), controlled substances for moderate to severe pain (#2, #4), an antipsychotic (#2), topical medications (#3), an oral diabetic medication (#3), a mild pain reliever (#3), a medication for high cholesterol (#3), and a medication used to prevent heart disease (#3). [Refer to Tag 330 10A NCAC 13G .1004(a) Medication Administration (Type A1 Violation)]. 7. Based on observations, interviews, and record review, the facility failed to ensure infection control measures were implemented during medication administration on 02/06/26 by the Administrator/medication aide observed who failed to wash or sanitize her hands prior to preparing and after administering multiple oral medications to 4 of 4 residents (#1, #2, #3, #4) including putting the pills in her bare ungloved hands and feeding crushed medications in	C 185		

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C 185	Continued From page 24 applesauce to two residents. [Refer to Tag 346 10A NCAC 13G .1004(n) Medication Administration (Type A2 Violation)]. 8. Based on observations, interviews, and record reviews, the facility failed to ensure all residents' medications and the medication closet were locked when not under the direct physical supervision of staff in charge of medication administration on 02/05/26 and 02/06/26. [Refer to Tag 353 10A NCAC 13G .1006(b) Medication Storage (Type B Violation)]. 9. Based on observations, interviews, and record reviews, the facility failed to ensure readily retrievable records that accurately reconciled the receipt and administration of controlled substances for 2 of 2 hospice residents (#2, #4) with orders for controlled substances used to treat moderate to severe pain (#2, #4) and a controlled substance used to treat anxiety and agitation (#2). [Refer to Tag 367 10A NCAC 13G .1008(a) Controlled Substances (Type A2 Violation)]. _____ The facility failed to ensure the Administrator was responsible for the total operation and management of the facility to ensure care and services were provided to maintain the health, safety, and welfare of residents. The facility failed to provide personal care and supervision to the residents as evidenced by residents being found saturated in urine and feces. The facility failed to ensure the quarterly licensed health professional support (LHPS) reviews and evaluations for residents with LHPS tasks were completed quarterly and included a physical assessment, evaluation of care provided, and recommendations based on the physical assessment and evaluation of the residents	C 185		

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C 185	Continued From page 25 including tasks for assistance with ambulation and transferring, medication through injection, medication through inhalation, collecting and testing of fingerstick blood sugars, care for pressure ulcers, and care of a urinary catheter. The facility failed to ensure proper sanitation was used when administering medications. The facility failed to ensure infection control measures were implemented during medication administration by the Administrator/medication aide observed who failed to wash or sanitize her hands prior to preparing and after administering multiple oral medications to residents including putting the pills in her bare ungloved hands and feeding crushed medications in applesauce to two residents. The facility failed to ensure staff who administered medications to residents had completed the state approved 5-hour and 10-hour or 15-hour medication aide training courses), completed the medication administration clinical skills validation checklist, and passed the state written medication aide exam as required. the facility failed to ensure readily retrievable records that accurately reconciled the receipt and administration of controlled substances for 2 of 2 hospice residents with orders for controlled substances used to treat moderate to severe pain and a controlled substance used to treat anxiety and agitation. These failures of the facility resulted in serious neglect which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/06/26 for this violation. THIS FACILITY WAS ISSUED A SUMMARY SUSPENSION ON 02/12/26.	C 185		

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C 187	Continued From page 26	C 187		
C 187	10A NCAC 13G .0601 (e)(f) Management And Other Staff 10A NCAC 13G .0601 Management And Other Staff (e) At all times the administrator or supervisor-in-charge shall be in the facility or within 500 feet of the facility with a means of two-way telecommunication. The administrator or supervisor-in-charge is directly responsible for assuring that all required duties are carried out in the facility and for assuring that at no time is a resident left alone in the facility without a staff member. (f) When the administrator or supervisor-in-charge are not in the facility or within 500 feet of the facility, a staff person who meets the staff qualification requirements of this Subchapter shall be on duty in the facility. The staff person shall be on duty in the facility no more than eight hours per 24 hours and no more than 24 hours total per week. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the Administrator failed to ensure that a qualified staff person was on duty in the facility while they were away from the facility.	C 187		

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C 187	Continued From page 27 The findings are: Review of Staff B's personnel record revealed: -Staff B was hired on 04/22/25 as a personal care aide (PCA). -There was no documentation of Staff B was hired as a medication aide (MA). -There was no documentation of Staff B completing the medication administration clinical skills validation checklist. -There was no documentation of Staff B passing the state written MA examination. -There was no documentation of Staff B completing the state approved 5-hour, 10-hour, and/or 15-hour MA training courses. Interview with Staff B on 02/05/26 at 11:12am revealed: -She usually worked at the facility as a PCA on Thursdays from 3:00pm - 7:00pm and on Fridays, Saturdays, and Sundays from 8:00am - 8:00pm. -The facility had no other staff now except for her and the Administrator. -The Administrator "occasionally" prepared medications for the residents and handed to her to take and administer to the residents without the Administrator observing her. -She did not recall the last time the Administrator had prepared and handed medications to her to administer to the residents. -She was not a MA, had no training to be a MA, and she was not interested in becoming a MA. -The Administrator was aware she was not a MA, did not have training to be a MA, and did not want to become a MA. Observation of Staff B on 02/06/26 at 8:00am revealed: -Staff B went into a resident's room to provide personal care and get the resident up for the day.	C 187		

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C 187	Continued From page 28 -There was a scattered red rash in the middle of the resident's lower back. -There was a quarter-sized reddened area on her sacrum with the edges on the left side noted to have open areas of pink tissue. -Staff B got a tube of Nystatin cream from the resident's nightstand drawer and applied Nystatin cream to the rash on the resident's lower back and the excoriated skin on her sacral area after cleaning the resident's skin. (Nystatin cream in a topical prescription medication used to treat fungal infections of the skin.) Second interview with Staff B on 02/06/26 from 8:00am - 8:19am revealed: -The rash and the excoriated area on the resident had been there for about a week or two. -She usually applied the Nystatin cream to both areas and the areas would go away. -When she left on Sundays, the resident's skin would be clear, but when she returned to work on Thursdays, the resident's skin on her back and bottom would be red again. Third interview with Staff B on 02/06/26 at 10:45am revealed: -The Administrator sometimes left the resident's medications prepared for administration on the kitchen counter when she left the facility. -The Administrator told her what time to administer the medications to the residents, and she would administer the prepared medications to the residents at that time while the Administrator was away. -The last time she administered medications to the residents when the Administrator was not at the facility was on Saturday, 01/31/26. -She administered medications prepared and left by the Administrator about once a week.	C 187		

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C 187	Continued From page 29 Interview with the Administrator on 02/10/26 at 11:04am revealed: -She was the only MA at the facility and the only one who administered medications. -A resident had an order to put Nystatin cream on reddened skin, and she usually applied the resident's Nystatin cream. -The PCAs could apply skin barrier cream, not Nystatin cream. -She denied preparing and leaving medications for Staff B or any other staff to administer to the residents.	C 187		
C 188	10A NCAC 13G .0601 (g) Management And Other Staff 10A NCAC 13G .0601 Management And Other Staff (g) Additional staff shall be employed as needed for housekeeping and the supervision and care of the residents in accordance with the rules of this Subchapter. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to ensure the total operation and management of the facility to ensure there were enough staff on duty at night to provide care and supervision to the residents. The findings are:	C 188		

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C 188	Continued From page 30 Observation of the facility on 02/06/26 between 7:21am and 7:40am revealed: -The surveyor began knocking at the front door at 7:21am. -The Administrator answered the door at 7:30am. -There were no lights on in the facility. -Two residents were lying in bed but were wide awake. -Two residents were in bed sleeping. -There was a urine odor in two of the residents' rooms. -There was no other staff in the facility except the Administrator. a. Review of Resident #2's current FL-2 dated 03/29/25 revealed: -Diagnoses included unspecified dementia, metabolic encephalopathy, normal pressure hydrocephalus, seizures, myoclonus, and history of falling. -The resident was constantly disoriented. -The resident was semi-ambulatory and required assistance with bathing and dressing. -The resident was incontinent of bowel and bladder. -The resident's skin was documented as normal. Review of Resident #2's Resident Register revealed: -The resident was admitted to the facility on 03/21/25 from a skilled rehabilitation facility. -The resident required assistance for dressing, bathing, nail care, shaving, ambulation, correspondence, getting in/out of bed, toileting, hair/grooming, skin care, mouth care, feeding, positioning/turning, scheduling appointments, and orientation to time and place. -The resident had significant memory loss and must be directed.	C 188		

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C 188	Continued From page 31 -The resident had a wheelchair, hearing aids, and eyeglasses. Review of Resident #2's current assessment and care plan dated 05/16/25 revealed: -The resident was non-ambulatory and had limited range of motion in his upper extremities. -The resident's skin and respirations were normal. -The resident had daily incontinence of bowel and bladder. -The resident was always disoriented, had significant memory loss, and must be directed. -The resident's vision was limited and he could hear loud sounds/voices. -The resident was documented as having no speech. -The resident was totally dependent on staff assistance with eating, toileting, ambulation, bathing, dressing, grooming/personal hygiene, and transferring. -The resident's care plan was signed by a hospice nurse on 05/28/25. Review of Resident #2's hospice visit note dated 12/22/25 revealed: -The resident looked to be uncomfortable, making groaning sounds and restless in his Broda chair (a specialized wheelchair designed for those with mobility challenges, emphasizing comfort, support, and enhanced mobility especially for those who may have difficulty sitting for extended periods). -The nurse was unable to obtain the resident's blood pressure due to movement and continuous flexion in his arms. -The resident was dependent on staff for all activities of daily living (ADLs) and he was unable to make his needs known. -The resident was a 1 - 2 person assist and could	C 188		

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be transferred to his Broda chair.
-The resident's legs stayed crossed at the ankles and when nurse uncrossed his legs, the resident immediately began recrossing his legs.
-The resident had very poor range of motion in his bilateral upper and lower extremities.
-The resident's skin was "dusky, cool, and dry to touch"; the resident had thin, fragile skin.
-The resident had a new stage 1 pressure injury noted on his coccyx/sacrum area.
-The nurse cleansed the area and applied thick barrier cream and a foam pad.

Review of Resident #2's hospice visit note dated 12/24/25 revealed:
-On 10/10/25, the resident developed a stage II coccyx wound that had healed.
-On 12/22/25, the resident had a re-developed stage II pressure wound to sacrum.

Review of Resident #2's hospice visit note dated 01/21/26 revealed:
-The resident required total care with all activities of daily living including feeding.
-The resident was chairbound and used a Broda chair.

Interview with a personal care aide (PCA) on 02/05/26 at 11:12am revealed:
-She usually worked at the facility as a PCA on Thursdays from 3:00pm - 7:00pm and on Fridays, Saturdays, and Sundays from 8:00am - 8:00pm.
-The Administrator called her into work this morning (Thursday, 02/05/26) because the only other staff member, another PCA, quit yesterday, 02/04/26.
-The facility had no other staff now except for her and the Administrator.
-She and the former PCA did not work night shift.
-There were no staff in the facility at night except

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for the Administrator.
-The Administrator was always the night staff person on duty.
-When she came in on her workdays at 8:00am in the morning, the residents were usually still in bed.
-The residents were "always wet" and sometimes soiled with feces when she arrived in the mornings.
-Resident #2 was always wet and sometimes soiled when she arrived at 8:00am on her workdays.
-Resident #2 had skin breakdown on his "tailbone" but she did not recall how long he had the skin breakdown.
-The Administrator would leave her at the facility alone with the four residents about every other day that she was on duty if they needed groceries.
-When the Administrator left the facility, the Administrator would leave monitors from the video cameras with the staff so they could use the cameras to monitor the residents.

Interview with a Resident #2's hospice nurse on 02/06/26 at 10:08am revealed:
-Her hospice agency started providing hospice services to Resident #2 on 01/24/46.
-When she came to the facility on Wednesday, 02/04/26, Resident #2 was soaked in heavy urine and it was soaked through the hoyer lift pad and the incontinence pad.

Observation of Resident #2 on 02/06/26 at 10:30am revealed:
-The resident's incontinence brief was saturated with urine as well as the incontinence pad and the bed sheets.
-The back of the resident's blue shirt was soaked in urine from the bottom of the shirt up to the

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resident's shoulder blades.
-The resident grimaced multiple times as the hospice nurse and PCA changed his clothing.

Interview with Resident #2's hospice nurse on 02/06/26 at 11:10am revealed:
-She found the resident wet and saturated with urine again today, 02/06/26.
-The hospice agency had decided to remove this resident from the facility today, 02/06/26.
-The resident was exhibiting active pain.
-The Administrator had left the facility and there was no medication aide (MA) to administer medications and only one PCA to provide care for the residents currently.
-They were concerned about the facility not providing supervision and personal care to the residents.
-The resident was known to have pain so they were concerned without a MA at the facility, the residents' pain would not be treated.

b. Review of Resident #4's current FL-2 dated 03/18/25 revealed:
-Diagnoses included dementia, functional quadriplegia, hypertension, congestive heart failure, general muscle weakness, atrial fibrillation, major depressive disorder, and metabolic encephalopathy.
-The resident was non-ambulatory and required assistance with bathing and dressing.
-The resident was incontinent of bowel and bladder.
-The resident's skin was documented as normal.

Review of Resident #4's Resident Register revealed:
-The resident was admitted to the facility on 03/25/25 from a skilled rehabilitation facility.
-The resident required assistance for dressing,

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bathing, nail care, ambulation, correspondence, getting in/out of bed, toileting, hair/grooming, skin care, mouth care, positioning/turning, scheduling appointments, and orientation to time and place.
-The resident had significant memory loss and must be directed.
-The resident had a wheelchair and hearing aids.

Review of Resident #4's current assessment and care plan dated 03/24/25 revealed:
-The resident was non-ambulatory and had limited range of motion in his upper extremities.
-The resident's skin and respirations were normal.
-The resident had daily incontinence of bowel and bladder.
-The resident was sometimes disoriented, forgetful and needed reminders.
-The resident's hearing was very limited and the resident had hearing aids.
-The resident was totally dependent on staff assistance with toileting, ambulation, bathing, dressing, grooming/personal hygiene, and transferring.
-The resident was independent with eating.
-The resident's care plan was signed by the Administrator on 03/24/25.

Observation of Resident #4's room on 02/06/26 at 7:49am revealed:
-The door to the room was closed.
-After knocking and upon entry, there were two residents alone in the room.
-There were no lights on in the room, but some light was coming through the closed window blinds.
-Resident #4 was lying in her hospital bed with bilateral half bedrails in the up position.
-Resident #4 was awake with her eyes opened.
-Resident #4 was lying on her back under the bed

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covers.
-There was a strong odor of urine in the room.

Observation of Resident #4 on 02/06/26 at 8:26am revealed:
-The personal care aide (PCA) went into Resident #4's room to provide personal care to the resident.
-Resident #4 was still lying in bed with her eyes open.
-Resident #4's incontinence brief was saturated with dark yellow urine stains and there were clumps of wet body powder in the brief and on the resident's vaginal area and buttocks area.
-There was a large brown bowel movement that was stuck to the resident's skin and had to be wiped several times to remove it.
-The blue hoyer lift pad underneath the resident was saturated with urine.
-The incontinence pad underneath the hoyer lift pad was saturated and stained with yellow urine and had lumps of body powder scattered on top of the pad.
-There resident's skin on her bottom was slightly pink and there were no open areas or skin breakdown.

Interview with the PCA on 02/06/26 at 8:26am revealed:
-Resident #4 was always wet when she provided incontinence care to the resident when she came in the mornings.
-The resident was never dry in the mornings.
-The resident's incontinence brief, hoyer lift pad, and incontinence pad were always wet in the mornings.
-The resident was also frequently soiled with feces when she came in the mornings.
-The resident was "over 300 pounds" and should be assisted by two staff with incontinence care

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and transferring.
-When she was the only PCA working, the Administrator did not offer to help her provide care to Resident #4.
-She thought the Administrator would help if she asked her, but she should not have to ask the Administrator for help because the Administrator knew Resident #4 was a 2-person assist.
-She had never noticed any redness or skin breakdown on Resident #4.
-Before the former PCA quit on Wednesday, 02/04/26, they were both at the facility on Thursdays and Fridays and they both provided assistance to Resident #4 together.
-They also used a hoyer lift to transfer Resident #4 and now she had to use the hoyer lift by herself since the other PCA quit.
-The former PCA used to work on Mondays - Fridays from 9:30am - 5:30pm.
-After the PCA provided incontinence care to Resident #4 and changed the resident's clothes while the resident was in bed, the PCA left the resident in bed and stated she needed a break.

Observation of the facility on 02/06/26 from 9:47am - 9:55am revealed:
-The PCA knocked on the Administrator's bedroom door but the Administrator did not open the door.
-The PCA knocked on the door again one minute later and the Administrator came out of the bedroom.
-The Administrator sanitized her hands and went to Resident #4's room with the PCA.
-The Administrator assisted the PCA with putting on the resident's pants and repositioning the resident in bed.
-The resident was left lying in bed.
-The resident was not gotten up by staff and had not been served breakfast.

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C 188	Continued From page 38 -At 9:55am, the Administrator came out of Resident #4's room. Interview with the Administrator on 02/06/26 at 9:55am revealed she was about to leave the facility to take herself to the hospital. Observation of the Administrator on 02/06/26 at 10:01am revealed the Administrator walked out of the kitchen and reported she was going to the bathroom and then to the hospital. Observation of Resident #4 on 02/06/25 at 10:53am revealed the resident was in bed eating breakfast. Interview with Resident #4's hospice nurse on 02/06/26 at 11:10am revealed: -The hospice agency had decided to remove Resident #4 from the facility today, 02/06/26. -The Administrator had left the facility and there was no medication aide (MA) to administer medications and only one PCA to care for the residents currently. -When she arrived to the facility on Wednesday, 02/04/26 at 10:53am, Resident #4 was eating breakfast in bed and was not dressed yet. -The Administrator was the only staff at the facility when she arrived on 02/04/26 at 10:53am. -They were concerned about the facility not providing supervision and personal care to the residents. -Resident #4 was known to have pain so they were concerned without a MA at the facility, the residents' pain would not be treated. Observation of Resident #4 on 02/06/26 at 5:40pm revealed Resident #4 was picked up by a transport service at the facility to be moved to a skilled nursing facility for 5-day emergency respite	C 188		

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C 188	Continued From page 39 care through the hospice agency. Interview with the Administrator on 02/09/26 at 3:41pm revealed: -Facility staff left the facility at 8:00pm daily. -She was on duty after 8:00pm daily. -She checked the residents for incontinence at midnight and 4:00am. -She slept on and off during the night. -While she slept at night there was no other staff on duty to monitor the residents. -Facility staff came on duty at 8:00am. Non-compliance was identified at violation levels in the following areas: Based on observations, interviews, and record reviews, the facility failed to provide personal care and to attend to personal care needs for 2 of 4 sampled residents (#2, #4) who were non-ambulatory including failure to provide incontinence care and the residents being saturated with urine (#2, #4) and soiled with feces (#4) including one resident with a stage 2 pressure ulcer (#2). [Refer to Tag 242 10A NCAC 13G .0901(a) Personal Care and Supervision (Type A1 Violation)]. The facility failed to have enough staff to provide care and supervision to residents including 2 residents (#2, #4) who required assistance with all activities of daily living and were incontinent of bowel and bladder and found on multiple occasions to be saturated with urine and fecal matter, in the morning when the personal care aide (PCA) arrived. The facility failed to provide qualified staff to administer as needed pain medications for two residents receiving end of life care when the Administrator left the building leaving staff and residents unattended. These	C 188		

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C 188	Continued From page 40 failures of the facility resulted in serious neglect which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/09/26 for this violation. THIS FACILITY WAS ISSUED A SUMMARY SUSPENSION ON 02/12/26.	C 188		
C 202	10A NCAC 13G .0702 (a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination, and Immunizations (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 4 sampled residents (#2, #4) were tested for Tuberculosis (TB) disease in compliance with the guidelines from the Centers for Disease Control and Prevention. The findings are: 1. Review of Resident #2's current FL-2 dated 03/29/25 revealed: -Diagnoses included unspecified dementia,	C 202		

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HEARTS OF GOLD FAMILY CARE	1004 EDENBURGHS KEEP DR KNIGHTDALE, NC 27545

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metabolic encephalopathy, normal pressure hydrocephalus, seizures, myoclonus, and history of falling.
-The resident was constantly disoriented.

Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 03/21/25 from a skilled rehabilitation facility.

Review of Resident #2's record revealed no documentation of any tuberculosis (TB) skin testing.

Interview with the Administrator on 02/10/26 at 11:04am revealed:
-She could not locate any TB skin tests for Resident #2.
-Resident #2 came from a skilled nursing rehabilitation facility when he was admitted to the facility.
-Resident #2 had one TB skin test from the rehabilitation facility but she could not find it.
-Resident #2 had a second TB skin placed after he was admitted to the facility, but she could not find that one either.
-She did not realize Resident #2's TB skin tests were not in his record.

Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable.

Refer to interview with the Administrator on 02/09/26 at 8:25am.

2. Review of Resident #4's current FL-2 dated 03/18/25 revealed diagnoses included congestive heart failure, hypertension, metabolic encephalopathy and muscle weakness.

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C 202	Continued From page 42 Review of Resident #4's Resident Register dated 03/30/25 revealed she was admitted to the facility from another facility on 03/25/25. Review of Resident #4's record revealed: -There was documentation that a 1st step tuberculosis (TB) test was administered on 03/18/25 and read as negative on 03/20/25. -There was no documentation that a 2nd step TB test was administered and read. -There was no documentation for a chest x-ray. Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable. Refer to interview with the Administrator on 02/09/26 at 8:25am. _____ Interview with the Administrator on 02/09/26 at 8:25am revealed: -Residents who came from another facility with one step of the TB test needed a second step after admission. -Residents who were admitted from home needed to get their first step TB test before admission and their second step after admission. -She was responsible for ensuring the residents admitted to the facility had their 1st and 2nd step TB tests.	C 202		
C 236	10A NCAC 13G .0802 (a) (c) Resident Care Plan 10A NCAC 13G .0802 Resident Care Plan (a) The facility shall develop and implement a care plan for each resident based on the resident's assessment completed in accordance with Rule .0801 of this Section. The care plan	C 236		

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C 236	Continued From page 43 shall be resident-centered and include the resident's preferences related to the provision of care and services. A copy of each resident's current care plan shall be maintained in a location in the facility where it can be accessed by facility staff who are responsible for the implementation of the care plan. (c) The care plan shall include the following: (1) a description of services, supervision, tasks, and level of assistance to be provided to address the resident's needs identified in the resident's assessment in Rule .0801 of this Section; (2) frequency of the services or tasks to be performed; (3) revisions of tasks and frequency based on reassessments in accordance with Rule .0801 of this Section; (4) licensed health professional tasks required according to Rule .0903 of this Section; (5) a dated signature of the assessor upon completion; and (6) a dated signature of the resident's physician or physician extender as defined in Rule .0102 of this Subchapter within 15 days of completion of the care plan certifying the resident is under this physician's care and has a medical diagnosis with associated physical or mental limitations warranting the provision of the personal care services in the above care plan in accordance with G.S. 131D-2.15. This shall not apply to residents assessed through the Medicaid State Plan Personal Care Services Assessment for the portion of the assessment covering tasks needed for each activity of daily living of this Rule for which care planning and signing are directed by Medicaid.	C 236		

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C 236	Continued From page 44 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure an annual assessment and care plan was completed as evidenced by the care plans not being signed and dated by the residents' primary care provider (PCP) for 2 of 4 sampled residents (#2, #4). The findings are: 1. Review of Resident #2's current FL-2 dated 03/29/25 revealed: -Diagnoses included unspecified dementia, metabolic encephalopathy, normal pressure hydrocephalus, seizures, myoclonus, and history of falling. -The resident was constantly disoriented. -The resident was semi-ambulatory and required assistance with bathing and dressing. -The resident was incontinent of bowel and bladder. -The resident's skin was documented as normal. Review of Resident #2's Resident Register revealed: -The resident was admitted to the facility on 03/21/25 from a skilled rehabilitation facility. -The resident required assistance for dressing, bathing, nail care, shaving, ambulation, correspondence, getting in/out of bed, toileting, hair/grooming, skin care, mouth care, feeding, positioning/turning, scheduling appointments, and orientation to time and place. -The resident had significant memory loss and must be directed. -The resident had a wheelchair, hearing aids, and eyeglasses. Review of Resident #2's current assessment and	C 236		

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care plan dated 05/16/25 revealed:
-The resident was non-ambulatory and had limited range of motion in his upper extremities.
-The resident's skin and respirations were normal.
-The resident had daily incontinence of bowel and bladder.
-The resident was always disoriented, had significant memory loss, and must be directed.
-The resident's vision was limited and he could hear loud sounds/voices.
-The resident was documented as having no speech.
-The resident was totally dependent for staff assistance with eating, toileting, ambulation, bathing, dressing, grooming/personal hygiene, and transferring.
-The resident's care plan was signed by a hospice nurse on 05/28/25.
-The resident's care plan was not signed by a prescribing practitioner.

Interview with the Administrator on 02/10/26 at 11:04am revealed:
-Resident #2 required total assistance for all activities of daily living (ADLs).
-Resident #2's care plan was signed by a registered nurse.

Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable.

Refer to interview with the Administrator on 02/10/26 at 11:04am.

2. Review of Resident #4's current FL-2 dated 03/18/25 revealed diagnoses included congestive heart failure, hypertension, metabolic encephalopathy and muscle weakness.

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C 236	Continued From page 46 Review of Resident #4's Resident Register dated 03/30/25 revealed she was admitted to the facility from another facility on 03/25/25. Review of Resident #4's current care plan dated 03/24/25 revealed: -The primary care provider (PCP) had not signed the care plan. -She was non-ambulatory and required a Hoyer lift for transfers. -She was totally dependent on toileting, bathing, dressing, grooming, hygiene, and transferring. -The resident's care plan was not signed by a prescribing practitioner. Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable. Refer to interview with the Administrator on 02/10/26 at 11:04am. _____ Interview with the Administrator on 02/10/26 at 11:04am revealed: -She was responsible for residents' care plans. -She did not know a prescribing practitioner had to sign the residents' care plans.	C 236		
C 242	10A NCAC 13G .0901(a) Personal Care and Supervision 10A NCAC 13G .0901 Personal Care and Supervision (a) Family care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves.	C 242		

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C 242	Continued From page 47 This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide personal care and to attend to personal care needs for 2 of 4 sampled residents (#2, #4) who were non-ambulatory including failure to provide incontinence care and the residents being saturated with urine (#2, #4) and soiled with feces (#4) including one resident with a stage 2 pressure ulcer (#2). The findings are: Interview with a personal care aide (PCA) on 02/05/26 at 11:12am revealed: -She usually worked at the facility as a PCA on Thursdays from 3:00pm - 7:00pm and on Fridays, Saturdays, and Sundays from 8:00am - 8:00pm. -The Administrator called her into work this morning (Thursday, 02/05/26) because the only other staff member, another PCA, quit yesterday, 02/04/26. -The facility had no other staff now except for her and the Administrator. -She and the former PCA did not work night shift. -There were no staff in the facility at night except for the Administrator. -The Administrator was always the night staff person on duty. -When she came in on her workdays at 8:00am in the morning, the residents were usually still in bed. -The residents were "always wet" and sometimes soiled with feces when she arrived in the mornings. -The Administrator would leave her at the facility alone with the four residents about every other	C 242		

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day that she was on duty.
-When the Administrator left the facility, the Administrator would leave monitors from the video cameras with the staff so they could use the cameras to monitor the residents.

Observation of the facility on 02/06/26 between 7:21am and 7:52am revealed:
-Surveyor began knocking at the front door at 7:21am.
-The Administrator answered the door at 7:30am.
-Upon entrance of the facility, the surveyor observed the Administrator holding her stomach and grimacing.
-The Administrator stated her stomach was hurting, she had been up all night, was not feeling well and planned to go the emergency department when the other staff arrived.
-There were no lights on in the facility.
-Two residents were lying in bed but were wide awake.
-Two residents were in bed sleeping.
-There was a urine odor in two resident rooms.
-There was no other staff in the facility except the Administrator.
-At 7:52am, a PCA arrived at the facility.

Second interview with the PCA on 02/06/26 at 8:26am revealed:
-She provided personal care to all residents in the facility on the days she worked since the other PCA quit on Wednesday, 02/04/26.
-The Administrator did not help her with providing personal care to the residents.
-The Administrator just watched her on the cameras in the residents' rooms.

Observation of the facility on 02/06/26 at 10:32am revealed the Administrator left the facility so only one PCA was left at the facility to care for 4

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C 242	Continued From page 49 residents, including 3 non-ambulatory residents. Telephone interview with a former PCA on 02/09/26 at 10:45am revealed: -She worked at the facility for about 6 months, but her last day was Wednesday, 02/04/26. -She worked as a PCA at the facility from 9:00am - 5:00pm on Mondays - Fridays. -She was the only PCA working on Mondays, Tuesdays, and Wednesdays. -The hospice aide would come on Wednesdays. -The facility's other PCA came in at 3:00pm on Thursdays and helped her get the residents in bed that night. -She provided meals and provided personal care to residents when she worked at the facility. -When she arrived to the facility each morning at 9:00am, all residents were still in bed. -She was responsible for getting all residents up except for one resident who got herself up. -Sometimes when she arrived in the mornings, the residents would be wet and the urine would be soaked through the incontinence brief down to the incontinence pad. -Sometimes the residents would be soiled with feces as well. Interview with the Administrator on 02/09/26 at 3:41pm revealed: -She was not feeling well on Friday, 02/06/26. -Staff left the facility at 8:00pm on 02/05/26. -She was on duty after 8:00pm. -She checked the residents for incontinence at midnight and 4:00am. -She slept on and off during the night. -While she slept at night there was no other staff on duty to monitor the residents. -Facility staff came on duty at 8:00am. 1. Review of Resident #2's current FL-2 dated	C 242		

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C 242	Continued From page 50 03/29/25 revealed: -Diagnoses included unspecified dementia, metabolic encephalopathy, normal pressure hydrocephalus, seizures, myoclonus, and history of falling. -The resident was constantly disoriented. -The resident was semi-ambulatory and required assistance with bathing and dressing. -The resident was incontinent of bowel and bladder. -The resident's skin was documented as normal. Review of Resident #2's Resident Register revealed: -The resident was admitted to the facility on 03/21/25 from a skilled rehabilitation facility. -The resident required assistance for dressing, bathing, nail care, shaving, ambulation, correspondence, getting in/out of bed, toileting, hair/grooming, skin care, mouth care, feeding, positioning/turning, scheduling appointments, and orientation to time and place. -The resident had significant memory loss and must be directed. -The resident had a wheelchair, hearing aids, and eyeglasses. Review of Resident #2's current assessment and care plan dated 05/16/25 revealed: -The resident was non-ambulatory and had limited range of motion in his upper extremities. -The resident's skin and respirations were normal. -The resident had daily incontinence of bowel and bladder. -The resident was always disoriented, had significant memory loss, and must be directed. -The resident's vision was limited and he could hear loud sounds/voices. -The resident was documented as having no	C 242		

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C 242	Continued From page 51 speech. -The resident was totally dependent on staff assistance with eating, toileting, ambulation, bathing, dressing, grooming/personal hygiene, and transferring. -The resident's care plan was signed by a hospice nurse on 05/28/25. Interview with the personal care aide (PCA) on 02/05/26 at 11:12am revealed: -Resident #2 was always wet and sometimes soiled with feces when she arrived at 8:00am on her workdays. -Resident #2 had skin breakdown on his "tailbone" but she did not recall how long he had the skin breakdown. Observation of Resident #2 on 02/06/26 at 7:45am revealed: -The double doors to Resident #2's room were closed. -After knocking and upon entry, the resident was alone in the room. -There were no lights on in the room, but some light was coming through the closed window blinds. -Resident #2 was lying in bed with his eyes opened but he did not speak or attempt to speak when spoken to. -The resident was lying in a hospital bed with bilateral half rails in the up position and the head of the bed was partially raised. -The resident was lying on his right side under the covers with his legs pulled up close to his body. -There was a light odor of urine in the room near the resident and his bed. -There were two oral syringes lying on the bedside table beside the bowl of applesauce. -One of the oral syringes contained applesauce and the other oral syringe was empty.	C 242		

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C 242	Continued From page 52 -There was a navy blue insulated cup with a lid and straw on the bedside table beside one of the oral syringes. Second observation of Resident #2 on 02/06/26 at 8:53am revealed: -The PCA went into Resident #2's room. -The resident was still lying in his hospital bed in the same position as observed at 7:45am. -The resident grimaced when the PCA attempted to move his legs, so the PCA stopped and went out of the room. Third observation of the PCA on 02/06/26 at 8:54am revealed: -The PCA left Resident #2's room without providing any personal care to the resident. -Resident #2 was lying in bed in the same position as 7:45am that morning. -The PCA walked back into the living room area. Interview with the Administrator on 02/06/26 at 9:11am revealed: -Resident #2 had not been doing well the last couple of days. -Resident #2 was a hospice patient and she thought the resident was transitioning (when the body begins shutting down and preparing for death). Observation of the facility on 02/06/26 at 9:41am revealed: -Resident #2's family member arrived at the facility. -Resident #2 had not been assisted from his bed to his Broda wheelchair and no one had provided incontinent care to the resident that morning or fed him breakfast. Interview with the Administrator on 02/06/26 at	C 242		

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C 242	Continued From page 53 9:55am revealed she was about to leave the facility to take herself to the hospital. Review of Resident #2's previous hospice provider visit note dated 12/22/25 revealed: -The resident looked to be uncomfortable, making groaning sounds and restless in his Broda chair (a specialized wheelchair designed for those with mobility challenges, emphasizing comfort, support, and enhanced mobility especially for those who may have difficulty sitting for extended periods). -The nurse was unable to obtain the resident's blood pressure due to movement and continuous flexion in his arms. -The resident was dependent on staff for all activities of daily living (ADLs) and he was unable to make his needs known. -The resident was a 1 - 2 person assist and could be transferred to his Broda chair. -The resident's legs stayed crossed at the ankles and when the nurse uncrossed his legs, the resident immediately began recrossing his legs. -The resident had very poor range of motion in his bilateral upper and lower extremities. -The resident's skin was "dusky, cool, and dry to touch"; the resident had thin, fragile skin. -The resident had a new stage 1 pressure injury noted on his coccyx/sacrum area. -The nurse cleansed the area and applied thick barrier cream and a foam pad. Review of Resident #2's previous hospice provider visit note dated 12/24/25 revealed: -On 10/10/25, the resident developed a stage II coccyx wound that had healed. -On 12/22/25, the resident had a re-developed stage II pressure wound to sacrum. Review of Resident #2's previous hospice	C 242		

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HEARTS OF GOLD FAMILY CARE	1004 EDENBURGHS KEEP DR KNIGHTDALE, NC 27545

(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
C 242	Continued From page 54 provider visit note dated 01/21/26 revealed: -The resident required total care with all activities of daily living including feeding. -The resident was chairbound and used a Broda chair. Interview with Resident #2's previous hospice aide on 01/23/26 at 8:46am revealed: -The Administrator was sometimes the only staff member on duty upon her arrival. -Residents #2 was awake but remained in bed between 11:00am and 12:00pm when she arrived. -Residents #2 was heavily soiled when she arrived around 11:00am. -She could not recall specific dates and times; however, the information was documented in the agency's notes. Interview with Resident #2's previous hospice nurse on 01/23/26 at 9:05am revealed: -She began providing services to Resident #2 in November 2025. -She provided services to Resident #2 on Wednesdays. -She expressed concerns of neglect for Resident #2 when she entered the facility. -She documented her concerns in her nursing progress notes. -Resident #2 was always in bed when she arrived at approximately 12:00pm. -She would typically get residents out of bed when she arrived; however, the Administrator requested that she not get Resident #2 out of bed. -On 01/21/26 at approximately 12:15pm, Resident #2 was heavily soiled with double pads underneath him and urine had seeped into the mattress. -She observed Resident #2 and wearing double	C 242		

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C 242	Continued From page 55 briefs approximately 2 to 3 times during the month of November 2025 and December 2025. -She witnessed Resident #2 soaked in urine, with urine saturating the sheets, mattress, and floor during her weekly visits. -Her nursing specialty was wound care. -She was concerned that the Administrator was not following physician orders for Resident #2. -She completed an incident report after observing the Administrator apply Calcium Alginate to Resident #2's buttocks, which caused skin deterioration and resulted in a wound on the coccyx. -The wound measured 0.2 cm x 0.2 cm and was progressing toward a Stage III pressure injury. -The Calcium Alginate "ate away" viable tissue. -The wound edges showed erythema and maceration, which were (common signs of periwound skin damage caused by excessive moisture and irritation) due to prolonged exposure to urine. -She addressed concerns with the Administrator, who stated she would do what she wanted to do. -She made several attempts to educate the Administrator regarding appropriate wound care, but the Administrator refused to follow recommendations. -She recommended a urinary catheter to reduce moisture-related skin breakdown; the Administrator refused. -There was a physician order to use a Hoyer lift for transfers; however, the Administrator refused to use the Hoyer lift and instead lifted the resident under his arms. -Resident #2 was observed to be consistently kept in bed. Interview with Resident #2's current hospice nurse on 02/06/26 at 10:08am revealed: -Her hospice agency started providing hospice	C 242		

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C 242	Continued From page 56 services to Resident #2 on 01/24/26. -Resident #2 was seen by a different hospice agency prior to that date. -Resident #2 already had a stage 2 pressure ulcer on his sacrum and scratches mostly on his right arm when they started services with the resident. -When she came to the facility on Wednesday, 02/04/26, Resident #2 was soaked in heavy urine and it was soaked through the hoyer lift pad and the incontinence pad. Observation of the facility on 02/06/26 at 10:18am revealed: -The Administrator was outside, ready to leave. -Surveyor went outside to inform the Administrator the hospice nurse and Resident #2's family member were looking for her. -The Administrator came back inside the facility. Second interview with Resident #2's current hospice nurse on 02/06/26 at 10:20am revealed: -She had to find the Administrator today to get the supplies to do a dressing change on Resident #2's pressure ulcer. -The supplies were locked in the medication closet. Observation of Resident #2 on 02/06/26 from 10:21am - 10:30am revealed: -The resident was lying in his hospital bed. -The PCA was in the room preparing to provide incontinence care and the hospice nurse was going to change the resident's dressing on his sacral pressure ulcer. -Resident #2 grimaced when they lowered the head of the bed to the down position. -The Administrator came in the resident's room with wound supplies for the resident's sacral pressure ulcer.	C 242		

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C 242	Continued From page 57 -The resident's incontinence brief was saturated with urine as well as the incontinence pad and the bed sheets. -The back of Resident #2's blue shirt was soaked in urine from the bottom of the shirt up to the resident's shoulder blades. -The hospice nurse removed a bordered foam dressing from the resident's sacral area. -There was a sacral wound with approximately a 2cm open area in the middle with pink tissue present and the surrounding tissue was pale purplish in color. -There was an approximately 2 - 3cm superficial open area with red tissue on the resident's right hip area. -The resident grimaced multiple times as the hospice nurse and PCA changed his clothing. Third interview with Resident #2's current hospice nurse on 02/06/26 at 10:30am revealed: -She assessed Resident #2's pain using the "PAINAD" scale. (The PAINAD scale is specifically designed to assess pain in those who may be unable to communicate their discomfort verbally, such as those with dementia or other cognitive impairments. The scoring based on breathing, vocalization, facial expression, body language, and consolability. Interpretation of scores is 0 - 3 = mild pain; 4 - 6 = moderate pain; and 7 - 10 = severe pain.) -She assessed Resident #2's pain this morning at a score of 6 (moderate pain). -Resident #2's stage 2 pressure ulcer on his sacral area looked about the same as it did when she saw it on Wednesday, 02/04/26. -The reddened area on his right hip area was not there on Wednesday, 02/04/26, when she saw the resident. -She thought the resident may have scratched himself causing the wound on his right hip	C 242		

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because he had a tendency to scratch his arms also.
-Their hospice agency's biggest goal for Resident #2 was comfort and pain control.
-She was going to discuss moving Resident #2 to hospice respite care with the resident's family.

Interview with the PCA on 02/06/26 at 10:35am revealed the reddened scratched area on Resident #2's right hip was not there yesterday, 02/05/26, when she provided care to the resident.

Fourth interview with Resident #2's current hospice nurse on 02/06/26 at 11:10am revealed:
-She found Resident #2 wet and saturated with urine on Wednesday, 02/04/26, and again today, 02/06/26.
-The hospice agency had decided to remove Resident #2 from the facility today, 02/06/26.
-Resident #2 was exhibiting active pain.
-The Administrator had left the facility and there was no medication aide (MA) to administer medications and only one PCA to provide care for the residents currently.
-They were concerned about the facility not providing supervision and personal care to the residents.
-Resident #2 was known to have pain so they were concerned without a MA at the facility, the residents' pain would not be treated.

Interview with the Administrator on 02/09/26 at 3:41pm revealed:
-She was awake every 2 hours to provide water to Resident #2 to prevent him from being dehydrated.
-She did not check Resident #2 for incontinence every 2 hours.
-While she slept at night there was no other staff on duty to monitor the residents.

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C 242	Continued From page 59 -Facility staff came on duty at 8:00am. Interview with the Administrator on 02/10/26 at 11:04am revealed: -A lot of times, Resident #2's incontinence pad was wet and not his incontinence brief because the resident would urinate outside of the incontinence brief. -Sometimes Resident #2 did not urinate all night and sometimes he urinated a lot. -She checked on the residents about 11:00pm at night and if they were wet, she would change them. -She checked on the residents again around 4:00am. -Resident #2 being saturated with urine on Wednesday, 02/04/26, and Friday, 02/06/26, was probably because it had been more than 4 hours since the resident was changed. Observation of Resident #2 on 02/06/26 at 2:35pm revealed Resident #2 was picked up by a transport service at the facility to be moved to a skilled nursing facility for 5-day emergency respite care through the hospice agency. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable. 2. Review of Resident #4's current FL-2 dated 03/18/25 revealed: -Diagnoses included dementia, functional quadriplegia, hypertension, congestive heart failure, general muscle weakness, atrial fibrillation, major depressive disorder, and metabolic encephalopathy. -The resident was non-ambulatory and required assistance with bathing and dressing. -The resident was incontinent of bowel and	C 242		

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bladder.
-The resident's skin was documented as normal.

Review of Resident #4's Resident Register revealed:
-The resident was admitted to the facility on 03/25/25 from a skilled rehabilitation facility.
-The resident required assistance for dressing, bathing, nail care, ambulation, correspondence, getting in/out of bed, toileting, hair/grooming, skin care, mouth care, positioning/turning, scheduling appointments, and orientation to time and place.
-The resident had significant memory loss and must be directed.
-The resident had a wheelchair and hearing aids.

Review of Resident #4's current assessment and care plan dated 03/24/25 revealed:
-The resident was non-ambulatory and had limited range of motion in his upper extremities.
-The resident's skin and respirations were normal.
-The resident had daily incontinence of bowel and bladder.
-The resident was sometimes disoriented, forgetful and needed reminders.
-The resident's hearing was very limited and the resident had hearing aids.
-The resident was totally dependent on staff assistance with toileting, ambulation, bathing, dressing, grooming/personal hygiene, and transferring.
-The resident was independent with eating.
-The resident's care plan was signed by the Administrator on 03/24/25.

Interview with Resident #4's previous hospice aide on 01/23/26 at 8:46am revealed:
-The Administrator was sometimes the only staff member on duty upon her arrival.

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C 242	Continued From page 61 -Resident #4 was awake but remained in bed between 11:00am and 12:00pm when she arrived. -Resident #4 was heavily soiled when she arrived around 11:00am. -She could not recall specific dates and times; however, the information was documented in the agency's notes. Interview with Resident #4's previous hospice nurse on 01/23/26 at 9:05am revealed: -She began providing services to Resident #4 in November 2025. -She provided services to Resident #4 on Wednesdays. -She expressed concerns of neglect for Resident #4 when she entered the facility. -She documented her concerns in her nursing progress notes. -Resident #4 was always in bed when she arrived at approximately 12:00pm. -On 01/21/26 at approximately 12:15pm., Resident #4 was heavily soiled with double pads underneath her and urine had seeped into the mattress. -She observed Resident #4 wearing double briefs approximately 2 to 3 times during the month of November 2025 and December 2025. -She witnessed Resident #4 soaked in urine, with urine saturating the sheets, mattress, and floor during her weekly visits. Observation of Resident #4's room on 02/06/26 at 7:49am revealed: -The door to the room was closed. -After knocking and upon entry, there were two residents alone in the room. -There were no lights on in the room, but some light was coming through the closed window blinds.	C 242		

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C 242	Continued From page 62 -Resident #4 was lying in her hospital bed with bilateral half bedrails in the up position. -Resident #4 was awake with her eyes opened. -Resident #4 was lying on her back under the bed covers. -There was a strong odor of urine in the room. Observation of Resident #4 on 02/06/26 at 8:26am revealed: -The personal care aide (PCA) went into Resident #4's room to provide personal care to the resident. -Resident #4 was still lying in bed with her eyes open. -Resident #4's incontinence brief was saturated with dark yellow urine stains and there were clumps of wet body powder in the brief and on the resident's perineal and buttocks area. -There was a large brown bowel movement that was stuck to the resident's skin and had to be wiped several times to remove it. -The blue hoyer lift pad underneath the resident was saturated with urine. -The incontinence pad underneath the hoyer lift pad was saturated and stained with yellow urine and had lumps of body powder scattered on top of the pad. -There resident's skin on her bottom was slightly pink and there were no open areas or skin breakdown. Interview with the PCA on 02/06/26 at 8:26am revealed: -Resident #4 was always wet when she provided incontinence care to the resident when she came in the mornings. -The resident was never dry in the mornings. -The resident's incontinence brief, hoyer lift pad, and incontinence pad were always wet in the mornings.	C 242		

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C 242	Continued From page 63 -The resident was also frequently soiled with feces when she came in the mornings. -The resident was "over 300 pounds" and should be assisted by two staff with incontinence care and transferring. -When she was the only PCA working, the Administrator did not offer to help her provide care to Resident #4. -She thought the Administrator would help if she asked her, but she should not have to ask the Administrator for help because the Administrator knew Resident #4 was a 2-person assist. -She had never noticed any redness or skin breakdown on Resident #4. -Before the former PCA quit on Wednesday, 02/04/26, they were both at the facility on Thursdays and Fridays and they both provided assistance to Resident #4 together. -They also used a hoyer lift to transfer Resident #4 and now she had to use the hoyer lift by herself since the other PCA quit. -The former PCA used to work on Mondays - Fridays from 9:30am - 5:30pm. -After the PCA provided incontinence care to Resident #4 and changed the resident's clothes while the resident was in bed, the PCA left the resident in bed and stated she needed a break. Interview with the Administrator on 02/06/26 at 9:21am revealed she was going to leave the facility to go to the hospital since she was not feeling well. Observation of the facility on 02/06/26 from 9:47am - 9:55am revealed: -The PCA knocked on the Administrator's bedroom door but the Administrator did not open the door. -The PCA knocked on the door again one minute later and the Administrator came out of the	C 242		

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C 242	Continued From page 64 bedroom. -The Administrator sanitized her hands and went to Resident #4's room with the PCA. -The Administrator assisted the PCA with putting on the resident's pants and repositioning the resident in bed. -The resident was left lying in bed. -The resident was not gotten up by staff and had not been served breakfast. -At 9:55am, the Administrator came out of Resident #4's room. Observation of Resident #4 on 02/06/25 at 10:53am revealed the resident was in bed eating breakfast. Interview with Resident #4's hospice nurse on 02/06/26 at 11:10am revealed: -The hospice agency had decided to remove Resident #4 from the facility today, 02/06/26. -The Administrator had left the facility and there was no medication aide (MA) to administer medications and only one PCA to care for the residents currently. -When she arrived to the facility on Wednesday, 02/04/26 at 10:53am, Resident #4 was eating breakfast in bed and was not dressed yet. -The Administrator was the only staff at the facility when she arrived on 02/04/26 at 10:53am. -They were concerned about the facility not providing supervision and personal care to the residents. -Resident #4 was known to have pain so they were concerned without a MA at the facility, the residents' pain would not be treated. Observation of Resident #4 on 02/06/26 at 5:40pm revealed Resident #4 was picked up by a transport service at the facility to be moved to a skilled nursing facility for 5-day emergency respite	C 242		

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C 242	Continued From page 65 care through the hospice agency. Interview with the Administrator on 02/10/26 at 11:04am revealed: -She checked on the residents about 11:00pm at night and if they were wet, she would change them. -She checked on the residents again around 4:00am. -Resident #4 being saturated with urine on Wednesday, 02/04/26, and Friday, 02/06/26, was probably because it had been more than 4 hours since the resident was changed. Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable. _____ The facility failed to provide personal care to two non-ambulatory residents who were receiving hospice services (#2, #4). Resident #2, who had a stage 2 pressure ulcer on his sacral area, was found saturated in urine on the mornings of 02/04/26 and 02/06/26, including the incontinence pad, bed sheets, and the back of his shirt up to his shoulder blades. Resident #4 was found saturated in urine and soiled in feces on the mornings of 02/04/26 and 02/06/26 including urine saturated in the hoyer lift pad and incontinence pad. A PCA, a previous hospice aide and a previous hospice nurse reported the residents were always wet and saturated in urine and/or soiled with feces. This failure of the facility resulted in serious neglect of the residents and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/09/26 for this violation.	C 242		

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C 242	Continued From page 66 THIS FACILITY WAS ISSUED A SUMMARY SUSPENSION ON 02/12/26.	C 242		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .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: Based on observations, interviews, and record reviews, the facility failed to ensure health care coordination and follow-up for 1 of 4 sampled residents (#2) by failing to notify the hospice provider of a change and deterioration in the resident's condition. The findings are: Review of Resident #2's current FL-2 dated 03/29/25 revealed: -Diagnoses included unspecified dementia, metabolic encephalopathy, normal pressure hydrocephalus, seizures, myoclonus, and history of falling. -The resident was constantly disoriented. -The resident was semi-ambulatory and required assistance with bathing and dressing. -The resident was incontinent of bowel and bladder. Review of Resident #2's Resident Register revealed: -The resident was admitted to the facility on 03/21/25 from a skilled rehabilitation facility. -The resident required assistance for dressing, bathing, nail care, shaving, ambulation, correspondence, getting in/out of bed, toileting,	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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HEARTS OF GOLD FAMILY CARE	1004 EDENBURGHS KEEP DR KNIGHTDALE, NC 27545

(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
C 246	Continued From page 67 hair/grooming, skin care, mouth care, feeding, positioning/turning, scheduling appointments, and orientation to time and place. -The resident had significant memory loss and must be directed. -The resident had a wheelchair, hearing aids, and eyeglasses. Review of Resident #2's current assessment and care plan dated 05/16/25 revealed: -The resident was non-ambulatory and had limited range of motion in his upper extremities. -The resident's skin and respirations were normal. -The resident had daily incontinence of bowel and bladder. -The resident was always disoriented, had significant memory loss, and must be directed. -The resident's vision was limited and he could hear loud sounds/voices. -The resident was documented as having no speech. -The resident was totally dependent on staff assistance with eating, toileting, ambulation, bathing, dressing, grooming/personal hygiene, and transferring. Review of Resident #2's hospice visit note dated 01/21/26 revealed: -The resident required total care with all activities of daily living including feeding. -The resident was chairbound and used a Broda chair (a specialized wheelchair designed for those with mobility challenges, emphasizing comfort, support, and enhanced mobility especially for those who may have difficulty sitting for extended periods). -The resident ate approximately 50% of two small meals per day.	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 246	Continued From page 68 Observation of Resident #2 on 02/05/26 at 10:19am revealed: -Resident #2 was lying in bed with his eyes opened but he did not speak or attempt to speak when spoken to. -The resident was lying in a hospital bed with bilateral half bedrails in the up position and the head of the bed was partially raised. -The resident was lying on his right side under the covers with his legs pulled up close to his body. -There was an oral syringe lying on the bedside table near the bed with a pink, clear liquid inside the oral syringe. -There was a navy blue insulated cup with a lid and straw on the bedside table beside the oral syringe. Interview with the Administrator on 02/05/26 at 10:30am revealed: -The pink, clear liquid in the oral syringe in Resident #2's room was a flavored hydration drink she had mixed in water for Resident #2. -Resident #2 usually drank from the insulated cup with a straw but the resident would not drink from the straw that morning, 02/05/26, which was unusual for him. -She was using the oral syringe to give the resident fluids by mouth and to feed the resident that morning. -She did not usually have to use an oral syringe to feed the resident. Interview with the personal care aide (PCA) on 02/05/26 at 11:12am revealed: -Resident #2 did not usually need an oral syringe to drink or eat except for his crushed medications mixed in applesauce. -Resident #2 usually drank out of a cup with a straw so needing to drink out of a syringe this morning was not normal for the resident.	C 246		

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C 246	Continued From page 69 Second observation of Resident #2 on 02/06/26 at 7:45am revealed: -Resident #2 was lying in bed with his eyes opened but he did not speak or attempt to speak when spoken to. -The resident was lying in a hospital bed with bilateral half rails in the up position and the head of the bed was partially raised. -The resident was lying on his right side under the covers with his legs pulled up close to his body. -There was small white bowl with applesauce on the bedside table near the bed. -There were two oral syringes lying on the bedside table beside the bowl of applesauce. -One of the oral syringes contained applesauce and the other oral syringe was empty. -There was a navy blue insulated cup with a lid and straw on the bedside table beside one of the oral syringes. Third observation of Resident #2 on 02/06/26 at 8:53am revealed: -The PCA went into Resident #2's room. -The resident was still lying in his hospital bed in the same position as observed at 7:45am. -The resident grimaced when the PCA attempted to move his legs, so the PCA stopped and went out of the room. Second interview with the PCA on 02/06/26 at 8:53am revealed: -When she came in yesterday, 02/05/26, she noticed Resident #2 was not moving around as much. -She was unable to get the resident up in his chair. -The resident's legs were "more contracted" today. -She stopped trying to move the resident when he	C 246		

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C 246	Continued From page 70 grimaced because that meant he was in pain. Second interview with the Administrator on 02/06/26 at 9:11am revealed: -Resident #2 had not been doing well the last couple of days. -Resident #2 was a hospice patient and she thought the resident was transitioning (when the body begins shutting down and preparing for death). Third interview with the PCA on 02/06/26 at 9:39am revealed: -Resident #2 had not been opening his mouth to eat at least since yesterday, 02/05/26. -Resident #2 ate 30% of his supper meal last night. -She was going to try to feed Resident #2 this morning. -The Administrator was aware that Resident #2 had not been opening his mouth to eat. -She did not know if the resident's hospice provider had been notified. Third interview with the Administrator on 02/10/26 at 11:04am revealed: -On Thursday, 02/05/26, Resident #2 was "really lethargic", so she let him stay in bed all day and she gave him liquids. -Resident #2 usually sat up in his wheelchair every day. -If she had any questions about Resident #2's change in condition on 02/05/26, she would have called hospice. Interview with Resident #2's hospice nurse on 02/06/26 at 10:08am revealed: -Her hospice agency started providing hospice services to Resident #2 on 01/24/26. -Resident #2 was seen by a different hospice	C 246		

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C 246	Continued From page 71 agency prior to that date. -The facility could call their hospice agency 24 hours a day, 7 days a week if they needed anything. -When she saw Resident #2 on Wednesday, 02/04/26, he was alert and not as lethargic as today and he also made a gurgling noise, so she ordered some as needed (prn) medication for secretions. -She thought the resident may be starting to transition. -No one from the facility had notified her of the resident's decline yesterday, 02/05/26. -She would expect the facility staff to notify her of a change in Resident #2's condition 24 hours a day. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable.	C 246		
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .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: Based on observations, interviews, and record reviews, the facility failed to ensure blood sugar readings were implemented as ordered for 1 of 1 sampled residents with orders to check blood	C 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 249	Continued From page 72 sugars (#3). The findings are: Review of Resident #3's current FL-2 dated 07/04/25 revealed: -Diagnosis included right urethral stone and diabetes. -The resident was constantly disoriented. -The resident was incontinent with a suprapubic catheter. Review of Resident #3's signed physician's orders dated 07/04/25 revealed there was an order for Insulin Lispro, check and record blood sugar twice per day before lunch and dinner. (Lispro is rapid-acting insulin is used to treat diabetes). Review of Resident #3's December 2025 medication administration record (MAR) revealed there were no blood sugar readings recorded. Review of Resident #3's record revealed there were no MARs for January 2026 and February 2026. Observation of Resident #3's Brand A glucometer on 02/09/26 at 11:31am revealed: -The Administrator retrieved the glucometer from the Administrator's bedroom and indicated it belonged to Resident #3. -The glucometer was not labeled with any name on it. -The current date and time programmed in the glucometer was 02/09/26 at 1:08pm (1 hour and 37 minutes ahead of the current date and time. -There were only 8 readings in the memory of the glucometer since 12/26/25 at 7:46pm. -The blood sugar readings in the glucometer from	C 249		

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C 249	Continued From page 73 12/26/25 - 02/08/26 ranged from 143 - 346. -The resident's last 8 blood sugars in the memory included: 02/08/26 at 3:12pm = 203; 02/07/26 at 3:55pm = 143; 02/06/26 at 3:01pm = 212; 02/05/26 at 3:13pm = 311; 02/01/26 at 6:39pm = 211; 01/11/26 at 3:31pm = 219; 12/30/25 at 7:16pm = 216; and 12/26/25 at 7:46pm = 346. Interview with the Administrator on 02/10/26 at 11:04am revealed: -Resident #3 was the only diabetic resident in the facility. -She only used Resident #3's Brand A glucometer for Resident #3. -She checked Resident #3's blood sugar twice a day, in the afternoon and in the evening. -She thought the missing blood sugars from the Brand A glucometer may have been when she used a different Brand B glucometer for Resident #3 when the battery died in the Brand A glucometer. -She used a new Brand B glucometer to check Resident #3's blood sugar until she replaced the battery in the Brand A glucometer. -She could not recall the dates she used the Brand B glucometer to check Resident #3's blood sugar but she had been using the Brand A glucometer again for about 1 and ½ weeks. -She no longer had the Brand B glucometer because she did not like it, so she threw it away. Interview with Resident #3 on 02/05/26 at 10:42am revealed: -She was diabetic. -She thought her blood sugar was supposed to be checked everyday, but she was not sure how often it was being checked or when it was last checked. -She thought her blood sugar was running "okay" when it was checked.	C 249		

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C 249	Continued From page 74 Interview with Resident #3's primary care provider (PCP) on 02/10/26 at 2:22pm revealed: -She requested Resident #3's blood sugar readings in October 2025 but the Administrator sent her the blood sugar readings for June 2025. -She requested Resident #3's blood sugar readings the last time she was in the facility on 01/12/26 and was told by the Administrator she would email them to her. -She never received Resident #3's blood sugar readings in January 2026. -She was concerned the facility was not checking the residents' blood sugar because it could be high which could cause a hyperglycemic episode or organ failure. Second interview with the Administrator on 02/10/26 at 4:49pm revealed: -Resident #3 had an order for her blood sugar to be checked twice per day. -She recorded the blood sugar checks for Resident #3 on a sticky note and on the MAR. -She knew some blood sugar readings for Resident #3 were missing because she had not recorded them.	C 249		
C 254	10A NCAC 13G .0903(c) Licensed Health Professional Support 10A NCAC 13G .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist, respiratory care practitioner, or physical therapist in the on-site review and evaluation of the residents' health status, care plan, and care provided, as required in Paragraph (a) of this Rule, is completed within 30 days after admission	C 254		

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C 254	Continued From page 75 or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the quarterly licensed health professional support (LHPS) reviews and evaluations for 2 of 3 sampled residents (#2, #3) with LHPS tasks were completed quarterly and included a physical assessment, evaluation of care provided, and recommendations based on the physical assessment and evaluation of the residents including tasks for assistance with ambulation and transferring (#2, #3), medication through injection (#3), medication through inhalation (#2), collecting and testing of fingerstick blood sugars (#3), clean dressing changes (#2), care for pressure ulcers (#2), and care of a urinary catheter (#3). The findings are: 1. Review of Resident #2's current FL-2 dated	C 254		

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C 254	Continued From page 76 03/29/25 revealed: -Diagnoses included unspecified dementia, metabolic encephalopathy, normal pressure hydrocephalus, seizures, myoclonus, and history of falling. -The resident was constantly disoriented. -The resident was semi-ambulatory and required assistance with bathing and dressing. Review of Resident #2's Resident Register revealed: -The resident was admitted to the facility on 03/21/25 from a skilled rehabilitation facility. -The resident required assistance for dressing, bathing, nail care, shaving, ambulation, correspondence, getting in/out of bed, toileting, hair/grooming, skin care, mouth care, feeding, positioning/turning, scheduling appointments, and orientation to time and place. -The resident had significant memory loss and must be directed. -The resident had a wheelchair. Review of Resident #2's current assessment and care plan dated 05/16/25 revealed: -The resident was non-ambulatory and had limited range of motion in his upper extremities. -The resident had daily incontinence of bowel and bladder. -The resident was always disoriented, had significant memory loss, and must be directed. -The resident was totally dependent on staff assistance with eating, toileting, ambulation, bathing, dressing, grooming/personal hygiene, and transferring. Review of Resident #2's physician's order dated 08/18/25 revealed an order for Duoneb 1 vial via nebulizer every 6 hours as needed (prn) for shortness of breath. (Duoneb is used to treat	C 254		

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C 254	Continued From page 77	C 254		

breathing problems and a nebulizer is a machine that converts the Duoneb into a mist to be inhaled.)

Review of Resident #2's hospice visit note dated 12/22/25 revealed:
-The resident was dependent for all activities of daily living and he was unable to make his needs known.
-The resident was a 1 - 2 person assist and could be transferred to his Broda chair (a specialized wheelchair designed for those with mobility challenges, emphasizing comfort, support, and enhanced mobility especially for those who may have difficulty sitting for extended periods).
-The resident's legs stayed crossed at the ankles and when the nurse uncrossed his legs, the resident immediately began recrossing his legs.
-The resident had very poor range of motion in his bilateral upper and lower extremities.
-The resident's skin was "dusky, cool, and dry to touch"; the resident had thin, fragile skin.
-The resident had a new stage 1 pressure injury noted on his coccyx/sacrum area.
-The nurse cleansed the area and applied thick barrier cream and a foam pad.

Review of Resident #2's hospice visit note dated 01/21/26 revealed:
-The resident required total care with all activities of daily living including feeding.
-The resident was chairbound and used a Broda chair.

Telephone interview with a former personal care aide (PCA) on 02/09/26 at 10:45am revealed:
-Resident #2 required personal care assistance with bathing, dressing, feeding, and transferring.
-The Administrator sometimes helped her get Resident #2 up and transferred to his wheelchair.

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C 254	Continued From page 78 -Sometimes, she was only staff person at the facility, and she would transfer the resident by herself. -Resident #2 had a sore on his bottom and the Administrator would put cream and a dressing on it. Observation of Resident #2 on 02/06/26 at 10:30am revealed: -The hospice nurse removed a bordered foam dressing from the resident's sacral area. -There was a sacral wound with approximately a 2cm open area in the middle with pink tissue present and the surrounding tissue was pale purplish in color. Telephone interview with Resident #2's previous hospice provider's case manager on 01/28/26 at 2:00pm revealed: -Their agency was providing hospice services for Resident #2 up until 01/24/26 when he was transferred to a different hospice agency. -Resident #2 previously had a sacral wound that they were managing with wet to dry dressings. -The wound to his sacrum had closed. -On the last visit with Resident #2 on 01/21/26 when the hospice nurse observed the resident's sacral area, a Calcium Alginate dressing had been applied instead of the ordered wet to dry dressing. (Calcium Alginate is primarily used to treat stage 3-4 pressure ulcers and promote a moist wound environment. A stage 3 pressure ulcer involves full thickness skin loss and exposure of the fatty tissue beneath. A stage 4 pressure ulcer extends down to the muscle, bone, or joints.) -On Resident #2's visit on 01/21/26, the area on his sacrum that was healed was now open and a Stage 2 pressure ulcer and the healthy tissue around the wound had deteriorated. (A stage 2	C 254		

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C 254	Continued From page 79	C 254		

pressure ulcer is partial thickness skin loss that looks like an abrasion or blister.)
-When staff asked the Administrator where the Calcium Alginate dressing came from and why she had applied it to Resident #2's sacral area she got "back and forth answers" about it.

Interview with Resident #2's current hospice nurse on 02/06/26 at 10:08am revealed:
-Her hospice agency started providing hospice services to Resident #2 on 01/24/26.
-Resident #2 was seen by a different hospice agency prior to that date.
-Resident #2 had already had a stage 2 pressure ulcer on his sacrum when they started services with the resident.
-Currently, they were applying Calcium Alginate and a bordered foam dressing to Resident #2's pressure ulcer on his sacrum twice a week.
-She last saw Resident #2's stage 2 pressure ulcer on Wednesday, 02/04/26, and it was healing at that time.

Review of Resident #2's record revealed Resident #2's licensed health professional support (LHPS) tasks included ambulation using assistive devices, transferring, medication through inhalation, clean dressing changes, and care for pressure ulcers.

Review of Resident #2's most current LHPS review dated 09/22/25 revealed:
-The nurse documented the resident's LHPS task was prn nebulizer.
-The nurse documented the resident used nebulizer daily as needed.
-There were no other LHPS tasks listed for Resident #2.
-There was no physical assessment documented on the LHPS form for any LHPS tasks, including

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C 254	Continued From page 80	C 254		

the nebulizer.
-The LHPS review did not address Resident #2's LHPS tasks of ambulation using an assistive device, transferring, clean dressing changes, or care of a pressure ulcer.
-There were no recommendations noted on the form.

Review of Resident #2's record revealed there was no quarterly LHPS evaluation since the one completed on 09/22/25.

Interview with the Administrator on 02/10/26 at 11:04am revealed:
-Resident #2's LHPS review was last completed on 09/22/25 because the resident was no longer using the nebulizer.
-Resident #2 required total assistance with activities of daily living including ambulation and transferring.
-Resident #2 was a 2-person assist but one staff person could transfer him.
-Resident #2 had a sore on his bottom that was healing better with no more drainage and it was now closed and dry to her knowledge.
-The hospice nurse was doing dressing changes, and she would put on a new dressing if one fell off.
-She was not aware all those tasks should be addressed on the LHPS quarterly reviews.

Interview with the facility's Landlord on 02/06/26 at 4:02pm revealed:
-She was a Registered Nurse (RN).
-She was not an employee of the facility.
-She owned the house and was the Landlord to the facility business owners.
-She did not recall doing an LHPS review for Resident #2.
-After reviewing the signature on Resident #2's

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C 254	Continued From page 81 LHPS review form, she confirmed it was her signature on the document. -She first stated the other writing on the LHPS form was not her handwriting but after a second look, she stated it was her handwriting. -She was aware she was supposed to include all of Resident #2's LHPS tasks in the LHPS review. -The Administrator had asked her to do an LHPS review for Resident #2's nebulizer only so she did not address any other LHPS tasks. -She was aware the LHPS review was supposed to include a physical assessment of the LHPS tasks. -She gave no explanation for not including a physical assessment with Resident #2's LHPS review. -She was aware LHPS reviews were to be done quarterly but no one at the facility had asked her to come back to do another LHPS review for Resident #2. Refer to interview with the Landlord on 02/06/26 at 4:05pm. Refer to interview with the Administrator on 02/09/26 at 8:25am. 2. Review of Resident #3's current FL-2 dated 07/04/25 revealed: -Diagnosis included right urethral stone and diabetes. -The resident was constantly disoriented. -The resident was incontinent with a suprapubic urinary catheter. -There was an order for Insulin Glargine 100unit/ml injection, inject 17 units daily. (Glargine is a long-acting insulin used to control type 1 or type 2 diabetes). -There was an order for Insulin Lispro, inject per facility protocol. (Lispro is a rapid-acting insulin	C 254		

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C 254	Continued From page 82 used to treat type 1 or type 2 diabetes). Review of Resident #3's current care plan dated 12/08/25 revealed: -She was totally dependent on toileting, ambulation, grooming and transferring. -She required extensive assistance with bathing and dressing. -There was no documentation of her insulin injections and blood sugar fingerstick. Observation of Resident #3 on 02/05/26 at 10:42am revealed: -A personal care aide (PCA) assisted Resident #3 with transferring from the bed to a wheelchair. -The resident had a urinary catheter bag hanging on the side of the wheelchair with dark yellow urine. Review of Resident #3's physician's orders dated 03/07/25 revealed there was an order to check and record blood sugars and administer Insulin Lispro per sliding scale; 201-250= 2 units, 251-300= 4 units; 301- 350= 6 units; 351- 400= 8 units; 401- 450= 10 units; 451- 500= 12 units; 500 or greater call primary care provider (PCP). Review of Resident #3's record revealed Resident #3's licensed health professional support (LHPS) tasks included ambulation using an assistive device, transferring, medication through injection, collecting and testing of fingerstick blood sugar, and care of a urinary catheter. Review of Resident #3's most current LHPS review dated 09/09/25 revealed: -The personal care task currently present was catheter care. -There was no documentation of the medication	C 254		

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C 254	Continued From page 83 administration through injection, collecting and testing of fingerstick blood sugars, ambulation using an assistive device, and transferring. -There was no documentation of a LHPS completed quarterly after 09/09/25. Interview with the Administrator on 02/09/26 at 8:25am revealed: -Resident #3 was never assessed for her fingerstick blood sugars and insulin injections. -She did not know Resident #3's fingerstick blood sugars and insulin injections were tasks. Refer to interview with the Landlord on 02/06/26 at 4:05pm. Refer to interview with the Administrator on 02/09/26 at 8:25am. _____ Interview with the Landlord on 02/06/26 at 4:05pm revealed: -She was a Registered Nurse (RN). -She had conducted LHPS tasks for the facility in the past. -Her signature appeared on LHPS task documentation for the facility. -She signed blank LHPS task forms at the request of the Administrator without conducting resident assessments. -She did not perform physical assessments prior to signing the LHPS documentation. Interview with the Administrator on 02/09/26 at 8:25am revealed: -The LHPS reviews were completed quarterly. -She completed the tasks information on the LHPS review forms. -She was responsible to ensure the residents' tasks were physically assessed and documented on the LHPS review form.	C 254		

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C 254	Continued From page 84 The facility failed to ensure a Registered Nurse completed quarterly licensed health professional support (LHPS) evaluations for two hospice residents (#2, #4). Resident #2's LHPS tasks included ambulation, transferring, medication through inhalation, clean dressing changes, and care of a pressure ulcer. There was no LHPS review with a physical assessment or recommendations for Resident #2 who had a stage 2 pressure ulcer on his sacral area. Resident #2's LHPS tasks included ambulation, transferring, medication through injections, fingerstick blood sugars, and care of urinary catheter. There was no LHPS review with a physical assessment or recommendations for Resident #2's LHPS tasks. This failure of the facility was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. THIS FACILITY WAS ISSUED A SUMMARY SUSPENSION ON 02/12/26.	C 254		
C 270	10A NCAC 13G .0904 (c)(7) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service Menus in Family Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by:	C 270		

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C 270	Continued From page 85 Based on observations, interviews and record reviews, the facility failed to have matching therapeutic menus for the guidance of food service staff for 3 of 3 sampled residents (#1, #3, #4) with physician orders for low sodium (#1), diabetic diet (#3), and heart healthy, mechanically soft (#4). The findings are: Review of the facility's menus on 01/06/26 revealed there were no menus for a low sodium diet, diabetic diet, or heart healthy mechanical soft. Observation of the kitchen on 02/06/26 between 7:30am and 9:47am revealed: -There was a diet extension spreadsheet for Friday. -The diet extension included therapeutic diet menus for a consistent carbohydrate, mechanical soft chop, mechanical soft ground, puree, no added salt, and finger food. 1. Review of Resident #1's current FL-2 dated 09/30/25 revealed: -Diagnoses included hypertension, Lewy body dementia, and osteoporosis. -There was a diet order for a low sodium diet. Refer to interview with the personal care aide on 02/06/26 between 10:10am and 10:49am. Refer to interview with the Administrator on 02/06/26 at 8:00am. 2. Review of Resident #3's current FL-2 dated 07/04/25 revealed: -Diagnosis included right urethral stone and diabetes.	C 270		

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C 270	Continued From page 86 -There was a diet order for a diabetic diet. Refer to interview with the personal care aide on 02/06/26 between 10:10am and 10:49am. Refer to interview with the Administrator on 02/06/26 at 8:00am. 3. Review of Resident #4's current FL-2 dated 03/18/25 revealed diagnoses included congestive heart failure, hypertension, metabolic encephalopathy and muscle weakness. Review of Resident #4's diet order dated 02/05/26 revealed a diet order for heart healthy, mechanically soft. Interview with the Administrator on 02/06/26 at 8:00am revealed: -Resident #4 did not eat mechanically soft food; she followed a regular menu. -She thought a heart healthy diet meant not adding salt to the food. Refer to interview with the personal care aide on 02/06/26 between 10:10am and 10:49am. Refer to interview with the Administrator on 02/06/26 at 8:00am. _____ Interview with the personal care aide on 02/06/26 between 10:10am and 10:49am revealed she knew there were therapeutic menus in the facility but she did not use them. Interview with the Administrator on 02/06/26 at 8:00am revealed: -The residents' diet orders were on their FL-2. -She did not have any difficult diet orders where she needed a therapeutic menu.	C 270		

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C 270	Continued From page 87 -She was aware the diet orders had to match the therapeutic menus but she did not understand.	C 270		
C 311	10A NCAC 13G .0909 Residents' Rights 10A NCAC 13G .0909 Resident Rights A family care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure residents were free from neglect as evidence by failure to attending to personal care needs for 2 of 4 sampled residents (#2, #4) who were non-ambulatory including failure to provide incontinence care and the residents being saturated with urine (#2, #4) and soiled with feces (#4) including one resident with a stage 2 pressure ulcer (#2); failure to administer a controlled substance pain medication to a hospice resident actively in pain requiring intervention by the hospice nurse and surveyor; and failed to provide residents with privacy as evidenced by an audio and video surveillance system being operational in all residents' rooms. The findings are: 1. Interview with a personal care aide (PCA) on 02/05/26 at 11:12am revealed: -The facility had no other staff now except for her and the Administrator. -There were no staff in the facility at night except for the Administrator.	C 311		

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C 311	Continued From page 88 -When she came in on her workdays at 8:00am in the morning, the residents were usually still in bed. -The residents were "always wet" and sometimes soiled with feces when she arrived in the mornings. Observation of the facility on 02/06/26 between 7:21am and 7:40am revealed: -Surveyor began knocking at the front door at 7:21am. -The Administrator answered the door at 7:30am. -Upon entrance of the facility, the surveyor observed the Administrator holding her stomach and grimacing. -The Administrator stated her stomach was hurting, she had been up all night, was not feeling well and planned to go the emergency department when the other staff arrived. -There were no lights on in the facility. -Two residents were lying in bed but were wide awake. -Two residents were in bed sleeping. -There was a urine odor in two resident rooms. -There was no other staff in the facility except the Administrator. Observation on 02/06/26 at 7:52am revealed a PCA arrived at the facility. Interview with the PCA on 02/06/26 at 8:26am revealed: -She provided personal care to all residents in the facility on the days she worked since the other PCA quit on Wednesday, 02/04/26. -The Administrator did not help her with providing personal care to the residents. Observation on 02/06/26 at 10:32am revealed the Administrator left the facility so only one PCA was	C 311		

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C 311	Continued From page 89 left at the facility to care for 4 residents, including 3 non-ambulatory residents. a. Review of Resident #2's current FL-2 dated 03/29/25 revealed: -Diagnoses included unspecified dementia, metabolic encephalopathy, normal pressure hydrocephalus, seizures, myoclonus, and history of falling. -The resident was constantly disoriented. -The resident was semi-ambulatory and required assistance with bathing and dressing. -The resident was incontinent of bowel and bladder. Review of Resident #2's current assessment and care plan dated 05/16/25 revealed: -The resident was non-ambulatory and had limited range of motion in his upper extremities. -The resident had daily incontinence of bowel and bladder. -The resident was always disoriented, had significant memory loss, and must be directed. -The resident was totally dependent on staff assistance with eating, toileting, ambulation, bathing, dressing, grooming/personal hygiene, and transferring. Review of Resident #2's hospice visit note dated 12/24/25 revealed: -On 10/10/25, the resident developed a stage II coccyx wound that had healed. -On 12/22/25, the resident had a re-developed stage II pressure wound to sacrum. Interview with the personal care aide (PCA) on 02/05/26 at 11:12am revealed: -Resident #2 was always wet and sometimes soiled when she arrived at 8:00am on her workdays.	C 311		

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C 311	Continued From page 90 -Resident #2 had skin breakdown on his "tailbone" but she did not recall how long he had the skin breakdown. Observation of Resident #2 on 02/06/26 at 7:45am revealed: -The double doors to Resident #2's room were closed. -After knocking and upon entry, the resident was alone in the room. -There were no lights on in the room, but some light was coming through the closed window blinds. -Resident #2 was lying in bed with his eyes opened but he did not speak or attempt to speak when spoken to. -The resident was lying in a hospital bed with bilateral half rails in the up position and the head of the bed was partially raised. -The resident was lying on his right side under the covers with his legs pulled up close to his body. -There was a purple blanket and a blue blanket covering the resident's body. -There was a light odor of urine in the room near the resident. Observation of Resident #2 on 02/06/26 at 8:53am revealed: -The PCA went into Resident #2's room. -The resident was still lying in his hospital bed in the same position as observed at 7:45am. -The resident grimaced when the PCA attempted to move his legs, so the PCA stopped and went out of the room. Observation of the PCA on 02/06/26 at 8:54am revealed: -The PCA left Resident #2's room without providing any personal care to the resident. -The PCA walked back into the living room area.	C 311		

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C 311	Continued From page 91 Observation of the facility on 02/06/26 at 9:41am revealed: -Resident #2's family member arrived at the facility. -Resident #2 had not been assisted from his bed to his wheelchair and no one had provided incontinence care to the resident that morning or fed him breakfast. Observation of the facility on 02/06/26 at 9:44am revealed Resident #2's hospice nurse arrived at the facility. Interview with the Administrator on 02/06/26 at 9:55am revealed she was about to leave the facility to take herself to the hospital. Observation of the Administrator on 02/06/26 at 10:01am revealed the Administrator walked out of the kitchen and reported she was going to the bathroom and then to the hospital. Interview with Resident #2's hospice nurse on 02/06/26 at 10:08am revealed: -Her hospice agency started providing hospice services to Resident #2 on 01/24/26. -Resident #2 was seen by a different hospice agency prior to that date. -Resident #2 had already had a stage 2 pressure ulcer on his sacrum and scratches mostly on his right arm when they started services with the resident. -When she came to the facility on Wednesday, 02/04/26, Resident #2 was soaked in heavy urine and it was soaked through the hoyer lift pad and the incontinence pad. Observation of the facility on 02/06/26 at 10:18am revealed:	C 311		

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C 311	Continued From page 92 -The Administrator was outside, ready to leave. -The surveyor went outside to inform the Administrator the hospice nurse and Resident #2's family member were looking for her. -The Administrator came back inside the facility. Interview with Resident #2's hospice nurse on 02/06/26 at 10:20am revealed: -She had to find the Administrator today to get the supplies to do a dressing change on Resident #2's pressure ulcer. -The supplies were locked in the medication closet. Observation of Resident #2 on 02/06/26 at 10:21am revealed: -The resident was lying in his hospital bed. -The PCA was in the room preparing to provide incontinence care and the hospice nurse was going to change the resident's dressing on his sacral pressure ulcer. -Resident #2 grimaced when they lowered the head of the bed to the down position. -The Administrator came in the resident's room with wound supplies for the resident's sacral pressure ulcer. Observation of Resident #2 on 02/06/26 at 10:30am revealed: -The resident's incontinence brief was saturated with urine as well as the incontinence pad and the bed sheets. -The back of Resident #2's blue shirt was soaked in urine from the bottom of the shirt up to the resident's shoulder blades. -The hospice nurse removed a bordered foam dressing from the resident's sacral area. -There was a sacral wound with approximately a 2cm open area in the middle with pink tissue present and the surrounding tissue was pale	C 311		

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C 311	Continued From page 93	C 311		

purplish in color.
-There was an approximately 2 - 3cm superficial open area with red tissue on the resident's right hip area.
-The resident grimaced multiple times as the hospice nurse and PCA changed his clothing.

Interview with Resident #2's hospice nurse on 02/06/26 at 10:30am revealed:
-Resident #2's stage 2 pressure ulcer on his sacral area looked about the same as it did when she saw it on Wednesday, 02/04/26.
-The reddened area on his right hip area was not there on Wednesday, 02/04/26, when she saw the resident.
-She thought the resident may have scratched himself causing the wound on his right hip because he had a tendency to scratch his arms also.
-Their hospice agency's biggest goal for Resident #2 was comfort and pain control.
-She was going to discuss moving Resident #2 to hospice respite care with the resident's family.

Interview with the hospice nurse on 02/06/26 at 11:10am revealed:
-She found Resident #2 wet and saturated with urine on Wednesday, 02/04/26, and again today, 02/06/26.
-The hospice agency had decided to remove Resident #2 from the facility today, 02/06/26.
-Resident #2 was exhibiting active pain.
-The Administrator had left the facility and there was no medication aide (MA) to administer medications and only one PCA to provide care for the residents currently.
-They were concerned about the facility not providing supervision and personal care to the residents.
-Resident #2 was known to have pain so they

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HEARTS OF GOLD FAMILY CARE	1004 EDENBURGHS KEEP DR KNIGHTDALE, NC 27545

(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
C 311	Continued From page 94 were concerned without a MA at the facility, the residents' pain would not be treated. Interview with the Administrator on 02/09/26 at 3:41pm revealed: -She was awake every 2 hours to provide water to Resident #2 to prevent him from being dehydrated. -She did not check Resident #2 for incontinence every 2 hours. -While she slept at night there was no other staff on duty to monitor the residents. -Facility staff came on duty at 8:00am. Interview with the Administrator on 02/10/26 at 11:04am revealed: -A lot of times, Resident #2's incontinence pad was wet and not his incontinence brief because he would urinate outside the incontinence brief. -Sometimes Resident #2 did not urinate all night and sometimes he urinated a lot. -She checked on the residents about 11:00pm at night and if they were wet, she would change them. -She checked on the residents again around 4:00am. -Resident #2 being saturated with urine on Wednesday, 02/04/26, and Friday, 02/06/26, was probably because it had been more than 4 hours since the resident was changed. Observation of Resident #2 on 02/06/26 at 2:35pm revealed Resident #2 was picked up by a transport service at the facility to be moved to a skilled nursing facility for 5-day emergency respite care through the hospice agency. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable.	C 311		

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C 311	Continued From page 95 [Refer to Tag 242, 10A NCAC 13G .0901(a) Personal Care and Supervision.] b. Review of Resident #4's current FL-2 dated 03/18/25 revealed: -Diagnoses included dementia, functional quadriplegia, hypertension, congestive heart failure, general muscle weakness, atrial fibrillation, major depressive disorder, and metabolic encephalopathy. -The resident was non-ambulatory and required assistance with bathing and dressing. -The resident was incontinent of bowel and bladder. Review of Resident #4's current assessment and care plan dated 03/24/25 revealed: -The resident was non-ambulatory and had limited range of motion in his upper extremities. -The resident had daily incontinence of bowel and bladder. -The resident was sometimes disoriented, forgetful and needed reminders. -The resident was totally dependent on staff assistance with toileting, ambulation, bathing, dressing, grooming/personal hygiene, and transferring. -The resident was independent with eating. Observation of Resident #4's room on 02/06/26 at 7:49am revealed: -The door to the room was closed. -After knocking and upon entry, there were two residents alone in the room. -There were no lights on in the room, but some light was coming through the closed window blinds. -Resident #4 was lying in her hospital bed with bilateral half bedrails in the up position.	C 311		

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C 311	Continued From page 96 -Resident #4 was awake with her eyes opened. -Resident #4 was lying on her back under the bed covers. -There was a strong odor of urine in the room. Observation of Resident #4 on 02/06/26 at 8:26am revealed: -The personal care aide (PCA) went into Resident #4's room to provide personal care to the resident. -Resident #4 was still lying in bed with her eyes open. -Resident #4's incontinence brief was saturated with dark yellow urine stains and there were clumps of wet body powder in the brief and on the resident's perineal and buttocks area. -There was a large brown bowel movement that was stuck to the resident's skin and had to be wiped several times to remove it. -The blue hoyer lift pad underneath the resident was saturated with urine. -The incontinence pad underneath the hoyer lift pad was saturated and stained with yellow urine and had lumps of body powder scattered on top of the pad. -There resident's skin on her bottom was slightly pink and there were no open areas or skin breakdown. Interview with the PCA on 02/06/26 at 8:26am revealed: -Resident #4 was always wet when she provided incontinence care to the resident when she came in the mornings. -The resident's incontinence brief, hoyer lift pad, and incontinence pad were always wet in the mornings. -The resident was also frequently soiled with feces when she came in the mornings. -The resident was "over 300 pounds" and should	C 311		

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be assisted by two staff with incontinence care and transferring.
-When she was the only PCA working, the Administrator did not offer to help her provide care to Resident #4.
-She had never noticed any redness or skin breakdown on Resident #4.
-After the PCA provided incontinence care to Resident #4 and changed the resident's clothes while the resident was in bed, the PCA left the resident in bed and stated she needed a break.

Interview with the Administrator on 02/06/26 at 9:21am revealed she was going to leave the facility to go to the hospital since she was not feeling well.

Observation of the facility on 02/06/26 from 9:47am - 9:55am revealed:
-The PCA knocked on the Administrator's bedroom door but the Administrator did not open the door.
-The PCA knocked on the door again one minute later and the Administrator came out of the bedroom.
-The Administrator sanitized her hands and went to Resident #4's room with the PCA.
-The Administrator assisted the PCA with putting on the resident's pants and repositioning the resident in bed.
-The resident was left lying in bed.
-The resident was not gotten up by staff and had not been served breakfast.
-At 9:55am, the Administrator came out of Resident #4's room.

Interview with the Administrator on 02/06/26 at 9:55am revealed she was about to leave the facility to take herself to the hospital.

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C 311	Continued From page 98 Observation of the Administrator on 02/06/26 at 10:01am revealed the Administrator walked out of the kitchen and reported she was going to the bathroom and then to the hospital. Interview with Resident #4's hospice nurse on 02/06/26 at 11:10am revealed: -The hospice agency had decided to remove Resident #4 from the facility today, 02/06/26. -The Administrator had left the facility and there was no medication aide (MA) to administer medications and only one PCA to care for the residents currently. -When she arrived at the facility on Wednesday, 02/04/26 at 10:53am, Resident #4 was eating breakfast in bed and was not dressed yet. -The Administrator was the only staff at the facility when she arrived on 02/04/26 at 10:53am. -They were concerned about the facility not providing "supervision and personal care" to the residents. -Resident #4 was known to have pain so they were concerned without a MA at the facility, the residents' pain would not be treated. Observation of Resident #4 on 02/06/26 at 5:40pm revealed Resident #4 was picked up by a transport service at the facility to be moved to a skilled nursing facility for 5-day emergency respite care through the hospice agency. Interview with the Administrator on 02/10/26 at 11:04am revealed: -She checked on the residents about 11:00pm at night and if they were wet, she would change them. -She checked on the residents again around 4:00am. -Resident #4 being saturated with urine on Wednesday, 02/04/26, and Friday, 02/06/26, was	C 311		

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C 311	Continued From page 99 probably because it had been more than 4 hours since the resident was changed. Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable. [Refer to Tag 242, 10A NCAC 13G .0901(a) Personal Care and Supervision.] 2. Review of Resident #2's current FL-2 dated 03/29/25 revealed diagnoses included unspecified dementia, metabolic encephalopathy, normal pressure hydrocephalus, seizures, myoclonus, and history of falling. Review of Resident #2's hospice order dated 01/05/26 revealed a new order to start Hydrocodone/Acetaminophen (APAP) 5/325mg 1 tablet every 6 hours as needed (prn) for pain. (Hydrocodone/APAP is a controlled substance used for moderate to severe pain.) Observation of Resident #2's medications on hand on 02/05/26 at 3:05pm revealed: -There was a supply of Hydrocodone/APAP 5/325mg dispensed on 01/27/26 with 56 tablets. -The instructions were to take 1 tablet every 6 hours as needed for pain. Observation of Resident #2 on 02/06/26 at 8:53am revealed: -The personal care aide (PCA) went into Resident #2's room. -The resident grimaced when the PCA attempted to move his legs, so the PCA stopped and went out of the room. Interview with the PCA on 02/06/26 at 8:53am revealed:	C 311		

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C 311	Continued From page 100 -When she came in yesterday, 02/05/26, she noticed Resident #2 was not moving around as much. -She was unable to get the resident up in his chair when he was "like this". -The resident's legs were "more contracted" today. -She stopped trying to move the resident when he grimaced because that meant he was in pain. Interview with the Administrator on 02/06/26 at 9:55am revealed: -She was about to leave the facility to take herself to the hospital. -She had administered the residents all the medication they would need. Observation of Resident #2 on 02/06/26 at 10:21am revealed: -The resident was lying in his hospital bed. -The PCA was in the room preparing to provide incontinence care and the hospice nurse was going to change the resident's dressing on his sacral pressure ulcer. -Resident #2 grimaced when they lowered the head of the bed to the down position. -The Administrator came in the resident's room with wound supplies for the resident's sacral pressure ulcer. -The hospice nurse notified the Administrator was in pain and needed his Hydrocodone/APAP pain medication. -The Administrator reported to the hospice nurse that she had given Tylenol to Resident #2 that morning and she would administer his Hydrocodone/APAP once she returned from taking herself to the hospital. (Tylenol is a mild pain reliever.) -The surveyor intervened and reminded the Administrator during the morning medication pass	C 311		

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C 311	Continued From page 101 observed on 02/06/26, she did not administer any Tylenol or any other pain medication to Resident #2. Second interview with the Administrator on 02/06/26 at 10:23am revealed: -She made no comment about not administering Tylenol or any pain medication to the resident. -She again stated she would administer Resident #2's Hydrocodone/APAP once she returned from the hospital. -The surveyor intervened and reported to the Administrator that the resident was in pain and needed pain medication now. Observation on 02/06/26 from 10:24am - 10:29am revealed: -The hospice nurse reiterated to the Administrator that Resident #2 was in pain and needed the Hydrocodone/APAP administered now. -The Administrator turned around, walked quickly out of Resident #2's room and walked to the medication closet. -The Administrator did not wash or sanitize her hands and did not use a MAR. -The Administrator unlocked and opened the medication closet door and reached her bare hands into Resident #2's plastic bin with his medications. -She punched one Hydrocodone/APAP 5/325mg tablet into her bare hand from Resident #2's bubble card. -The Administrator went to the kitchen and crushed the Hydrocodone/APAP tablet in a pill crusher with Resident #2's initials. -She poured the crushed powder into the end of an oral syringe with some puffs of powder coming out of the syringe as she poured it in. -She used her bare finger to stop up the other end of the oral syringe so the powder would not	C 311		

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come out.
-She then used the tip of the oral syringe to pull up some applesauce inside the syringe with the crushed medication powder.
-As she pushed the plunger on the oral syringe to move the contents toward the tip of the syringe, some of puffs of the crushed powdered medication came out of the tip of the syringe.
-Most of the crushed powdered medication was near the tip of the syringe while the applesauce filled the rest of the oral syringe.
-The crushed medication was not mixed in the applesauce.
-At 10:29am, the Administrator took the oral syringe with the crushed Hydrocodone/APAP and applesauce and pushed the contents of the oral syringe into Resident #2's mouth while the resident was lying flat in bed.
-The Administrator did not offer to or attempt to raise the head of the bed before administering the medication to Resident #2.

Interview with Resident #2's hospice nurse on 02/06/26 at 10:30am revealed:
-She assessed Resident #2's pain using the "PAINAD" scale. (The PAINAD scale is specifically designed to assess pain in those who may be unable to communicate their discomfort verbally, such as those with dementia or other cognitive impairments. The scoring based on breathing, vocalization, facial expression, body language, and consolability. Interpretation of scores is 0 - 3 = mild pain; 4 - 6 = moderate pain; and 7 - 10 = severe pain.)
-She assessed Resident #2's pain this morning at a score of 6 (moderate pain).
-She thought the Administrator was in a hurry when she administered Resident #2's Hydrocodone/APAP.
-The Administrator should have put the head of

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C 311	Continued From page 103 Resident #2's bed in the up position before she administered the pain medication. -Administering the pain medication while the resident was lying flat in the bed put the resident at risk of aspiration (when something other than air gets into your airway which could lead to airway blockages and infection). -Their hospice agency's biggest goal for Resident #2 was comfort and pain control. -Not receiving pain medication when needed would cause the resident's pain to be uncontrolled. Second interview with Resident #2's hospice nurse on 02/06/26 at 11:10am revealed: -The hospice agency had decided to remove Resident #2 from the facility today, 02/06/26. -The Administrator had left the facility and there was no MA to administer medications and only one PCA to care for the residents currently. -Resident #2 was known to have pain so they were concerned without a MA at the facility, the resident's pain would not be treated. Observation of Resident #2 on 02/06/26 at 2:35pm revealed Resident #2 was picked up by a transport service at the facility to be moved to a skilled nursing facility for 5-day emergency respite care through the hospice agency. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable. [Refer to Tag 330, 10A NCAC 13G .1004(a) Medication Administration.] 3. Review of the facility's Resident Contract and Service Agreement revealed: -There was a section for "Consent to	C 311		

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C 311	Continued From page 104 Photograph". -The purpose was to consent to photographs and videos to be used for the following reasons: identification purposes intended to assist with the delivery of care and/or dietary services in order to ensure the resident's best interest and needs were met and the images would be treated as confidential; recognition of anniversary, birthday, celebrations and events attended while living as a resident at the facility and those images may be posted online to enable family and others to enjoy seeing celebrations and events and for marketing purposes. -There was nothing documented in the contract for permission to use video surveillance with audio at all times in residents' rooms. a. Review of Resident #1's current FL-2 dated 09/30/25 revealed diagnoses included Lewy body dementia, hypertension, and osteoporosis. b. Review of Resident #2's current FL-2 dated 03/29/25 revealed diagnoses included unspecified dementia, metabolic encephalopathy, normal pressure hydrocephalus, seizures, myoclonus, and history of falling. c. Review of Resident #3's current FL-2 dated 07/04/25 revealed diagnoses included right ureteral stone and diabetes. d. Review of Resident #4's current FL-2 dated 03/18/25 revealed diagnoses included dementia, functional quadriplegia, hypertension, congestive heart failure, general muscle weakness, atrial fibrillation, major depressive disorder, and metabolic encephalopathy. Observation of Resident #2's room on 02/05/26 at 10:19am revealed there was a video camera	C 311		

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C 311	Continued From page 105 plugged into a wall electrical outlet near the bottom of the built-in bookshelf and there was a green light illuminated on the video camera. Observation of a resident room on 02/05/26 at 10:42am revealed: -Resident #3 and Resident #4 shared the room. -There was a video camera sitting on the corner of a bookshelf to the left of the room, aimed toward the residents' beds, but more angled toward Resident #4's bed. Observation of Resident #1's room on 02/07/26 at 11:00am revealed a video camera located on a dresser facing the entrance door inside the resident's private bedroom. Review of Resident #1's resident contract and admission documentation revealed under the sections for Consent to Photograph, the resident's family declined the use of images and videos on 09/30/25. Interview with Resident #1 on 02/07/26 at 11:00am revealed: -She did not like having the video camera in her room; it made her feel uncomfortable. -She did not know why the video camera was in her room. Interview with Resident #2's family member on 02/05/26 at 2:00pm revealed: -The camera in Resident #2's was put in the room by facility staff. -She thought the facility staff used it to monitor the resident and she was okay with them monitoring the resident. Interview with Resident #3 on 02/05/26 at 10:42am revealed:	C 311		

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C 311	Continued From page 106 -She had never noticed there was a camera in the room, so she did not know how long it had been there. -When asked if she had any concerns about the camera, she indicated she did not know why it was in the room. Based on observations, interviews, and record reviews, it was determined that Resident #4 was not interviewable. Interview with a personal care aide (PCA) on 02/05/26 at 11:12am revealed when the Administrator left the facility, the Administrator would leave monitors from the video cameras with the staff so they could use the cameras to monitor the residents. Second interview with the PCA on 02/06/26 at 8:26am revealed: -The Administrator did not help her with providing personal care to the residents. -The Administrator just watched her on the cameras in the residents' rooms when she assisted the residents with personal care. Third interview with the PCA on 02/07/26 at 11:54am revealed: -The Administrator left the facility daily. -The Administrator could view all areas of the facility, including inside each residents' bedroom, from her phone. -The cameras located in the residents' bedrooms included audio capability. Interview with the Administrator on 02/09/26 at 3:30pm revealed: -She slept at night. -She was able to monitor the residents during the day and at night from her cell phone.	C 311		

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HEARTS OF GOLD FAMILY CARE	1004 EDENBURGHS KEEP DR KNIGHTDALE, NC 27545

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C 311	Continued From page 107 -The residents' families were aware of the cameras. -The cameras were an extra security and convenience for her to monitor the residents. -The cameras did not have the capability to record. -The cameras had the capability for her to hear inside each residents' room. -The monitoring of the cameras was not a part of the resident contract/admission packet. -She did not get written consent from families to use cameras in the residents' rooms. _____ The facility failed to ensure residents were free of neglect and had the right to privacy. Resident #2, a hospice resident with a stage 2 pressure sore, was found saturated in urine on 02/04/26 and 02/06/26. Resident #4, a hospice resident, was found saturated in urine and soiled with feces on 02/04/26 and 02/06/26. The personal care aide (PCA) reported residents were always wet and sometimes soiled with feces when she came to work at 8:00am. The Administrator and the PCA were the only two staff employed by the facility to care for 4 residents, including 3 non-ambulatory residents. Resident #2 exhibited moderate pain on 02/06/26 but the Administrator stated she would administer his controlled substance pain medication after she returned from taking herself to the hospital. Intervention by the hospice nurse and surveyor was required to get the Administrator to administer the pain medication resulting in a delay in treating the resident's pain. The facility failed to maintain the residents' privacy by having video camera surveillance at all times in all residents' rooms even when personal care was being provided to the residents. This failure of the facility resulted in substantial neglect of the residents and constitutes a Type A1 Violation.	C 311		

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C 311	Continued From page 108 The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/09/26 for this violation. THIS FACILITY WAS ISSUED A SUMMARY SUSPENSION ON 02/12/26.	C 311		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family 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: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 4 sampled residents (#2, #3, #4) including errors with two insulins (#3), controlled substances for moderate to severe pain (#2, #4), an antipsychotic (#2), topical medications (#3), an oral diabetic medication (#3), a mild pain reliever (#3), a medication for high cholesterol (#3), and a medication used to prevent heart disease (#3). The findings are: Review of the facility's Pharmacy Policy and	C 330		

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C 330	Continued From page 109 Procedure Manual dated January 2023 revealed: -Section 1 was not included in the notebook. -Sections 2 through 4 included: Medication Orders; Medication Ordering and Receiving from the Pharmacy Provider; and Medication Storage. -There was no section in the manual for Medication Administration. 1. Review of Resident #2's current FL-2 dated 03/29/25 revealed diagnoses included unspecified dementia, metabolic encephalopathy, normal pressure hydrocephalus, seizures, myoclonus, and history of falling. a. Review of Resident #2's hospice order dated 01/05/26 revealed a new order to start Hydrocodone/Acetaminophen (APAP) 5/325mg 1 tablet every 6 hours as needed (prn) for pain. (Hydrocodone/APAP is a controlled substance used for moderate to severe pain.) Review of Resident #2's record and the facility's medication administration record (MAR) notebook on 02/05/26 revealed: -There was no January 2026 MAR for Resident #2. -There was no February 2026 MAR for Resident #2. Interview with the Administrator on 02/05/26 at 1:16pm revealed: -All residents' January 2026 and February 2026 MARs were mixed in with some other papers because she was working on changing to an electronic records system. -She accidentally shredded the residents' January 2026 and February 2026 MARs along with some other papers about 2 days ago in the middle of the night. -She requested new MARs from the pharmacy on	C 330		

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C 330	Continued From page 110 the day before yesterday (02/03/26) and was waiting to receive the MARs in the mail. -She did not have a fax machine at the facility for the MARs to be faxed. Telephone interview with the Pharmacy Manager at the facility's contracted pharmacy on 02/10/26 at 4:32pm revealed: -The pharmacy dispensed 56 Hydrocodone/APAP 5/325mg tablets for Resident #2 on 01/05/26. -The supply dispensed on 01/05/26 was delivered to the facility early in the morning (did not see exact time documented) on 01/06/26. -The pharmacy dispensed 56 Hydrocodone/APAP 5/325mg tablets for Resident #2 on 01/27/26. -The supply dispensed on 01/27/26 was delivered to the facility on 01/28/26 at 2:29am. -The instructions for both supplies were to take 1 tablet every 6 hours as needed for pain. Observation of Resident #2's medications on hand on 02/05/26 at 3:05pm revealed: -There was a supply of Hydrocodone/APAP 5/325mg dispensed on 01/27/26 with 56 tablets. -The instructions were to take 1 tablet every 6 hours as needed for pain. -There was a controlled substance record (CSR) attached to the bubble card with a rubber band. -There were 29 tablets sealed in bubbles numbered 1 - 29 on the bubble card. -There was a small plastic ziploc bag stapled to the back of the bubble card with 11 white tablets with the same imprint code as the Hydrocodone/APAP 5/325mg tablets sealed in the bubbles on the front of the bubble card. -There was nothing written on the ziploc bag and no medication label on the ziploc bag. -There was a total of 40 Hydrocodone/APAP 5/325mg tablets in and attached to the bubble card.	C 330		

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C 330	Continued From page 111 Review of Resident #2's CSR kept with the bubble card for Resident #2's Hydrocodone/APAP 5/325mg dispensed on 01/27/26 revealed: -The CSR had a prescription label at the top for a supply of 56 Hydrocodone/APAP 5/325mg tablets dispensed on 01/27/26. -The first documented dose was on 01/28/26 at 5:00am leaving a balance of 55 tablets. -There was a second entry on 01/28/26 at 4:30pm with 1 tablet documented as administered declining the balance to 54 tablets. -There was a third entry on 01/29/26 at 5:00am with 1 tablet documented as administered declining the balance to 53 tablets. -There was a fourth entry on 01/29/26 at 12:00pm with 1 tablet documented as administered declining the balance to 52 tablets. -There was a fifth entry on 01/29/26 at 7:00pm with 1 tablet documented as administered but the amount remaining was documented as 54 instead of 51. -The count continued to be declined from 54 on 01/29/26 at 7:00pm to 40 tablets on 02/02/26 at 11:45pm although 54, 53, and 52 for the remaining balance had been documented twice each on the CSR. -There was a total of 19 doses documented as administered on the CSR from 01/28/26 - 02/02/26 with a balance of 40 tablets but if 19 doses were administered, the remaining balance during that time frame should have been 37. Review of Resident #2's record and the facility's MAR notebook on 02/05/26 revealed there was no other CSR for Resident #2's Hydrocodone/APAP 5/325mg. Second interview with the Administrator on 02/06/26 at 3:05pm revealed:	C 330		

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C 330	Continued From page 112 -She had not noticed the CSR for Resident #2's Hydrocodone/APAP 5/325mg dispensed on 01/27/26 was not documented correctly. -She did not know why she documented 54 as the remaining balance on 01/29/26 when it should have been 51 tablets. -She may have used some tablets from a previous supply and documented on the CSR for this supply, but she was not sure. -The tablets in the small plastic ziploc bag stapled to Resident #2's Hydrocodone/APAP 5/325mg bubble card were the same medication that was in the bubble card. -She had punched out and prepared the prn Hydrocodone/APAP tablets when preparing medications but if the resident did not need them, she would put the tablet in the ziploc bag. -When asked why she prepared the prn medication in advance instead of preparing it only when it was needed, the Administrator raised her voice and repeated multiple times that was the way she did it. -She was unable to offer any other explanation for 11 Hydrocodone/APAP tablets being punched out and stored in a ziploc bag or for the CSR documentation being inaccurate. Interview with Resident #2's hospice nurse on 02/06/26 at 11:10am revealed: -She usually checked controlled substance counts once a week for hospice residents. -On Wednesday, 02/04/26, Resident #2 had 40 Hydrocodone/APAP 5/325mg tablets. -The 40 Hydrocodone/APAP 5/325mg tablets were all sealed in the bubble card. -There were no Hydrocodone/APAP 5/325mg tablets in a ziploc bag attached to Resident #2's bubble card. Observation of Resident #2 on 02/06/26 at	C 330		

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C 330	Continued From page 113 8:53am revealed: -The personal care aide (PCA) went into Resident #2's room. -The resident grimaced when the PCA attempted to move his legs, so the PCA stopped and went out of the room. Interview with the PCA on 02/06/26 at 8:53am revealed: -When she came in yesterday, 02/05/26, she noticed Resident #2 was not moving around as much. -She was unable to get the resident up in his chair when he was "like this". -The resident's legs were "more contracted" today. -She stopped trying to move the resident when he grimaced because that meant he was in pain. Third interview with the Administrator on 02/06/26 at 9:55am revealed: -She was about to leave the facility to take herself to the hospital. -She had administered the residents all the medication they would need. Observation of Resident #2 on 02/06/26 at 10:21am revealed: -The resident was lying in his hospital bed. -The PCA was in the room preparing to provide incontinence care and the hospice nurse was going to change the resident's dressing on his sacral pressure ulcer. -Resident #2 grimaced when they lowered the head of the bed to the down position. -The Administrator came in the resident's room with wound supplies for the resident's sacral pressure ulcer. -The hospice nurse notified the Administrator that Resident #2 was in pain and needed his	C 330		

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C 330	Continued From page 114 Hydrocodone/APAP pain medication. -The Administrator reported to the hospice nurse that she had given Tylenol to Resident #2 that morning and she would administer his Hydrocodone/APAP once she returned from taking herself to the hospital. (Tylenol is for mild pain.) -The surveyor intervened and reminded the Administrator during the morning medication pass observed on 02/06/26, she did not administer any Tylenol or any other pain medication to Resident #2. Fourth interview with the Administrator on 02/06/26 at 10:23am revealed: -She made no comment about not administering Tylenol or any pain medication to the resident. -She again stated she would administer Resident #2's Hydrocodone/APAP once she returned from the hospital. -The surveyor intervened and reported to the Administrator that the resident was in pain and needed pain medication now. Observation on 02/06/26 from 10:24am - 10:29am revealed: -The hospice nurse reiterated to the Administrator that Resident #2 was in pain and needed the Hydrocodone/APAP administered now. -The Administrator turned around, walked quickly out of Resident #2's room and walked to the medication closet. -The Administrator did not wash or sanitize her hands and did not use a MAR. -The Administrator unlocked and opened the medication closet door and reached her bare hands into Resident #2's plastic bin with his medications. -She punched one Hydrocodone/APAP 5/325mg tablet into her bare hand from Resident #2's	C 330		

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C 330	Continued From page 115 bubble card. -The Administrator went to the kitchen and crushed the Hydrocodone/APAP tablet in a pill crusher with Resident #2's initials. -She poured the crushed powder into the end of an oral syringe with some puffs of powder coming out of the syringe as she poured it in. -She used her bare finger to stop up the other end of the oral syringe so the powder would not come out. -She then used the tip of the oral syringe to pull up some applesauce inside the syringe with the crushed medication powder. -As she pushed the plunger on the oral syringe to move the contents toward the tip of the syringe, some of puffs of the crushed powdered medication came out of the tip of the syringe. -Most of the crushed powdered medication was near the tip of the syringe while the applesauce filled the rest of the oral syringe. -The crushed medication was not mixed in the applesauce. -At 10:29am, the Administrator took the oral syringe with the crushed Hydrocodone/APAP and applesauce and pushed the contents of the oral syringe into Resident #2's mouth while the resident was lying flat in bed. -The Administrator did not offer to or attempt to raise the head of the bed before administering the medication to Resident #2. Second interview with Resident #2's hospice nurse on 02/06/26 at 10:30am revealed: -She assessed Resident #2's pain using the "PAINAD" scale. (The PAINAD scale is specifically designed to assess pain in those who may be unable to communicate their discomfort verbally, such as those with dementia or other cognitive impairments. The scoring based on breathing, vocalization, facial expression, body	C 330		

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C 330	Continued From page 116 language, and consolability. Interpretation of scores is 0 - 3 = mild pain; 4 - 6 = moderate pain; and 7 - 10 = severe pain.) -She assessed Resident #2's pain this morning at a score of 6 (moderate pain). -She thought the Administrator was in a hurry when she administered Resident #2's Hydrocodone/APAP. -The Administrator should have put the head of Resident #2's bed in the up position before she administered the pain medication. -Administering the pain medication while the resident was lying flat in the bed put the resident at risk of aspiration (when something other than air gets into your airway which could lead to airway blockages and infection). -Their hospice agency's biggest goal for Resident #2 was comfort and pain control. -Not receiving pain medication when needed would cause the resident's pain to be uncontrolled. Third interview with Resident #2's hospice nurse on 02/06/26 at 11:10am revealed: -The hospice agency had decided to remove Resident #2 from the facility today, 02/06/26. -The Administrator had left the facility and there was no medication aide (MA) to administer medications and only one PCA to care for the residents currently. -Resident #2 was known to have pain so they were concerned without a MA at the facility, the resident's pain would not be treated. Observation of Resident #2 on 02/06/26 at 2:35pm revealed Resident #2 was picked up by a transport service at the facility to be moved to a skilled nursing facility for 5-day emergency respite care through the hospice agency.	C 330		

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C 330	Continued From page 117 Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable. b. Review of Resident #2's physician orders dated 08/18/25 revealed: -There was an order for Olanzapine 2.5mg once a day in the morning. (Olanzapine is an antipsychotic used to treat psychosis and mood disorders.) -There was an order for Olanzapine 7.5mg at bedtime. Review of Resident #2's hospice order dated 01/07/26 revealed: -The facility staff reported Resident #2 was having increased hallucinations. -There was an order to increase Olanzapine to 5mg in the morning for hallucinations and continue Olanzapine 7.5mg at night. Review of Resident #2's December 2025 medication administration record (MAR) revealed: -There was an entry for Olanzapine 2.5mg 1 tablet every morning scheduled at 9:00am. -Olanzapine 2.5mg was documented as administered at 9:00am from 12/01/25 - 12/19/25. -Olanzapine 2.5mg was not documented as administered from 12/20/25 - 12/31/25 with no reason noted. -There was an entry for Olanzapine 7.5mg 1 tablet at bedtime scheduled at 8:00pm. -Olanzapine 7.5mg was documented as administered at 8:00pm from 12/01/25 - 12/18/25. -Olanzapine 7.5mg was not documented as administered from 12/19/25 - 12/31/25 with no reason noted. Review of Resident #2's record and the facility's MAR notebook on 02/05/26 revealed:	C 330		

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C 330	Continued From page 118 -There was no January 2026 MAR for Resident #2. -There was no February 2026 MAR for Resident #2. Interview with the Administrator on 02/05/26 at 1:16pm revealed: -The residents' January 2026 and February 2026 MARs were mixed in with some other papers because she was working on changing to an electronic records system. -She accidentally shredded the residents' January 2026 and February 2026 MARs along with some other papers about 2 days ago in the middle of the night. -She requested new MARs from the pharmacy on the day before yesterday (02/03/26) and was waiting to receive the MARs in the mail. -She did not have a fax machine at the facility. Telephone interview with the Pharmacy Manager at the facility's contracted pharmacy on 02/10/26 at 4:32pm revealed: -The pharmacy dispensed 14 Olanzapine 5mg tablets for Resident #2 on 01/09/26. -The pharmacy dispensed 14 Olanzapine 5mg tablets for Resident #2 on 01/24/26. -The pharmacy dispensed 14 Olanzapine 7.5mg tablets for Resident #2 on 11/24/25. -The pharmacy dispensed 14 Olanzapine 7.5mg tablets for Resident #2 on 12/22/25. -The pharmacy dispensed 14 Olanzapine 7.5mg tablets for Resident #2 on 01/12/26. Observation of Resident #2's medications on hand on 02/05/26 at 3:13pm revealed: -There was a supply of Olanzapine 5mg tablets dispensed on 01/09/26 with instructions to take 1 tablet every morning. -There were 7 of 14 Olanzapine 5mg tablets	C 330		

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C 330	Continued From page 119 remaining from the 01/09/26 supply. -There was a supply of Olanzapine 5mg tablets dispensed on 01/24/26 with instructions to take 1 tablet every morning. -There were 14 of 14 Olanzapine 5mg tablets remaining from the 01/24/26 supply. -On 02/05/26, only 7 Olanzapine 5mg tablets had been used from the 28 tablets dispensed since 01/09/26, a 28-day time period. -There was a supply of Olanzapine 7.5mg tablets dispensed on 11/24/25 with instructions to take 1 tablet at bedtime. -There were 14 of 14 Olanzapine 7.5mg tablets remaining from the 11/24/25 supply. -There was a supply of Olanzapine 7.5mg tablets dispensed on 12/22/25 with instructions to take 1 tablet at bedtime. -There were 6 of 14 Olanzapine 7.5mg tablets remaining from the 12/22/25 supply. -There was a supply of Olanzapine 7.5mg tablets dispensed on 01/12/26 with instructions to take 1 tablet at bedtime. -There were 14 of 14 Olanzapine 7.5mg tablets remaining from the 01/12/26 supply. -On 02/05/26, only 8 Olanzapine 7.5mg tablets had been used from the 42 tablets dispensed since 11/24/25, a 74-day time period. Interviews with the Administrator on 02/06/26 at 3:05pm and 02/10/26 at 11:04am revealed: -Resident #2 did not usually refuse medications. -She did not realize Resident #2 still had medications on hand from previous months. -She did not know why there were supplies of Resident #2's Olanzapine 5mg tablets and 7.5mg tablets dispensed in previous months still on hand and not administered. -If there was a supply of medication with an old date, she used that supply first before using a more current supply.	C 330		

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C 330	Continued From page 120 -She administered Resident #2's medications and she did not know why so many were left over and had not been used. Telephone interview with Resident #2's current hospice nurse on 02/10/26 at 4:29pm revealed not receiving Olanzapine as ordered could cause Resident #2 to have hallucinations and agitation. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable. 2. Review of Resident #4's current FL-2 dated 03/18/25 revealed diagnoses included dementia, functional quadriplegia, hypertension, congestive heart failure, general muscle weakness, atrial fibrillation, major depressive disorder, and metabolic encephalopathy. Review of Resident #4's physician orders dated 08/18/25 revealed an order for Oxycodone 5mg 1 tablet every 4 hours as needed (prn) for pain. (Oxycodone is a controlled substance used to treat moderate to severe pain.) Review of Resident #4's hospice order dated 12/18/25 revealed an order to discontinue Oxycodone. Review of Resident #4's December 2025 medication administration record (MAR) revealed: -There was an entry for Oxycodone 5mg 1 tablet every 4 hours prn pain. -There was no Oxycodone 5mg documented as administered in December 2025. -There was a handwritten note that Oxycodone was discontinued but no date indicated. Review of Resident #4's hospice order dated	C 330		

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C 330	Continued From page 121 01/25/26 revealed a new order to start Oxycodone 5mg 1 tablet every 6 hours prn pain. Review of Resident #4's record on 02/05/26, 02/06/26, and 02/09/26 revealed there were no January 2026 and February 2026 MARs. Interview with the Administrator on 02/05/26 at 1:16pm revealed: -All residents' January 2026 and February 2026 MARs were mixed in with some other papers because she was working on changing to an electronic records system. -She accidentally shredded the residents' January 2026 and February 2026 MARs along with some other papers about 2 days ago in the middle of the night. -She requested new MARs from the pharmacy on the day before yesterday (02/03/26) and was waiting to receive the MARs in the mail. -She did not have a fax machine at the facility. Telephone interview with the Pharmacy Manager at the facility's contracted pharmacy on 02/11/26 at 9:31am revealed: -The pharmacy dispensed 84 Oxycodone 5mg tablets for Resident #4 on 11/12/25. -The pharmacy dispensed 84 Oxycodone 5mg tablets for Resident #4 on 11/25/25. -There were 2 cards of 42 tablets each dispensed to equal 84 tablets. -The pharmacy dispensed 54 Oxycodone 5mg tablets (1 card) for Resident #4 on 01/27/26. -The instructions were to take 1 tablet every 4 hours as needed for pain. Review of Resident #4's controlled substance record (CSR) for Oxycodone 5mg tablets dispensed on 11/12/25 revealed: -There was a CSR for card 2 of 2 for 42 of 84	C 330		

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C 330	Continued From page 122 Oxycodone 5mg tablets dispensed on 11/12/25. -All 42 Oxycodone 5mg tablets dispensed in card 2 of 2 were documented as administered from 11/14/25 at 8:00am through 11/26/25 at 11:00pm, leaving a balance of 0. -There was no CSR for card 1 of 2 for 42 of 84 Oxycodone 5mg tablets dispensed on 11/12/25. Review of Resident #4's CSR for Oxycodone 5mg tablets dispensed on 11/25/25 revealed: -There was a CSR for card 2 of 2 for 42 of 84 Oxycodone 5mg tablets dispensed on 11/25/25. -All 42 Oxycodone 5mg tablets dispensed in card 2 of 2 were documented as administered from 11/27/25 at 5:30am through 12/09/25 at 8:30pm, leaving a balance of 0. -There was no CSR for card 1 of 2 for 42 of 84 Oxycodone 5mg tablets dispensed on 11/25/25. Review of Resident #4's CSR for Oxycodone 5mg tablets dispensed on 01/27/26 revealed: -There was a CSR for 1 card of 54 Oxycodone 5mg tablets dispensed on 01/27/26. -The first dose was documented as administered on 01/27/26 at 11:00pm, leaving a balance of 53. -There were 3 doses documented as administered on 01/28/26 at 7:00am, 2:00pm, and 7:30pm, leaving a balance of 50. -There was a dose documented as administered on 01/29/26 at 5:00am and 01/29/26 at 11:00am, leaving a balance of 48. -The last dose documented on the CSR was 01/29/26 at 5:00pm but the remaining balance was left blank but should have been documented as 47 tablets. Second interview with the Administrator on 02/06/26 at 3:05pm revealed: -The CSRs for Resident #4's Oxycodone 5mg tablets should be in the MAR notebook.	C 330		

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C 330	Continued From page 123 -If the CSRs were not in the MAR notebook, they probably had been shredded when she accidentally shredded the MARs about 2 days ago. Observation of Resident #4's medications on hand on 02/06/26 at 4:45pm revealed there were no Oxycodone 5mg tablets available for administration. Interview with Resident #4's hospice nurse on 02/06/26 at 11:10am revealed: -She usually checked controlled substance counts once a week for hospice residents. -On Wednesday, 02/04/26, Resident #4 had 29 Oxycodone 5mg tablets on hand at the facility. -The Administrator reported to her that Resident #4 had no Oxycodone on hand today, 02/06/26. -The Administrator told her that she would have to get Resident #4 some more Oxycodone. -The Administrator gave no explanation as to what happened to the 29 Oxycodone 5mg tablets that were on hand 2 days ago on 02/04/26. Third interview with the Administrator on 02/10/26 at 11:04am revealed: -She was not feeling well on Wednesday, 02/04/26, when Resident #4's hospice nurse was at the facility. -She failed to contact Resident #4's hospice nurse to let the nurse know that she had miscounted Resident #4's Oxycodone while the nurse was at the facility on 02/04/26. -Resident #4's hospice nurse asked her how many Oxycodone tablets Resident #4 had on 02/04/26. -She told the nurse there were 29 Oxycodone tablets on 02/04/26 but she miscounted and there were "actually 18 or 19" Oxycodone tablets on hand on 02/04/26.	C 330		

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C 330	Continued From page 124 -She did not think the hospice nurse looked at the amount of Oxycodone on hand on 02/04/26; the hospice nurse just asked her to tell her the number. -There were none of Resident #4's Oxycodone tablets on hand on Friday, 02/06/26 because she had administered all 18 or 19 tablets to the resident since Wednesday, 02/04/26. -She had given all 18 or 19 tablets to Resident #4 because the resident was in pain and she did not document on the MAR or CSR when she administered the tablets. -She could not recall if it had been 6 hours between doses because she did not write it down, so she just continued to administer the Oxycodone to Resident #4 from 02/04/26 - 02/06/26. -When reminded if administered according to the order prn every 6 hours, no more than 4 tablets in a 24-hour period should be administered, she again repeated she administered all 18 or 19 tablets from 02/04/26 - 02/06/26. -She had no concerns about administering more than double the dose of Oxycodone to Resident #4 in a 48-hour period. -The resident was not sleepy or oversedated when she administered the Oxycodone to the Resident from 02/04/26 - 02/06/26. -She did not recall what time she administered the last Oxycodone to Resident #4 on 02/06/26. -She gave no explanation for failing to notify Resident #4's hospice nurse about reporting the wrong amount of Oxycodone on 02/04/26 or that she administered all 18 or 19 Oxycodone to Resident #4. Telephone interview with Resident #4's hospice nurse on 02/10/26 at 4:29pm revealed: -The Administrator reported Resident #4 had 29 Oxycodone tablets on Wednesday, 02/04/26,	C 330		

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C 330	Continued From page 125	C 330		

during her visit to the facility.
-She counted Resident #4's Oxycodone tablets in the bubble card on Wednesday, 02/04/26, and there were 29 tablets on hand.
-The Administrator may not have realized that she observed and counted Resident #4's Oxycodone herself on Wednesday, 02/04/26, because the Administrator was helping another resident who spilled shampoo in the bathroom.
-The Administrator had not contacted her about making an error when the Administrator counted Resident #4's Oxycodone on 02/04/26.
-The Administrator had not reported she had administered 18 to 19 prn Oxycodone tablets to Resident #4 from 02/04/26 - 02/06/26.
-If the Administrator had administered 18 to 19 Oxycodone 5mg tablets to Resident #4 in a 48-hour period, Resident #4 would have symptoms of overdose; the resident would have been lethargic and "out of it".
-When she observed Resident #4 on 02/04/26 and 02/06/26, the resident was not oversedated and the resident was not in pain.

Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable.

3. Review of Resident #3's current FL-2 dated 07/04/25 revealed:
-Diagnosis included right urethral stone and diabetes.
-The resident was constantly disoriented.
-The resident was incontinent with a suprapubic catheter.

a. Review of Resident #3's current FL-2 dated 07/04/25 revealed there was an order for insulin Glargine 100unit/ml injection, inject 17 units daily. (Glargine is a long-acting insulin used to control

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C 330	Continued From page 126 type 1 or type 2 diabetes). Review of Resident #3's December 2025 medication administration record (MAR) revealed: -There was an entry for Glargine 100unit/ml injection, inject 17 units daily, scheduled at 9:00am. -There was documentation the Glargine was administered from 12/01/25 to 12/17/25 at 9:00am. -There was no documentation the Glargine was administered from 12/18/25 to 12/31/25 at 9:00am. Review of Resident #3's record on 02/05/26 and 02/06/26 revealed: -There were no January 2026 MARs to review. -There were no February 2026 MARs to review. Interview with the Administrator on 02/05/26 at 1:16pm revealed: -The residents' January 2026 and February 2026 MARs were mixed in with some other papers because she was working on changing to an electronic records system. -She accidentally shredded the residents' January 2026 and February 2026 MARs along with some other papers about 2 days ago in the middle of the night. -She requested new MARs from the pharmacy on the day before yesterday (02/03/26) and was waiting to receive the MARs in the mail. Observation of the Administrator on 02/06/26 from 08:58am - 9:23am revealed: -The Administrator prepared medications for all residents without using any MARs, including Resident #3. -The Administrator did not obtain and prepare any Glargine insulin for Resident #3 when she	C 330		

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C 330	Continued From page 127 prepared the resident's other morning medications. Observation of the Administrator on 02/06/26 from 9:56am - 10:01am revealed: -At 9:57am, the Administrator administered the prepoured morning medications to Resident #3 but no Glargine insulin was prepared and administered. -Resident #3 was in the living room eating breakfast. -Resident #3 did not receive Glargine insulin on 02/06/26 as ordered. -The Administrator did not refer to or document on any MARs. Review of Resident #3's record on 02/09/26 revealed there were no January 2026 MARs to review. Review of Resident #3's February 2026 MAR provided on 02/09/26 revealed: -There was an entry for Glargine 100unit/ml injection, inject 17 units daily, scheduled at 9:00am. -Glargine insulin was documented as administered at 9:00am with breakfast from 02/06/26 - 02/09/26. Observation of Resident #3's medications on hand on 02/10/25 at 8:56am revealed: -The Glargine was not dispensed with the facility's contracted pharmacy. -The dispensed date of the Glargine pens was 01/31/26. -There were 5 Glargine pens in the refrigerator in the opened manufacturer's box. Interview with the Administrator on 02/10/26 at 11:04am revealed:	C 330		

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C 330	Continued From page 128 -She gave Resident #3 Glargine insulin around 7:00am on 02/06/26, right before the surveyors arrived to the facility. -The residents were usually served breakfast around 9:00am. -She had no explanation when asked why she would administer Insulin Glargine at 7:00am if it was ordered to be administered with breakfast and breakfast was usually served at 9:00am. Telephone interview with Resident #3's primary care provider (PCP) on 02/10/26 at 2:10pm revealed: -Not receiving insulin could cause the resident's blood sugar to run high, which could cause diabetic ketoacidosis, and organ failure. -The Administrator last sent MARs for June 2025 but there was no blood sugars documented on Resident #3's MARs and there were only 3 days with staff initials on those MARs. -She had seen some of Resident #3's blood sugars documented in the past (could not recall date) and she did not recall having concerns about the past readings. b. Review of Resident #3's current FL-2 dated 07/04/25 revealed there was an order for insulin Lispro 100unit/ml, inject per facility protocol. (Lispro is a rapid-acting insulin used to treat type 1 or type 2 diabetes). Review of Resident #3's physician's orders dated 03/07/25 revealed there was an order to check and record blood sugars and administer Lispro per sliding scale; 201-250= 2 units, 251- 300= 4 units; 301- 350= 6 units; 351- 400= 8 units; 401-450= 10 units; 451- 500= 12 units; 500 or greater call primary care provider (PCP). Review of Resident #3's December 2025 MAR	C 330		

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C 330	Continued From page 129 revealed: -There was an entry for Lispro 100unit/ml injection, check and record blood sugar twice per day, scheduled at 11:00am and 4:00pm. -There was documentation the Lispro was administered from 12/01/25 to 12/17/25 at 11:00am and 4:00pm. -There was no documentation the Lispro was administered from 12/18/25 to 12/31/25 at 11:00am and 4:00pm. -There were no documentation of the blood sugar readings. Review of Resident #3's record on 02/05/26 and 02/06/26 revealed: -There were no January 2026 MARs to review. -There were no February 2026 MARs to review. Interview with the Administrator on 02/05/26 at 1:16pm revealed: -The residents' January 2026 and February 2026 MARs were mixed in with some other papers because she was working on changing to an electronic records system. -She accidentally shredded the residents' January 2026 and February 2026 MARs along with some other papers about 2 days ago in the middle of the night. -She requested new MARs from the pharmacy on the day before yesterday (02/03/26) and was waiting to receive the MARs in the mail. Review of Resident #3's record on 02/09/26 revealed there were no January 2026 MARs to review. Review of Resident #3's February 2026 MAR on 02/09/26 revealed there was no documentation medications were administered.	C 330		

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C 330	Continued From page 130 Observation of Resident #3's medications on hand on 02/10/25 at 8:56am revealed: -The dispensing date of the Lispro pens was 06/20/25. -There were 2 Lispro pens in the refrigerator. Telephone interview with the Pharmacy Manager at the facility's contracted pharmacy on 02/09/26 at 1:37pm revealed: -There was an active order for the Lispro twice per day with lunch and dinner for Resident #3. -The Lispro was last dispensed on 06/20/25. Telephone interview with Resident #3's primary care provider (PCP) on 02/10/26 at 2:22pm revealed she was concerned the facility was not checking the residents' blood sugar because it could be high which could cause a hyperglycemic episode or organ failure. c. Review of Resident #3's current FL-2 dated 07/04/25 revealed there was an order for Acetaminophen 325mg tablet, take 1 tablet daily. (Acetaminophen is used to treat minor pain and reduce fever). Review of Resident #3's December 2025 medication administration record (MAR) revealed: -There was an entry for Acetaminophen 325mg tablet, take 1 tablet daily, scheduled at 2:00pm. -There was no documentation the Acetaminophen 325mg was administered at 2:00pm. Review of Resident #3's record on 02/05/26 and 02/06/26 revealed: -There were no January 2026 MARs to review. -There were no February 2026 MARs to review. Interview with the Administrator on 02/05/26 at	C 330		

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C 330	Continued From page 131 1:16pm revealed: -The residents' January 2026 and February 2026 MARs were mixed in with some other papers because she was working on changing to an electronic records system. -She accidentally shredded the residents' January 2026 and February 2026 MARs along with some other papers about 2 days ago in the middle of the night. -She requested new MARs from the pharmacy on the day before yesterday (02/03/26) and was waiting to receive the MARs in the mail. Review of Resident #3's record on 02/09/26 revealed there were no January 2026 MARs to review. Review of Resident #3's February 2026 MAR provided on 02/09/26 revealed: -Pages 1 and 4 were missing. -There was no entry for the Acetaminophen 325mg tablet, take 1 tablet daily, scheduled at 2:00pm. Observation of Resident #3's medications on hand on 02/09/25 at 10:51am revealed there were no Acetaminophen 325mg tablets with instructions to take 1 tablet daily available. Telephone interview with the Pharmacy Manager at the facility's contracted pharmacy on 02/09/26 at 1:37pm revealed: -There was an active order for scheduled Acetaminophen 325mg tablet, take 1 tablet daily for Resident #3. -The scheduled Acetaminophen was last dispensed on 05/12/25. Telephone interview with Resident #3's primary care provider (PCP) on 02/10/26 at 2:22pm	C 330		

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C 330	Continued From page 132 revealed she was concerned the resident's pain was not being controlled if it were not administered. d. Review of Resident #3's current FL-2 dated 07/04/25 revealed there was an order for Aspirin 81mg, take 1 tablet daily. (Aspirin is used to treat pain, inflammation, and reduce the risk of heart attacks and strokes). Review of Resident #3's December 2025 MAR revealed: -There was an entry for Aspirin 81mg, take 1 tablet daily, scheduled at 8:00am. -There was documentation the Aspirin 81mg was administered from 12/01/25 to 12/17/25 at 8:00am. -There was no documentation the Aspirin 81mg was administered from 12/18/25 to 12/31/25 at 8:00am. Review of Resident #3's record on 02/05/26 and 02/06/26 revealed: -There were no January 2026 MARs to review. -There were no February 2026 MARs to review. Interview with the Administrator on 02/05/26 at 1:16pm revealed: -The residents' January 2026 and February 2026 MARs were mixed in with some other papers because she was working on changing to an electronic records system. -She accidentally shredded the residents' January 2026 and February 2026 MARs along with some other papers about 2 days ago in the middle of the night. -She requested new MARs from the pharmacy on the day before yesterday (02/03/26) and was waiting to receive the MARs in the mail.	C 330		

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C 330	Continued From page 133 Observation of the Administrator on 02/06/26 from 08:58am - 9:23am revealed: -The Administrator prepared medications for all residents without using any MARs, including Resident #3. -The Administrator did not prepare Aspirin 81mg when she prepared the resident's other morning medications. Observation of the Administrator on 02/06/26 from 9:56am - 10:01am revealed: -At 9:57am, the Administrator administered the prepoured morning medications to Resident #3 but no Aspirin 81mg was prepared and administered. -Resident #3 did not receive Aspirin 81mg on 02/06/26 as ordered. -The Administrator did not refer to or document on any MARs. Review of Resident #3's record on 02/09/26 revealed there were no January 2026 MARs to review. Review of Resident #3's February 2026 MARs provided on 02/09/26 revealed: -There was a handwritten entry for Aspirin 81mg 1 tablet once daily scheduled at 9:00am. -Aspirin was documented as administered at 9:00am from 02/06/26 - 02/09/26. Observation of Resident #3's medications on hand on 02/09/25 at 10:51am revealed there were no Aspirin 81mg tablets available. Telephone interview with the Pharmacy Manager at the facility's contracted pharmacy on 02/09/26 at 1:37pm revealed: -There was an active order for Aspirin 81mg, take 1 tablet daily.	C 330		

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C 330	Continued From page 134 -The scheduled Aspirin 81mg was last dispensed on 12/02/25. Interview with the Administrator on 02/10/26 at 11:04am revealed: -She thought she administered Aspirin to Resident #3 on 02/06/26. -She did not realize Resident #3 did not have any available. -She had no explanation for the documentation on the February 2026 MAR for Aspirin. Interview with Resident #3's primary care provider (PCP) on 02/10/26 at 2:22pm revealed the Aspirin was prescribed for the resident's heart which put her at high risk of a heart attack if it was not administered. e. Review of Resident #3's current FL-2 dated 07/04/25 revealed there was an order for Atorvastatin 10mg, take 1 tablet at bedtime. (Atorvastatin is used to treat high cholesterol). Review of Resident #3's December 2025 MAR revealed: -There was an entry for Atorvastatin 10mg, take 1 tablet at bedtime, scheduled at 8:00pm. -There was documentation the Atorvastatin 10mg was administered from 12/01/25 to 12/16/25 at 8:00pm. -There was no documentation the Atorvastatin 10mg was administered from 12/17/25 to 12/31/25 at 8:00pm. Review of Resident #3's record on 02/05/26 and 02/06/26 revealed: -There were no January 2026 MARs to review. -There were no February 2026 MARs to review. Interview with the Administrator on 02/05/26 at	C 330		

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C 330	Continued From page 135 1:16pm revealed: -The residents' January 2026 and February 2026 MARs were mixed in with some other papers because she was working on changing to an electronic records system. -She accidentally shredded the residents' January 2026 and February 2026 MARs along with some other papers about 2 days ago in the middle of the night. -She requested new MARs from the pharmacy on the day before yesterday (02/03/26) and was waiting to receive the MARs in the mail. Review of Resident #3's record on 02/09/26 revealed there were no January 2026 MARs to review. Review of Resident #3's February 2026 MARs on 02/09/26 revealed: -Pages 1 and 4 were missing. -There was no entry for the Atorvastatin 10mg, take 1 tablet daily, scheduled at 8:00pm. Observation of Resident #3's medications on hand on 02/09/25 at 10:51am revealed there were no Atorvastatin 10mg tablets available. Interview with the facility's contracted pharmacy on 02/09/26 at 1:37pm revealed: -There was an active order for Atorvastatin 10mg, take 1 tablet at bedtime. -The scheduled Atorvastatin 10mg was last dispensed on 11/07/25. Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable. f. Review of Resident #3's physician order dated 07/04/25 revealed an order for Zinc Oxide	C 330		

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ointment apply topically daily. (Zinc Oxide is a skin barrier ointment used to protect the skin and prevent skin breakdown.)

Review of Resident #3's physician order dated 09/10/25 revealed an order for Nystatin cream apply to groin and buttocks twice daily. (Nystatin is used to treat fungal infections of the skin.)

Review of Resident #3's record on 02/05/26 and 02/06/26 revealed:
-There were no January 2026 MARs to review.
-There were no February 2026 MARs to review.

Interview with the Administrator on 02/05/26 at 1:16pm revealed:
-The residents' January 2026 and February 2026 MARs were mixed in with some other papers because she was working on changing to an electronic records system.
-She accidentally shredded the residents' January 2026 and February 2026 MARs along with some other papers about 2 days ago in the middle of the night.
-She requested new MARs from the pharmacy on the day before yesterday (02/03/26) and was waiting to receive the MARs in the mail.

Observation of Resident #3's room on 02/05/26 at 10:59am revealed:
-There was a jar of Zinc Oxide ointment on top of Resident #3's chest of drawers.
-There was no prescription label with instructions on the jar.

Observation of Resident #3's room on 02/06/26 at 8:00am revealed:
-Resident #3 was lying in bed awake.
-The personal care aide (PCA) went into Resident #3's room to provide personal care and get the

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C 330	Continued From page 137 resident up for the day. -There was a scattered red rash in the middle of the resident's lower back. -There was a quarter-sized reddened area on her sacrum with the edges on the left side noted to have open areas of pink tissue. -The PCA got a tube of Nystatin cream from the resident's nightstand drawer and applied Nystatin cream to the rash on the resident's lower back and the excoriated skin on her sacral area after cleaning the resident's skin. Interview with the PCA on 02/06/26 from 8:00am - 8:19am revealed: -The rash and the excoriated area on Resident #3 had been there for about a week or two. -She usually applied the Nystatin cream to both areas and the areas would go away. -When she left on Sundays, the resident's skin would be clear, but when she returned to work on Thursdays, the resident's skin on her back and bottom would be red again. -The resident would sometimes complain of it hurting when she wiped the resident. Interview with the PCA on 02/05/26 at 11:12am revealed: -She was not a medication aide (MA), had no training to be a MA, and she was not interested in becoming a MA. -The Administrator was aware she was not a MA, did not have training to be a MA, and did not want to become a MA. Observation of the Administrator on 02/06/26 from 08:58am - 9:23am revealed the Administrator prepared medications for all residents without using any MARs, including Resident #3.	C 330		

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C 330	Continued From page 138 Interview with the Administrator on 02/06/26 at 9:55am revealed: -She was about to leave the facility to take herself to the hospital. -She had administered the residents all the medication they would need. -The surveyor prompted the Administrator that she had not administered medications she had prepared earlier that morning for Resident #3. Observation of the Administrator on 02/06/26 from 9:56am - 10:01am revealed: -At 9:57am, the Administrator administered the prepoured morning medications to Resident #3. -The Administrator did not offer or attempt to administer Zinc Oxide Ointment to Resident #3. -The Administrator did not refer to or document on any MARs. Review of Resident #3's record on 02/09/26 revealed there were no January 2026 MARs to review. Review of Resident #3's February 2026 MAR provided on 02/09/26 revealed: -There was an entry for Zinc Oxide ointment, spread topically to affected area once daily for protection scheduled at 8:00am. -Zinc Oxide ointment was documented as administered from 02/06/26 - 02/09/25. -There was an entry for Nystatin cream apply to groin and buttocks twice daily scheduled at 9:00am and 6:00pm. -Nystatin cream was documented as administered from 9:00am on 02/06/25 - 9:00am on 02/09/26. Interview with the Administrator on 02/10/26 at 11:04am revealed: -Resident #3 had an order to put Nystatin cream	C 330		

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on reddened skin.
-She usually applied Resident #3's Nystatin cream.
-The PCAs usually applied Zinc Oxide ointment after bathing Resident #3.
-The PCAs could apply Resident #3's Zinc Oxide ointment when they provided incontinence care to the resident.
-Resident #3's Nystatin cream was usually kept in the medication closet with the resident's other medications.
-She gave no explanation for not applying Zinc Oxide ointment to Resident #3 during the morning medication pass on 02/06/26 as ordered.
-Resident #3 had a "pink area" on her bottom that looked "the same".
-She had no explanation for the documentation on the February 2026 MAR for Nystatin and Zinc Oxide.

Telephone interview with Resident #3's primary care provider (PCP) on 02/10/26 at 2:10pm revealed:
-She was not aware of any current issues with Resident #3's skin.
-Not receiving Zinc Oxide ointment as ordered could have caused Resident #3's skin to breakdown.

g. Review of Resident #3's physician order dated 07/04/25 revealed an order for Metformin 500mg 1 tablet twice a day with meals. (Metformin lowers blood sugar. Metformin is an immediate released medication. Metformin ER is an extended released medication.)

Review of Resident #3's record on 02/05/26 and 02/06/26 revealed:
-There were no January 2026 medication administration records (MARs) to review.

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C 330	Continued From page 140 -There were no February 2026 MARs to review. Interview with the Administrator on 02/05/26 at 1:16pm revealed: -The residents' January 2026 and February 2026 MARs were mixed in with some other papers because she was working on changing to an electronic records system. -She accidentally shredded the residents' January 2026 and February 2026 MARs along with some other papers about 2 days ago in the middle of the night. -She requested new MARs from the pharmacy on the day before yesterday (02/03/26) and was waiting to receive the MARs in the mail. Observation of the Administrator on 02/06/26 from 08:58am - 9:23am revealed: -The Administrator prepared medications for all residents without using any MARs, including Resident #3. -The Administrator prepared one Metformin ER 500mg tablet instead of Metformin 500mg as ordered. Observation of the Administrator on 02/06/26 from 9:56am - 10:01am revealed: -At 9:57am, the Administrator administered the prepoured morning medications to Resident #3 including Metformin ER 500mg. -Resident #3 did not receive immediate release Metformin 500mg as ordered. -The Administrator did not refer to or document on any MARs. Review of Resident #3's record on 02/09/26 revealed there were no January 2026 MARs to review. Review of Resident #3's February 2026 MAR	C 330		

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C 330	Continued From page 141 provided on 02/09/26 revealed: -There was an entry for Metformin 500mg 1 tablet twice daily with meals scheduled at 9:00am and 6:00pm. -Metformin was documented as administered from 02/06/26 - 02/09/26 (9:00am). Observation of Resident #3's medications on hand on 02/09/26 at 10:51am revealed: -There was a supply of Metformin ER 500mg tablets dispensed on 11/08/24 with 30 of 60 tablets remaining. -There were no Metformin 500mg tablets available for administration. Telephone interview with the Pharmacy Manager at the facility's contracted pharmacy on 02/10/26 at 4:32pm revealed: -The pharmacy last dispensed 60 Metformin 500mg tablets for Resident #3 on 10/14/25. -The pharmacy last dispensed Metformin ER on 11/08/24 with 60 tablets. -The order changed on 11/13/24 from Metformin ER 500mg to immediate released Metformin 500mg twice a day. Interview with the Administrator on 02/10/26 at 11:04am revealed: -She administered Metformin ER to Resident #3 in error. -Metformin ER was an old medication and should not have been administered to Resident #3. -She pulled the wrong medication from the supply when she administered Metformin ER to Resident #3 on 02/06/26. -She did not have any Metformin 500mg on hand for Resident #3. -She then stated she had not noticed the Metformin ER she was administering to Resident #3 did not match the current order for immediate	C 330		

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C 330	Continued From page 142 release Metformin. Telephone interview with Resident #3's primary care provider (PCP) on 02/10/26 at 2:10pm revealed: -Resident #3 should be receiving Metformin 500mg not Metformin ER. -She did not have any immediate concerns about Resident #3 receiving the wrong formulation of Metformin but it should be administered as ordered. -She had seen some of Resident #3's blood sugars documented in the past (could not recall date) and she did not recall having concerns about the past readings. -Resident #3's hemoglobin A1C (a blood test that measures average blood sugar levels over the last 2 to 3 months) was 8.1 on 09/19/26, which was a good level for the resident. _____ The facility failed to administer medications as ordered to 3 of 4 sampled residents (#2, #3, #4). Resident #2, a hospice resident who was exhibiting moderate pain as determined by the hospice nurse did not receive a controlled substance for the pain because the Administrator wanted to wait until she returned from the hospital. The hospice nurse and surveyor intervened and had to request twice before the Administrator administered the pain medication to Resident #2 resulting in the resident's pain not being relieved in a timely manner. The Administrator reported she administered 18 to 19 tablets of a controlled substance pain medication to Resident #4 over a 2-day period which was more than double the ordered dosage, because she failed to document the time it was administered when no more than 4 tablets per day should have been administered putting the resident at risk of oversedation. Resident #3 did	C 330		

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C 330	Continued From page 143 not receive a rapid-acting insulin and a long-acting insulin as ordered putting the resident at risk of having high blood sugar which could cause diabetic ketoacidosis, and organ failure. Resident #3 did not receive Aspirin as ordered putting the resident at risk of having a heart attack. Resident #3's skin protectant ointment was not administered as ordered and the resident had skin breakdown on her sacral area. This failure of the facility resulted in serious neglect of the residents and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/06/26 for this violation. THIS FACILITY WAS ISSUED A SUMMARY SUSPENSION ON 02/12/26.	C 330		
C 334	10A NCAC 13G .1004 (e) Medication Administration 10A NCAC 13G .1004 Medication Administration (e) Medications shall not be crushed for administration until immediately before the medications are administered to the resident This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were not crushed for administration until immediately before the medications were administered to 3 of 4 residents (#1, #2, #4) during the medication pass on 02/06/26 to ensure safety and efficacy of the medications. The findings are:	C 334		

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C 334	Continued From page 144 Review of the facility's Pharmacy Policy and Procedure Manual dated January 2023 revealed: -Section 1 was not included in the notebook. -Sections 2 through 4 included: Medication Orders; Medication Ordering and Receiving from the Pharmacy Provider; and Medication Storage. -There was no section in the manual for Medication Administration. a. Review of Resident #1's current FL-2 dated 09/30/25 revealed diagnoses included Lewy body dementia, hypertension, and osteoporosis. b. Review of Resident #2's current FL-2 dated 03/29/25 revealed diagnoses included unspecified dementia, metabolic encephalopathy, normal pressure hydrocephalus, seizures, myoclonus, and history of falling. c. Review of Resident #4's current FL-2 dated 03/18/25 revealed diagnoses included dementia, functional quadriplegia, hypertension, congestive heart failure, general muscle weakness, atrial fibrillation, major depressive disorder, and metabolic encephalopathy. Observation of the Administrator on 02/06/26 from 8:58am - 9:23am revealed: -At 8:58am, the Administrator was in the kitchen preparing medications for the residents. -The Administrator had just finished preparing medications for Resident #1 and Resident #4. -Medications were already crushed and contained in an individual pill crusher with Resident #1's initials written on it. -Resident #1's pill crusher was not labeled with the name and strength of the medications that had been crushed and prepared in advance. -Medications were already crushed and contained	C 334		

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in an individual pill crusher with Resident #4's initials written on it.
-Resident #4's pill crusher was not labeled with the name and strength of the medications that had been crushed and prepared in advance.
-The Administrator then prepared three oral medications for Resident #2 including one liquid medication.
-The Administrator punched one Olanzapine 5mg tablet and put it in a pill crusher with Resident #2's initials then crushed it. (Olanzapine is an antipsychotic.)
-The Administrator opened two Depakote DR capsules and poured the contents of the capsules into the pill crusher with the crushed Olanzapine. (Depakote DR is used to treat seizure disorders and mood disorders.)
-The Administrator put the lid on top of the pill crusher and sat it on the counter along with the oral syringe with a liquid medication.
-At 9:08am, the Administrator took Resident #2's crushed medications and Resident #4's crushed medications and put them in two different small bowls and mixed them in applesauce.
-At 9:11am, the Administrator took the bowl with Resident #2's medications to the resident's room and used an oral syringe to administer about half of the crushed medications in applesauce to the resident.
-The Administrator fed the rest of the crushed medications with applesauce to Resident #2 using a spoon.
-Resident #2's medication was not crushed immediately before being administered to the resident.
-At 9:15am, the Administrator took the bowl with Resident #4's crushed medications in applesauce to the resident's room.
-The Administrator fed the crushed medications mixed in applesauce to Resident #4 using a

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C 334	Continued From page 146 spoon at 9:16am. -Resident #4's medication was not crushed immediately before being administered to the resident. -Resident #1's medications in the pill crusher were still sitting on the kitchen counter. -The Administrator did not offer the crushed medications to Resident #1. -At 9:21am, the Administrator put the resident's bins of medications back in the medication closet and locked the closet door. Observation of the Administrator on 02/06/26 at 9:23am revealed the Administrator left Resident #1's prepoured crushed medications in the pill crusher on the kitchen countertop. Interview with the Administrator on 02/06/26 at 9:55am revealed: -She was about to leave the facility to take herself to the hospital. -She had administered the residents all the medication they would need. -After being prompted by surveyor that she had not administered medications she had prepoured and crushed earlier for Resident #1. Observation of the Administrator on 02/06/26 from 9:56am - 10:01am revealed: -The Administrator poured the crushed medications from Resident #1's pill crusher that had been prepared earlier that morning into a small plastic white cup. -The Administrator did not mix the crushed medications in applesauce. -The Administrator walked to the living room and held out the small white plastic cup with crushed medications in front of Resident #1. -The Administrator asked Resident #1 if she wanted her medications with her coffee and the	C 334		

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C 334	Continued From page 147 resident replied, "no thank you". -Resident #1's medications were not crushed immediately before the medications were offered for administration to the resident. -The Administrator went back to the kitchen and put the crushed medications back into Resident #1's pill crusher and left them sitting on the counter. Interview with the Administrator on 02/10/26 at 11:04am revealed: -She prepared medications the same as usual on 02/06/26. -She usually prepared all medications at the same time, including any crushed medications. -She did not realize she was not supposed to crush medications until immediately before administering the crushed medications to each resident. -She was not familiar with specifics of prepouring medications, and she did not know the rules for prepouring medications.	C 334		
C 335	10A NCAC 13G .1004 (f) (1-4) Medication Administration 10A NCAC 13G .1004 Medication Administration (f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage: (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed	C 335		

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C 335	Continued From page 148 container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container; (2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name; (3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and (4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications prepared in advance were identified up to the point of administration and protected from contamination and spillage for 4 of 4 residents (#1, #2, #3, #4) during the medication pass on 02/06/26. The findings are: Review of the facility's Pharmacy Policy and Procedure Manual dated January 2023 revealed: -Section 1 was not included in the notebook. -Sections 2 through 4 included: Medication Orders; Medication Ordering and Receiving from the Pharmacy Provider; and Medication Storage.	C 335		

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C 335	Continued From page 149 -There was no section in the manual for Medication Administration. a. Review of Resident #1's current FL-2 dated 09/30/25 revealed diagnoses included Lewy body dementia, hypertension, and osteoporosis. b. Review of Resident #2's current FL-2 dated 03/29/25 revealed diagnoses included unspecified dementia, metabolic encephalopathy, normal pressure hydrocephalus, seizures, myoclonus, and history of falling. c. Review of Resident #3's current FL-2 dated 07/04/25 revealed diagnoses included right ureteral stone and diabetes. d. Review of Resident #4's current FL-2 dated 03/18/25 revealed diagnoses included dementia, functional quadriplegia, hypertension, congestive heart failure, general muscle weakness, atrial fibrillation, major depressive disorder, and metabolic encephalopathy. Observation of the Administrator on 02/06/26 from 08:58am - 9:23am revealed: -At 8:58am, the Administrator was in the kitchen preparing medications for the residents. -The Administrator had just finished preparing medications for Resident #1 and Resident #4. -Medications were already crushed and contained in an individual pill crusher with Resident #1's initials written on it. -Resident #1's pill crusher was not labeled with the name and strength of the medications, the planned time of administration, or the full name of the resident. -Medications were already crushed and contained in an individual pill crusher with Resident #4's initials written on it.	C 335		

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C 335	Continued From page 150 -Resident #4's pill crusher was not labeled with the name and strength of the medications, the planned time of administration, or the full name of the resident. -The Administrator prepared three oral medications for Resident #2 including one liquid medication. -The Administrator measured 7.5ml of Keppra 100mg/ml solution in an oral syringe for Resident #2. (Keppra is used to treat seizure disorders.) -The Administrator punched one Olanzapine 5mg tablet into her bare, ungloved hand and put it in a pill crusher with the resident's initials then crushed it. (Olanzapine is an antipsychotic.) -The Administrator opened two Depakote DR capsules and poured the contents of the capsules into the pill crusher with the crushed Olanzapine. (Depakote DR is used to treat seizure disorders and mood disorders.) -The Administrator put the lid on top of the pill crusher and sat it on the counter along with the oral syringe with Keppra solution. -The Administrator prepared 11 different oral medications for Resident #3 and put them in a small white plastic cup. -The medications in Resident #3's cups included: two Vitamin B12 500mcg gummies (a vitamin supplement); Lexapro 10mg (an antidepressant); Losartan 100mg (for high blood pressure); Ferrous Sulfate 325mg (an iron supplement); two Vitamin D3 50mcg tablets (for Vitamin D deficiency); Amlodipine 10mg (for heart and high blood pressure); Azo D Mannose 500mg (used to prevent urinary tract infections); two Tylenol 325mg tablets (for pain and fever); Probiotic (for gut health); Metformin ER 500mg (lowers blood sugar); and Hydrocodone/Acetaminophen 5/325mg (a controlled substance for moderate to severe pain). -The plastic cup was not labeled with the	C 335		

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C 335	Continued From page 151 resident's name, the name and strength of the medications inside the cup, or the planned time of administration. -The Administrator put the cup with Resident #3's medications on the counter beside the pill crushers. -The cup was not covered or sealed to protect from contamination or spillage. -At 9:08am, the Administrator took Resident #2's crushed medications and Resident #4's crushed medications and put them in two different small bowls and mixed them in applesauce. -She did not label the bowls with the names of the residents. -At 9:11am, the Administrator took the bowl with Resident #2's medications to the resident's room and used an oral syringe to administer about half of the crushed medications in applesauce to the resident. -The Administrator fed the rest of the crushed medications with applesauce to Resident #2 using a spoon but dropped a nickel-sized amount on the resident's shirt. -At 9:13am, the Administrator administered the Keppra solution in an oral syringe to Resident #2. -At 9:15am, the Administrator took the bowl with Resident #4's crushed medications in applesauce to the resident's room. -The Administrator fed the crushed medications mixed in applesauce to Resident #4 using a spoon at 9:16am. -Resident #1's medications in the pill crusher were still sitting on the kitchen counter. -Resident #3's medications in the small white plastic cup were still on the kitchen counter unlabeled and uncovered. -The Administrator did not offer medications to Resident #1 or Resident #3. -At 9:21am, the Administrator put the resident's bins of medications back in the medication closet	C 335		

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C 335	Continued From page 152 and locked the closet door. Observation of the Administrator on 02/06/26 at 9:23am revealed: -The Administrator left Resident #1's prepoured medications in the pill crusher on the kitchen countertop unattended. -The Administrator left Resident #3's prepoured medications in the small white plastic cup on the kitchen countertop unattended, unlabeled, and uncovered. Interview with the Administrator on 02/06/26 at 9:55am revealed: -She was about to leave the facility to take herself to the hospital. -She had administered the residents all the medication they would need. -After being prompted by surveyor that she had not administered medications she had prepoured earlier for Resident #1 and Resident #3. Observation of the Administrator on 02/06/26 from 9:56am - 10:01am revealed: -The Administrator poured the crushed medications from Resident #1's pill crusher into a small plastic white cup. -The Administrator did not mix the crushed medications in applesauce. -The Administrator walked to the living room and held out the small white plastic cup with crushed medications in front of Resident #1. -The Administrator asked Resident #1 if she wanted her medications with her coffee and the resident replied, "no thank you". -The Administrator went back to the kitchen and put the crushed medications back into Resident #1's pill crusher and left them sitting on the counter. -At 9:57am, the Administrator gave the white cup	C 335		

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C 335	Continued From page 153 with Resident #3's whole medications to Resident #3 while the resident was sitting in the living room. -Resident #3 took all of the medications that had been prepoured earlier that morning. -At 10:01am, the Administrator walked out of the kitchen and reported she was going to the bathroom and then to the hospital. Interview with the personal care aide (PCA) on 02/06/26 at 10:45am revealed: -The Administrator was the only medication aide (MA). -The Administrator usually prepared all residents' medications at the same time. -The Administrator sometimes left the residents' medications prepared in advance for administration on the kitchen counter before the Administrator left the facility. -The Administrator would tell her what time to administer the prepoured medications to the residents and she would administer the prepared medications to the residents at that time while the Administrator was away. -The last time she administered prepoured medications to the residents when the Administrator was not at the facility was on Saturday, 01/31/26. -She administered medications prepoured and left by the Administrator in the same pill crushers with residents' initials and the unlabeled, uncovered small white plastic cup about once a week. Interview with the Administrator on 02/10/26 at 11:04am revealed: -She prepared medications the same as usual on 02/06/26. -She did not realize preparing all residents medications at one time was considered	C 335		

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C 335	Continued From page 154 prepouring. -She was not familiar with specifics of prepouring medications, and she did not know the rules for prepouring medications. -She did not comment when asked about leaving prepoured medications for the PCA to administer.	C 335		
C 341	10A NCAC 13G .1004 (i) Medication Administration 10A NCAC 13G .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the staff person who administered medications documented on the medication administration records (MARs) immediately after administration of medications to 4 of 4 residents (#1, #2, #3, #4) and failed to ensure the staff person who administered medications actually observed 1 of 3 residents (#3) take their medication. The findings are: Review of the facility's Pharmacy Policy and Procedure Manual dated January 2023 revealed:	C 341		

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C 341	Continued From page 155 -Section 1 was not included in the notebook. -Sections 2 through 4 included: Medication Orders; Medication Ordering and Receiving from the Pharmacy Provider; and Medication Storage. -There was no section in the manual for Medication Administration. a. Review of Resident #1's current FL-2 dated 09/30/25 revealed diagnoses included Lewy body dementia, hypertension, and osteoporosis. b. Review of Resident #2's current FL-2 dated 03/29/25 revealed diagnoses included unspecified dementia, metabolic encephalopathy, normal pressure hydrocephalus, seizures, myoclonus, and history of falling. c. Review of Resident #3's current FL-2 dated 07/04/25 revealed diagnoses included right ureteral stone and diabetes. d. Review of Resident #4's current FL-2 dated 03/18/25 revealed diagnoses included dementia, functional quadriplegia, hypertension, congestive heart failure, general muscle weakness, atrial fibrillation, major depressive disorder, and metabolic encephalopathy. Interview with the Administrator on 02/05/26 at 1:16pm revealed: -The residents' January 2026 and February 2026 medication administration records (MARs) were mixed in with some other papers because she was working on changing to an electronic records system. -She accidentally shredded the residents' January 2026 and February 2026 MARs along with some other papers about 2 days ago in the middle of the night. -She requested new MARs from the pharmacy on	C 341		

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C 341	Continued From page 156 the day before yesterday (02/03/26) and was waiting to receive the MARs in the mail. -She did not have a fax machine at the facility to receive them via fax. -She had not thought about handwriting her own MARs until the replacement MARs came from the pharmacy. Observation of the Administrator on 02/06/26 from 08:58am - 9:23am revealed: -The Administrator was in the kitchen preparing medications for the residents. -The Administrator did not use any MARs while preparing medications for any of the residents. -The Administrator had just prepared medications for Resident #1 and Resident #4. -The medications for Resident #1 and Resident #4 were already crushed and in an individual pill crusher with the residents' initials. -The Administrator prepared three oral medications for Resident #2 including one liquid medication. -The Administrator put the lid on top of the pill crusher and sat it on the counter along with the oral syringe with the oral solution. -The Administrator prepared 11 different oral medications for Resident #3 and put them in a small white plastic cup. -The Administrator put the cup with Resident #3's medications on the counter beside the pill crushers. -At 9:08am, the Administrator took Resident #2's crushed medications and Resident #4's crushed medications and put them in two different small bowls and mixed them in applesauce. -At 9:11am, the Administrator took the bowl with Resident #2's medications to the resident's room and administered the medications to Resident #2. -The Administrator returned to the kitchen and did not document the administration of Resident #2's	C 341		

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C 341	Continued From page 157 medications on any MARs. -At 9:15am, the Administrator took the bowl with Resident #4's crushed medications in applesauce to the resident's room and administered medications to Resident #4. -The Administrator returned to the kitchen and did not document the administration of Resident #4's medications on any MARs. -The Administrator did not offer medications to Resident #1 or Resident #3 and left their medications sitting on the kitchen counter. -At 9:21am, the Administrator put the resident's bins of medications back in the medication closet and locked the closet door. Second observation of the Administrator on 02/06/26 from 9:56am - 10:01am revealed: -The Administrator poured the crushed medications from Resident #1's pill crusher into a small plastic white cup. -The Administrator did not mix the crushed medications in applesauce. -The Administrator walked to the living room and held out the small white plastic cup with crushed medications in front of Resident #1. -The Administrator asked Resident #1 if she wanted her medications with her coffee and the resident replied, "no thank you". -The Administrator went back to the kitchen and put the crushed medications back into Resident #1's pill crusher and left them sitting on the counter unsecured. -The Administrator did not document Resident #1's refusal of medications on any MARs. -At 9:57am, the Administrator gave the white cup with Resident #3's medications to Resident #3 while the resident was sitting in the living room. -The Administrator left the medications with Resident #3 in the living room while she went into the kitchen to prepare more coffee for the	C 341		

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C 341	Continued From page 158 resident. -Resident #3 took all the medications except for two vitamin gummies while the Administrator was in the kitchen with her back to the resident. -The Administrator did not observe the resident take the medications. -At 9:59am, the Administrator walked back to Resident #3 and gave her coffee and handed the resident the two vitamin gummies and walked away before the resident finished chewing and swallowing the vitamins. -The Administrator did not observe Resident #3 take the vitamin gummies. -The Administrator did not document the administration of Resident #3's medications on any MARs. -At 10:01am, the Administrator walked out of the kitchen and reported she was going to the bathroom and then to the hospital. Second interview with the Administrator on 02/10/26 at 11:04am revealed: -She used the instructions on the medications labels when she administered medications when she did not have MARs. -She made sure there were no medication changes in the residents' records. -She was aware she needed to document the administration of medications on the MARs; she just did not do it.	C 341		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name;	C 342		

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C 342	Continued From page 159 (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medication administration records (MARs) were maintained and accurate for 4 of 4 residents (#1, #2, #3, #4) residing at the facility with orders for multiple medications. The findings are: Review of the facility's Pharmacy Policy and Procedure Manual dated January 2023 revealed: -Section 1 was not included in the notebook. -Sections 2 through 4 included: Medication Orders; Medication Ordering and Receiving from the Pharmacy Provider; and Medication Storage. -There was no section in the manual for Medication Administration. 1. Review of Resident #2's current FL-2 dated 03/29/25 revealed diagnoses included	C 342		

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C 342	Continued From page 160 unspecified dementia, metabolic encephalopathy, normal pressure hydrocephalus, seizures, myoclonus, and history of falling. a. Review of Resident #2's current FL-2 dated 03/29/25 revealed: -There was an order for Depakote Sprinkles 125mg 2 capsules every 12 hours for seizures. (Depakote is used to treat and prevent seizures.) -There was an order for Melatonin 3mg 2 tablets once daily for sleep. (Melatonin is used to treat insomnia.) -There was an order for Olanzapine 2.5mg 1 tablet daily for antipsychotic. (Olanzapine is an antipsychotic used to treat psychosis and mood disorders.) -There was an order Olanzapine 5mg 1 tablet once a day for antipsychotic. Review of Resident #2's physician orders dated 08/18/25 revealed: -There was an order for Flomax 0.4mg 1 capsule at bedtime. (Flomax is used to treat benign prostatic hypertension and/or urinary retention.) -There was an order for Lorazepam 1mg every 6 hours as needed for agitation. (Lorazepam is a controlled substance used for anxiety and agitation.) -There was an order for Keppra 100mg/ml take 7.5ml (750mg) twice daily for seizures. (Keppra is used for seizure disorders.) Review of Resident #2's hospice orders dated 01/08/26 revealed: -There was an order to discontinue Olanzapine 2.5mg 1 tablet every morning for psychosis. -There was an order to start Olanzapine 5mg 1 tablet every morning for psychosis. Review of Resident #2's December 2025	C 342		

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C 342	Continued From page 161 medication administration record (MAR) revealed: -There was an entry for Depakote DR 125mg 2 tablets (250mg) every 12 hours scheduled at 8:00am and 8:00pm. -Depakote DR was not documented as administered at 8:00am from 12/20/25 - 12/31/25 and at 8:00pm on 12/17/25 and 12/20/25 - 12/31/25. -There was no reason for the omissions documented. -There was an entry for Keppra 100mg/ml take 7.5ml (750mg) twice daily for seizures scheduled at 9:00am and 6:00pm. -Keppra was not documented as administered from 6:00pm on 12/19/25 - 12/31/25. -There was no reason for the omissions documented. -There was an entry for Melatonin 3mg 2 tablets (6mg) at bedtime for insomnia scheduled at 8:00pm. -Melatonin was not documented as administered from 12/19/25 - 12/31/25. -There was no reason for the omissions documented. -There was an entry for Olanzapine 2.5mg 1 tablet every morning scheduled at 9:00am. -Olanzapine 2.5mg was not documented as administered from 12/20/25 - 12/31/25. -There was no reason for the omissions documented. -There was an entry for Olanzapine 7.5mg 1 tablet at bedtime scheduled at 8:00pm. -Olanzapine 7.5mg was not documented as administered from 12/19/25 - 12/31/25. -There was no reason for the omissions documented. -There was an entry for Flomax 0.4mg 1 capsule at bedtime scheduled at 8:00pm. -Flomax was not documented as administered from 12/19/25 - 12/31/25.	C 342		

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C 342	Continued From page 162 -There was no reason for the omissions documented. -There was an entry for Lorazepam 1mg 1 tablet every 6 hours as needed for agitation or restlessness. -Lorazepam 1mg was initialed as administered 24 times from 12/01/25 - 12/19/25. -There was no documentation of time of administration, reason for administration, or resulting effect for 24 of 24 occasions prn Lorazepam was initialed as administered. Observation of Resident #2's medications on hand on 02/05/26 at 3:00pm revealed: -There was a supply of Depakote DR 125mg capsules dispensed on 12/22/25 with 4 of 60 capsules remaining. -There was a supply of Keppra 100mg/ml liquid dispensed on 01/12/26 with approximately 90ml of 210ml remaining. -There was a supply of Melatonin 3mg tablets dispensed on 11/24/25 with 6 of 30 tablets remaining. -There was a supply of Melatonin 3mg tablets dispensed on 12/22/25 with 20 of 30 tablets remaining. -There was a supply of Melatonin 3mg tablets dispensed on 01/27/26 with 24 of 28 tablets remaining. -There was a supply of Olanzapine 5mg tablets dispensed on 01/09/26 with 7 of 14 tablets remaining. -There was a supply of Olanzapine 5mg tablets dispensed on 01/24/26 with 14 of 14 tablets remaining. -There was a supply of Olanzapine 7.5mg tablets dispensed on 11/24/25 with 14 of 14 tablets remaining. -There was a supply of Olanzapine 7.5mg tablets dispensed on 12/22/25 with 6 of 14 tablets	C 342		

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C 342	Continued From page 163 remaining. -There was a supply of Olanzapine 7.5mg tablets dispensed on 01/12/26 with 14 of 14 tablets remaining. -There was a supply of Tamsolusin 0.4mg capsules dispensed on 01/27/26 with 8 of 14 capsules remaining. -There was a supply of Lorazepam 1mg tablets dispensed on 12/11/25 with 52 of 60 tablets remaining. Review of Resident #2's record and the facility's MAR notebook on 02/05/26 revealed: -There was no January 2026 MAR for Resident #2. -There was no February 2026 MAR for Resident #2. Interview with the Administrator on 02/05/26 at 1:16pm revealed she did not have Resident #2's January 2026 and February 2026 MARs because she accidentally shredded them a couple of days ago. Second interview with the Administrator on 02/10/26 at 11:04am revealed: -She was aware she needed to document the date, time and effectiveness of prn medications on the MARs; she just did not do it. -For Resident #2's December 2025 MAR, the documentation was blank for the last half of the month because she failed to document the administration of his medications. -She administered Resident #2's medications but failed to document. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable.	C 342		

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C 342	Continued From page 164 Refer to interview with the Administrator on 02/05/26 at 1:16pm. b. Review of Resident #2's hospice order dated 01/05/26 revealed there was a new order for Hydrocodone/Acetaminophen (APAP) 5/325mg 1 tablet every 6 hours as needed for pain. (Hydrocodone/APAP is a controlled substance used for moderate to severe pain.) Observation of Resident #2's medications on hand on 02/05/26 at 3:05pm revealed: -There was a supply of Hydrocodone/APAP 5/325mg dispensed on 01/27/26 with 56 tablets. -The instructions were to take 1 tablet every 6 hours as needed for pain. -There was a total of 40 Hydrocodone/APAP 5/325mg tablets in and attached to the bubble card. Review of the Resident #2's controlled substance record (CSR) kept with the bubble card for Resident #2's Hydrocodone/APAP 5/325mg dispensed on 01/27/26 revealed: -The CSR had a prescription label at the top for a supply of 56 Hydrocodone/APAP 5/325mg tablets dispensed on 01/27/26. -There was a total of 19 doses documented as administered on the CSR from 01/28/26 - 02/02/26 with a balance of 40 tablets. Review of Resident #2's record and the facility's medication administration record (MAR) notebook on 02/05/26 revealed: -There was no January 2026 MAR for Resident #2. -There was no February 2026 MAR for Resident #2. -There were no MARs documenting the doses of Hydrocodone/APAP administered to Resident #2	C 342		

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C 342	Continued From page 165 in January or February 2026. Interview with the Administrator on 02/05/26 at 1:16pm revealed she did not have Resident #2's January 2026 and February 2026 MARs because she accidentally shredded them a couple of days ago. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable. Refer to interview with the Administrator on 02/05/26 at 1:16pm. 2. Review of Resident #3's current FL-2 dated 07/04/25 revealed: -Diagnosis included right urethral stone and diabetes. -The resident was constantly disoriented. -The resident was incontinent with a suprapubic catheter. -There was an order for Acetaminophen 325mg tablet, take 1 tablet daily. (Acetaminophen is used to treat minor pain and reduce fever). -There was an order for Aspirin 81mg, take 1 tablet daily. (Aspirin is used to treat pain, inflammation, and reduce the risk of heart attacks and strokes). -There was an order for Atorvastatin 10mg, take 1 tablet at bedtime. (Atorvastatin is used to treat high cholesterol). -There was an order for Insulin Glargine 100unit/ml injection, inject 17 units daily. (Glargine is a long-acting insulin used to control type 1 or type 2 diabetes). -There was an order for Insulin Lispro 100unit/ml injection, inject per facility protocol. (Lispro is a rapid-acting insulin used to treat type 1 or type 2 diabetes).	C 342		

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C 342	Continued From page 166 Review of Resident #3's physician's orders dated 03/07/25 revealed there was an order to check and record blood sugars and administer Lispro per sliding scale; 201-250= 2 units, 251- 300= 4 units; 301- 350= 6 units; 351- 400= 8 units; 401-450= 10 units; 451- 500= 12 units; 500 or greater call primary care provider (PCP). Review of Resident #3's December 2025 medication administration record (MAR) revealed: -There was no documentation the Glargine was administered from 12/18/25 to 12/31/25 at 9:00am. -There was no documentation the Lispro was administered from 12/18/25 to 12/31/25 at 11:00am and 4:00pm. -There were no documentation of the blood sugar readings. -There was no documentation the Acetaminophen 325mg was administered at 2:00pm. -There was no documentation the Aspirin 81mg was administered from 12/18/25 to 12/31/25 at 8:00am. -There was no documentation the Atorvastatin 10mg was administered from 12/17/25 to 12/31/25 at 8:00pm. Review of Resident #3's record on 02/05, 02/06/26, and 02/09/26 revealed there were no January 2026 MARs. Review of Resident #3's February 2026 MAR on 02/09/26 revealed: -There were missing pages from the MAR. -There were missing entries for Acetaminophen, Atorvastatin, and Aspirin. Refer to interview with the Administrator on	C 342		

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C 342	Continued From page 167 02/05/26 at 1:16pm. 3. Review of Resident #4's current FL-2 dated 03/18/25 revealed diagnoses included congestive heart failure, hypertension, metabolic encephalopathy and muscle weakness. Review of Resident #4's physician's order dated 02/02/26 revealed: -There was an order for Morphine 20mg/ml solution, take 0.25ml every 4 hours as needed (PRN) for pain. (Morphine is used to manage pain). -There was an order for Lorazepam 1mg tablet, take 1 every 4 hours PRN for anxiety and agitation. (Lorazepam is used to treat anxiety and agitation). -There was an order for Acetaminophen 500mg tablet, take 1 every 6 hours PRN for pain. (Acetaminophen is used to treat pain). -There was an order for Aripiprazole 10mg tablet, take daily. (Aripiprazole is used to treat schizophrenia and other mood disorders). -There was an order for Cyclobenzaprine 5mg tablet, take 1 every 8 hours PRN for muscle spasms. (Cyclobenzaprine is used to control muscle spasms). -There was an order for Lidocaine 4% patch, apply patch daily for pain. (Lidocaine patch is used to treat pain). -There was an order for Losartan potassium 50mg tablet, take 1 daily. (Losartan potassium is used to treat high blood pressure). -There was an order for Melatonin 3mg tablet, take 1 tablet daily. (Melatonin is used to treat sleep). -There was an order for Paroxetine 30mg tablet, take 1 daily. (Paroxetine is used to treat depression). -There was an order for Oxycodone 5mg tablet,	C 342		

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C 342	Continued From page 168 take 1 every 6 hours PRN for pain. (Oxycodone is used to treat pain). -There was an order for Quetiapine 25mg tablet, take 1 every 6 hours PRN hallucinations and delusions. (Quetiapine is used to treat hallucinations and delusions). -There was an order for Rizatriptan 5mg tablet, take 1 PRN for migraines. (Rizatriptan is used to treat migraines). Review of Resident #4's December 2025 medication administration record (MAR) revealed there were no medications documented as administered. Review of Resident #4's record on 02/05/26, 02/06/26, and 02/09/26 revealed there were no January 2026 and February 2026 MARs. Refer to interview with the Administrator on 02/05/26 at 1:16pm. 4. Review of Resident #1's current FL-2 dated 09/30/25 on 02/6/26 at 11:40am revealed: -Diagnoses included Lewy body dementia, hypertension, and osteoporosis. -There was an order for Tylenol 500 mg tablet every six hours as needed for pain. (Tylenol is used to control pain). -There was an order for Cymbalta 20 mg capsule daily. (Cymbalta is used to treat depression). -There was an order for Meloxicam 7.5 mg tablet twice daily. (Meloxicam is used to relieve pain). -There was an order for Exelon 4.6 mg patch daily. (Exelon is used to treat dementia). -There was an order for Seroquel 50 mg tablet daily. (Seroquel is used to schizophrenia, bipolar disorder or depression). Review of Resident #1's December 2025 MAR	C 342		

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C 342	Continued From page 169 revealed there was no documentation medications were administered. Review of Resident #1's record revealed there were no MARs for January 2026 and February 2026. Refer to interview with the Administrator on 02/05/26 at 1:16pm. _____ Interview with the Administrator on 02/05/26 at 1:16pm revealed: -The residents' January 2026 and February 2026 MARs were mixed in with some other papers because she was working on changing to an electronic records system. -She accidentally shredded the residents' January 2026 and February 2026 MARs along with some other papers about 2 days ago in the middle of the night. -She requested new MARs from the pharmacy on the day before yesterday (02/03/26) and was waiting to receive the MARs in the mail. -She did not have a fax machine at the facility to receive them via fax. -She had not thought about handwriting new MARs for the residents until the replacement MARs were received.	C 342		
C 346	10A NCAC 13G .1004(n) Medication Administration 10A NCAC 13G .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents.	C 346		

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C 346	Continued From page 170 This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record review, the facility failed to ensure infection control measures were implemented during medication administration on 02/06/26 by the Administrator/medication aide observed who failed to wash or sanitize her hands prior to preparing and after administering multiple oral medications to 4 of 4 residents (#1, #2, #3, #4) including putting the pills in her bare ungloved hands and feeding crushed medications in applesauce to two residents. The findings are: Review of the facility's undated Infection Control Policies and Procedures revealed: -The facility staff was to adhere to standard precautions for the care of all residents. -The facility staff was to adhere to hand hygiene policy when performing hand hygiene with either soap and water or alcohol-based hand rub. -The facility staff was to follow Centers for Disease Control (CDC) handwashing guidelines. -The facility staff should wash hands after touching blood, body fluids, secretions, excretions, and contaminated items. -The facility staff should decontaminate hands after removing gloves. -The facility staff should decontaminate hands between resident contacts. -The facility staff should practice hand hygiene whenever needed to avoid spreading microbes to other persons or areas. a. Review of Resident #1's current FL-2 dated 09/30/25 revealed diagnoses included Lewy body	C 346		

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C 346	Continued From page 171 dementia, hypertension, and osteoporosis. b. Review of Resident #2's current FL-2 dated 03/29/25 revealed diagnoses included unspecified dementia, metabolic encephalopathy, normal pressure hydrocephalus, seizures, myoclonus, and history of falling. c. Review of Resident #3's current FL-2 dated 07/04/25 revealed diagnoses included right ureteral stone and diabetes. d. Review of Resident #4's current FL-2 dated 03/18/25 revealed diagnoses included dementia, functional quadriplegia, hypertension, congestive heart failure, general muscle weakness, atrial fibrillation, major depressive disorder, and metabolic encephalopathy. Observation of the Administrator on 02/06/26 between 7:21am - 7:40am revealed: -Surveyor began knocking at the front door at 7:21am. -The Administrator answered the door at 7:30am. -The Administrator was grimacing. -The Administrator stated she had been up all night, was not feeling well and planned to go the emergency department when the other staff arrived. Observation of the Administrator on 02/06/26 from 08:58am - 9:21am revealed: -The Administrator was in the kitchen preparing medications for the residents. -The Administrator had already prepared medications for Resident #1 and Resident #4. -The medications for Resident #1 and Resident #4 were already crushed and in an individual pill crusher with the residents' initials. -The Administrator began preparing medications	C 346		

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C 346	Continued From page 172 for Resident #2. -The Administrator did not wash or sanitize her hands before preparing Resident #2's medications. -The Administrator prepared three oral medications for Resident #2 including one liquid medication. -The Administrator measured 7.5ml of an oral medication solution in an oral syringe for Resident #2. -The Administrator punched one medication tablet into her bare, ungloved hand and put it in a pill crusher with the resident's initials then crushed it. -The Administrator opened two medication capsules with her bare, ungloved hands and poured the contents of the capsules into the pill crusher with the crushed tablet. -The Administrator put the lid on top of the pill crusher and sat it on the counter along with the oral syringe with the oral medication solution. -The Administrator did not wash or sanitize her hands before preparing Resident #3's medications. -The Administrator punched all oral medications for Resident #3 into her bare, ungloved hands. -The Administrator prepared 11 different oral medications for Resident #3 and put them in a small white plastic cup. -The Administrator put the cup with Resident #3's medications on the counter beside the pill crushers. -At 9:08am, the Administrator took Resident #2's crushed medications and Resident #4's crushed medications and put them in two different small bowls and mixed them in applesauce. -The Administrator did not wash or sanitize her hands after preparing medications for the residents. -At 9:11am, the Administrator took the bowl with	C 346		

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C 346	Continued From page 173 Resident #2's medications to the resident's room and used an oral syringe to administer about half of the crushed medications in applesauce to the resident. -The Administrator fed the rest of the crushed medications with applesauce to Resident #2 using a spoon but dropped a nickel-sized amount on the resident's shirt. -At 9:13am, the Administrator administered the oral medication solution in an oral syringe to Resident #2. -The Administrator then held Resident #2's cup and straw to his mouth with her bare, ungloved hands, while the resident drank from the straw. -The Administrator returned to the kitchen and did not wash or sanitize her hands. -At 9:15am, the Administrator took the bowl with Resident #4's crushed medications in applesauce to the resident's room. -The Administrator fed the crushed medications mixed in applesauce to Resident #4 using a spoon at 9:16am. -The Administrator walked back to the kitchen with Resident #4's cup to get more water for the resident. -At 9:19am, the Administrator took the cup back to Resident #4's room and sat it on the over-the-bed table and positioned the straw with her bare, ungloved hand. -She turned on the resident's television with the remote, moved a rolling walker and laundry basket and then went back to the kitchen. -The Administrator did not wash or sanitize her hands. -Resident #1's medications in the pill crusher were still sitting on the kitchen counter. -Resident #3's medications in the small white plastic cup were still on the kitchen counter unlabeled and uncovered. -The Administrator did not offer medications to	C 346		

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C 346	Continued From page 174 Resident #1 or Resident #3. -At 9:21am, the Administrator put the resident's bins of medications back in the medication closet and locked the closet door. -She did not wash or sanitize her hands. Interview with the Administrator on 02/06/26 at 9:55am revealed: -She was about to leave the facility to take herself to the hospital. -She had administered the residents all the medication they would need. -After being prompted by the surveyor that she had not administered medications she had prepared earlier for Resident #1 and Resident #3, she reported Resident #1 always refused her medications. -The Administrator was reminded by the surveyor that she had to offer medications to the resident even though she had a history of refusing medications. Second observation of the Administrator on 02/06/26 from 9:56am - 10:01am revealed: -The Administrator did not wash or sanitize her hands. -The Administrator poured the crushed medications from Resident #1's pill crusher into a small plastic white cup. -The Administrator did not mix the crushed medications in applesauce. -The Administrator walked to the living room and held out the small white plastic cup with crushed medications in front of Resident #1. -The Administrator asked Resident #1 if she wanted her medications with her coffee and the resident replied, "no thank you". -The Administrator went back to the kitchen and put the crushed medications back into Resident #1's pill crusher and left them sitting on the	C 346		

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C 346	Continued From page 175 counter unsecured. -The Administrator did not wash or sanitize her hands. -At 9:57am, the Administrator gave the white cup with Resident #3's whole medications to Resident #3 while the resident was sitting in the living room. -Resident #3 took all of the medications except for two vitamin gummies. -At 9:59am, the Administrator walked back to Resident #3 and gave her coffee and handed the resident the two vitamin gummies with her bare, ungloved hands. -The Administrator did not wash or sanitize her hands. -At 10:01am, the Administrator walked out of the kitchen and reported she was going to the bathroom and then to the hospital because she was not feeling well. Interview with the Administrator on 02/10/26 at 11:04am revealed: -She usually washed her hands then pulled and prepared all residents' medications at the same time. -She prepared medications the same as usual on 02/06/26. -She usually punched the pills into her bare hands. -She then administered all residents medications. -She did not usually touch any residents' when she administered medications. -She usually washed her hands after she finished administering medications to all residents. Telephone interview with a resident's primary care provider (PCP) on 02/10/26 at 2:10pm revealed not washing or sanitizing hands between residents when administering medications could cause contamination and the transmission of	C 346		

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C 346	Continued From page 176 communicable diseases. _____ The facility failed to administer medications in accordance with infection control measures to all 4 residents residing at the facility, including 2 residents who were receiving hospice services. The Administrator was the only staff employed by the facility who administered medications. The Administrator prepared oral morning medications for all residents at the facility on 02/06/26 including an oral liquid medication and crushed medications. The Administrator punched all medications into her bare, ungloved hands when preparing the medications. The Administrator did not wash or sanitize her hands while preparing or after administering medications to the residents including feeding crushed medications in applesauce and touching two residents' straws with her bare, ungloved, unwashed hands. The Administrator had complained of not feeling well with gastrointestinal symptoms that morning prior to preparing and administering medications. Not preparing and administering medications using proper infection control measures put the residents at risk of contamination and transmission of communicable diseases. This failure of the facility put residents at substantial risk of physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/06/26 for this violation. THIS FACILITY WAS ISSUED A SUMMARY SUSPENSION ON 02/12/26.	C 346		
C 353	10A NCAC 13G .1006 (b) Medication Storage	C 353		

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C 353	Continued From page 177 10A NCAC 13G .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure all residents' medications and the medication closet were locked when not under the direct physical supervision of staff in charge of medication administration on 02/05/26 and 02/06/26. The findings are: Review of the facility's Pharmacy Policy and Procedure Manual dated January 2023 revealed: -Medications and biologicals were stored properly, following manufacturers' instructions or provider pharmacy recommendations, to maintain their integrity and to support safe, effective drug administration. -The medication supply should be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. -In order to limit access to prescription medications, only licensed nurses, pharmacy staff, and those lawfully authorized to administer medications (such as medication aides) were allowed access to medication carts. -Medication rooms, cabinets, and medication supplies should remain locked when not in use or attended by persons with authorized access.	C 353		

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C 353	Continued From page 178 a. Review of Resident #1's current FL-2 dated 09/30/25 revealed diagnoses included Lewy body dementia, hypertension, and osteoporosis. b. Review of Resident #2's current FL-2 dated 03/29/25 revealed diagnoses included unspecified dementia, metabolic encephalopathy, normal pressure hydrocephalus, seizures, myoclonus, and history of falling. c. Review of Resident #3's current FL-2 dated 07/04/25 revealed diagnoses included right ureteral stone and diabetes. d. Review of Resident #4's current FL-2 dated 03/18/25 revealed diagnoses included dementia, functional quadriplegia, hypertension, congestive heart failure, general muscle weakness, atrial fibrillation, major depressive disorder, and metabolic encephalopathy. Observation of the facility on 02/06/26 between 7:21am and 7:40am revealed: -The Administrator answered the door at 7:30am. -There were no lights on in the facility. -The medication closet in the hallway was opened with the keys hanging on a keychain in the lock of the doorknob. Observation of the hallway on 02/05/26 at 11:13am revealed: -The Administrator walked to the medication closet and opened the door while the door was still unlocked with the keys hanging from the doorknob. -There were blue plastic bins labeled with residents' names that contained the residents' prescription and non-prescription medications, including controlled substances. -The Administrator took a medication dose pack	C 353		

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C 353	Continued From page 179 from the medication closet, closed the door and left the keys hanging in the doorknob. -The Administrator walked back to the kitchen/dining room area and left the medication closet unlocked. Observation of the facility on 02/05/26 from 11:56am - 12:10pm revealed: -The Administrator left the facility at 11:56am. -The personal care aide (PCA) was left at the facility with the four residents. -At 12:10pm, the medication closet was still unlocked with the keys hanging in the doorknob. -There was an ambulatory resident in her room with the door opened which was right beside the medication closet. Interview with the PCA on 02/05/26 at 12:10pm revealed: -She had not noticed the medication closet was unlocked with the keys hanging in the doorknob. -She did not know why the Administrator left the medication closet unlocked. -She was not sure how long the Administrator would be away from the facility. Observation on 02/05/26 revealed the Administrator drove back in the facility's driveway at 12:14pm. Observation of the hallway on 02/05/26 at 1:55pm revealed: -The door to the medication closet was cracked open about an inch with the keys hanging in the doorknob. -There was one ambulatory resident in her room next to the unlocked medication closet. -There were two non-ambulatory residents in the living room near the medication closet and one visitor in the living room.	C 353		

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C 353	Continued From page 180 -There was a PCA in the dining room. -The Administrator, who was the only staff who administered medications, was not in view of the medication closet. Observation of the hallway on 02/05/26 at 2:35pm revealed the door to the medication closet was still cracked open about an inch with the keys hanging in the doorknob. Interview with the Administrator on 02/05/26 at 2:35pm revealed: -She was the only medication aide (MA) at the facility and the only staff with keys to the medication closet. -She usually kept the medication closet locked. -She had no explanation for the medication closet being unlocked with the keys hanging in the doorknob throughout the day on 02/05/26. -The controlled substances used to be kept in a locked box, but the lock broke on the box a couple of weeks ago. -The controlled substances were now kept in the medication closet stored with each individual residents' medication bins. Observation of the Administrator on 02/05/26 at 2:47pm revealed: -The Administrator walked to the unlocked medication closet and looked at some items on the shelves. -She then closed the medication closet door and locked it. Observation of the hallway on 02/06/26 at 7:43am revealed: -The door to the medication closet was cracked open about an inch with the keys hanging in the doorknob. -There was one ambulatory resident in her room	C 353		

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C 353	Continued From page 181	C 353		

next to the unlocked medication closet.
-The facility was dark and all four residents were still in bed.
-The Administrator was not in view of the medication closet.
-There were no other staff in the facility at that time.

Observation of the hallway on 02/06/26 at 8:48am revealed:
-The door to the medication closet was still cracked open about an inch with the keys hanging in the doorknob.
-There was one ambulatory resident in the living room near the medication closet drinking coffee and watching television.
-There was a second non-ambulatory resident in the living room near the medication closet drinking coffee and watching television.
-The PCA was in the kitchen area preparing breakfast and did not have view of the medication closet while in the kitchen.
-The Administrator was not in view of the medication closet.

Observation of the Administrator on 02/06/26 from 08:58am - 9:23am revealed:
-The Administrator was in the kitchen preparing medications for the residents.
-The Administrator had already prepared medications for Resident #1 and Resident #4.
-The medications for Resident #1 and Resident #4 were already crushed and in an individual pill crusher with the resident's initials sitting on the kitchen counter.
-The Administrator prepared three oral medications for Resident #2 including one liquid medication.
-The Administrator prepared 11 different oral medications for Resident #3 and put them in a

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C 353	Continued From page 182 small white plastic cup. -The Administrator put the cup with Resident #3's medications on the counter beside the pill crushers. -At 9:11am, the Administrator administered medications to Resident #2 in the resident's room, while leaving medications for the other 3 residents unsecured sitting on the kitchen counter. -The medications in the kitchen were not under the supervision of the Administrator. -At 9:15am, the Administrator returned to the kitchen and then took and administered Resident #4's medications to the resident's room at 9:16am. -The medications in the kitchen were not under the supervision of the Administrator while she administered medications in Resident #4's room. -The Administrator walked back to the kitchen with Resident #4's cup to get more water for the resident. -At 9:19am, the Administrator took the cup back to Resident #4's room and sat it on the over-the-bed table, again leaving unsecured medications in the kitchen. -Resident #1's medications in the pill crusher were still sitting on the kitchen counter. -Resident #3's medications in the small white plastic cup were still on the kitchen counter unlabeled and uncovered. -The Administrator did not offer medications to Resident #1 or Resident #3. -At 9:21am, the Administrator put the resident's bins of medications back in the medication closet and locked the closet door but she left Resident #1 and Resident #3's prepared medications unsecured in the kitchen. Interview with the Administrator on 02/06/26 at 9:21am revealed she was going to leave the	C 353		

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C 353	Continued From page 183 facility to go to the hospital since she was not feeling well. Observation of the Administrator and PCA on 02/06/26 at 9:23am revealed: -The Administrator did not answer when she was asked how residents would get any needed medications while she was away from the facility. -The Administrator walked away from the interview and went to the staff bedroom and shut the door. -The Administrator left Resident #1's medications in the pill crusher on the kitchen countertop unattended. -The Administrator left Resident #3's medications in the small white plastic cup on the kitchen countertop unattended, unlabeled, and uncovered. -The PCA went outside then to a resident's room so the medications in the kitchen were unsecured and accessible to anyone. -There were two residents in the living room eating breakfast right beside the open kitchen area with the unsecured medications. -One of the residents was ambulatory. Interview with the Administrator on 02/06/26 at 9:55am revealed: -She was about to leave the facility to take herself to the hospital. -She had administered the residents all the medication they would need. -The surveyor prompted the Administrator that she had not administered medications she had prepared earlier for Resident #1 and Resident #3 and left on the kitchen counter. -The Administrator was reminded by the surveyor that the medications should not be left unsecured when not under her direct supervision.	C 353		

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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
C 353	Continued From page 184 Observation of the Administrator on 02/06/26 from 9:56am - 10:01am revealed: -The Administrator poured the crushed medications from Resident #1's pill crusher into a small plastic white cup. -The Administrator did not mix the crushed medications in applesauce. -The Administrator walked to the living room and held out the small white plastic cup with crushed medications in front of Resident #1. -The Administrator asked Resident #1 if she wanted her medications with her coffee and the resident replied, "no thank you". -The Administrator went back to the kitchen and put the crushed medications back into Resident #1's pill crusher and left them sitting on the counter unsecured. -At 9:57am, the Administrator gave the white cup with Resident #3's whole medications to Resident #3 while the resident was sitting in the living room. -At 10:01am, the Administrator walked out of the kitchen and reported she was going to the bathroom and then to the hospital. -Resident #1's pill crusher with crushed medications were still sitting on the kitchen counter unsecured. Interview with the Administrator on 02/10/26 at 11:04am revealed: -She usually tried to keep the medication closet locked. -She had no explanation for leaving the medication closet unlocked two days in a row, 02/05/26 and 02/06/26. -She had no explanation for leaving the medications unattended on the kitchen counter on 02/06/26. _____ The facility failed to ensure medications for all	C 353		

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C 353	Continued From page 185 residents including, controlled substances for some residents were maintained under locked security except when under the direct supervision of staff who administered medications. The Administrator, who was the only staff employed by the facility who administered medications left the medication closet unlocked with the keys hanging in the doorknob throughout the day on 02/05/26 and again on 02/06/26, leaving medications accessible to residents, visitors, staff, and outside agencies. The Administrator also left medications on the counter in the kitchen unsecured and unlocked while she went to residents' room to administer medications, including leaving medications on the kitchen counter when she left the facility on 02/06/26 to take herself to the emergency department because she was not feeling well, even after being prompted by surveyor that medications were on the kitchen counter. The medications were accessible to residents including an ambulatory resident diagnosed with dementia. This failure of the facility was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/05/26 for this violation. THIS FACILITY WAS ISSUED A SUMMARY SUSPENSION ON 02/12/26.	C 353		
C 367	10A NCAC 13G .1008(a) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (a) A family care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and	C 367		

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C 367	Continued From page 186 disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure readily retrievable records that accurately reconciled the receipt and administration of controlled substances for 2 of 2 hospice residents (#2, #4) with orders for controlled substances used to treat moderate to severe pain (#2, #4) and a controlled substance used to treat anxiety and agitation (#2). The findings are: Review of the facility's Pharmacy Policy and Procedure Manual dated January 2023 revealed: -The pharmacy or the facility would prepare an individual resident controlled substance record (CSR) for each controlled substance (CS) medication prescribed for a resident as applicable per state law. -The CSR was to be placed in the medication administration record (MAR) or CSR book to be counted every shift. -At each shift change or when keys are surrendered, a physical inventory of all schedule II controlled substances was conducted by two licensed nurses or per state regulation and was documented on the CSR or verification of CS count report. -The facility may elect to count all controlled substances at shift change. -If a major discrepancy or a pattern of discrepancies occurred or if there was apparent	C 367		

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C 367	Continued From page 187 criminal activity, the Director of Nursing notified the Administrator, Pharmacy Manager, and Consultant Pharmacist immediately. 1. Review of Resident #4's current FL-2 dated 03/18/25 revealed diagnoses included dementia, functional quadriplegia, hypertension, congestive heart failure, general muscle weakness, atrial fibrillation, major depressive disorder, and metabolic encephalopathy. Review of Resident #4's physician orders dated 08/18/25 revealed an order for Oxycodone 5mg 1 tablet every 4 hours as needed (prn) for pain. (Oxycodone is a controlled substance used to treat moderate to severe pain.) Review of Resident #4's hospice order dated 12/18/25 revealed an order to discontinue Oxycodone. Review of Resident #4's December 2025 medication administration record (MAR) revealed: -There was an entry for Oxycodone 5mg 1 tablet every 4 hours prn pain. -There was no Oxycodone 5mg documented as administered in December 2025. -There was a handwritten note that Oxycodone was discontinued but no date indicated. Review of Resident #4's hospice order dated 01/25/26 revealed a new order to start Oxycodone 5mg 1 tablet every 6 hours prn pain. Review of Resident #4's record revealed there were no January 2026 and February 2026 MARs. Interview with the Administrator on 02/05/26 at 1:16pm revealed: -All residents' January 2026 and February 2026	C 367		

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C 367	Continued From page 188 MARs were mixed in with some other papers because she was working on changing to an electronic records system. -She accidentally shredded the residents' January 2026 and February 2026 MARs along with some other papers about 2 days ago in the middle of the night. -She requested new MARs from the pharmacy on the day before yesterday (02/03/26) and was waiting to receive the MARs in the mail. -She did not have a fax machine at the facility. Telephone interview with the Pharmacy Manager at the facility's contracted pharmacy on 02/11/26 at 9:31am revealed: -The pharmacy dispensed 84 Oxycodone 5mg tablets for Resident #4 on 11/12/25. -The pharmacy dispensed 84 Oxycodone 5mg tablets for Resident #4 on 11/25/25. -There were 2 cards of 42 tablets each dispensed to equal 84 tablets. -The pharmacy dispensed 54 Oxycodone 5mg tablets (1 card) for Resident #4 on 01/27/26. -The instructions were to take 1 tablet every 4 hours as needed for pain. Review of Resident #4's controlled substance record (CSR) for Oxycodone 5mg tablets dispensed on 11/12/25 revealed: -There was a CSR for card 2 of 2 for 42 of 84 Oxycodone 5mg tablets dispensed on 11/12/25. -All 42 Oxycodone 5mg tablets dispensed in card 2 of 2 were documented as administered from 11/14/25 at 8:00am through 11/26/25 at 11:00pm, leaving a balance of 0. -There was no CSR for card 1 of 2 for 42 of 84 Oxycodone 5mg tablets maintained in the facility to account for and accurately reconcile 42 of 84 Oxycodone 5mg tablets dispensed on 11/25/25.	C 367		

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C 367	Continued From page 189 Review of Resident #4's CSR for Oxycodone 5mg tablets dispensed on 11/25/25 revealed: -There was a CSR for card 2 of 2 for 42 of 84 Oxycodone 5mg tablets dispensed on 11/25/25. -All 42 Oxycodone 5mg tablets dispensed in card 2 of 2 were documented as administered from 11/27/25 at 5:30am through 12/09/25 at 8:30pm, leaving a balance of 0. -There was no CSR for card 1 of 2 for 42 of 84 Oxycodone 5mg tablets maintained in the facility to account for and accurately reconcile 42 of 84 Oxycodone 5mg tablets dispensed on 11/25/25. Review of Resident #4's CSR for Oxycodone 5mg tablets dispensed on 01/27/26 revealed: -There was a CSR for 1 card of 54 Oxycodone 5mg tablets dispensed on 01/27/26. -The first dose was documented as administered on 01/27/26 at 11:00pm, leaving a balance of 53. -There were 3 doses documented as administered on 01/28/26 at 7:00am, 2:00pm, and 7:30pm, leaving a balance of 50. -There was a dose documented as administered on 01/29/26 at 5:00am and 01/29/26 at 11:00am, leaving a balance of 48. -The last dose documented on the CSR was 01/29/26 at 5:00pm but the remaining balance was left blank but should have been documented as 47 tablets. Observation of Resident #4's medications on hand on 02/06/26 at 4:45pm revealed there were no Oxycodone 5mg tablets available for administration. Second interview with the Administrator on 02/06/26 at 3:05pm revealed: -The CSRs for Resident #4's Oxycodone 5mg tablets should be in the MAR notebook. -If the CSRs were not in the MAR notebook, they	C 367		

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C 367	Continued From page 190 had probably been shredded when she accidentally shredded the MARs about 2 days ago. Interview with Resident #4's hospice nurse on 02/06/26 at 11:10am revealed: -She usually checked controlled substance counts once a week for hospice residents. -On Wednesday, 02/04/26, Resident #4 had 29 Oxycodone 5mg tablets on hand at the facility. -She did not check any CSRs when she counted the controlled substances. -The Administrator reported to her that Resident #4 had no Oxycodone on hand today, 02/06/26. -The Administrator told her that she would have to get Resident #4 some more Oxycodone. -The Administrator gave no explanation as to what happened to the 29 Oxycodone 5mg tablets that were on hand 2 days ago on 02/04/26. Third interview with the Administrator on 02/10/26 at 11:04am revealed: -She was not feeling well on Wednesday, 02/04/26, when Resident #4's hospice nurse was at the facility. -She failed to contact Resident #4's hospice nurse to let the nurse know that she had miscounted Resident #4's Oxycodone while the nurse was at the facility on 02/04/26. -Resident #4's hospice nurse asked her how many Oxycodone tablets Resident #4 had on 02/04/26. -She told the nurse there were 29 Oxycodone tablets on 02/04/26 but she miscounted and there were "actually 18 or 19" Oxycodone tablets on hand on 02/04/26. -She did not think the hospice nurse looked at the amount of Oxycodone on hand on 02/04/26; the hospice nurse just asked her to tell her the number.	C 367		

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C 367	Continued From page 191 -There were none of Resident #4's Oxycodone tablets on hand on Friday, 02/06/26 because she had administered all 18 or 19 tablets to the resident since Wednesday, 02/04/26. -She had given all 18 or 19 tablets to Resident #4 because the resident was in pain and because she did not document on the MAR or CSR when she administered the tablets. -She could not recall if it had been 6 hours between doses because she did not write it down, so she just continued to administer the Oxycodone from 02/04/26 - 02/06/26. -When reminded if administered according to the order prn every 6 hours, no more than 4 tablets in a 24-hour period should be administered, she again repeated she administered all 18 or 19 tablets from 02/04/26 - 02/06/26. -She had no concerns about administering more than double the dose of Oxycodone to Resident #4 in a 48-hour period. -The resident was not sleepy or oversedated when she administered the Oxycodone to the Resident from 02/04/26 - 02/06/26. -She did not recall what time she administered the last Oxycodone to Resident #4 on 02/06/26. -She gave no explanation for failing to notify Resident #4's hospice nurse about reporting the wrong amount of Oxycodone on 02/04/26 or that she administered all 18 or 19 Oxycodone to Resident #4. -She was aware she was supposed to document administration of Resident #4's Oxycodone on the CSR but she failed to document it. -She gave no explanation for not documenting on the CSR for Resident #4's Oxycodone since 01/29/26. Telephone interview with Resident #4's hospice nurse on 02/10/26 at 4:29pm revealed: -The Administrator reported Resident #4 had 29	C 367		

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C 367	Continued From page 192 Oxycodone tablets on Wednesday, 02/04/26, during her visit to the facility. -She counted Resident #4's Oxycodone tablets in the bubble card on Wednesday, 02/04/26, and there were 29 tablets on hand. -The Administrator may not have realized that she observed and counted Resident #4's Oxycodone herself on Wednesday, 02/04/26, because the Administrator was helping another resident who spilled shampoo in the bathroom. -The Administrator had not contacted her about making an error when the Administrator counted Resident #4's Oxycodone on 02/04/26. -The Administrator had not reported she had administered 18 to 19 prn Oxycodone tablets to Resident #4 from 02/04/26 - 02/06/26. -If the Administrator had administered 18 to 19 Oxycodone 5mg tablets to Resident #4 in a 48-hour period, Resident #4 would have symptoms of overdose; the resident would have been lethargic and "out of it". -When she observed Resident #4 on 02/04/26 and 02/06/26, the resident was not oversedated and the resident was not in pain. Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable. 2. Review of Resident #2's current FL-2 dated 03/29/25 revealed diagnoses included unspecified dementia, metabolic encephalopathy, normal pressure hydrocephalus, seizures, myoclonus, and history of falling. a. Review of Resident #2's hospice order dated 01/05/26 revealed a new order to start Hydrocodone/Acetaminophen (APAP) 5/325mg 1 tablet every 6 hours as needed (prn) for pain. (Hydrocodone/APAP is a controlled substance	C 367		

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C 367	Continued From page 193 used for moderate to severe pain.) Review of Resident #2's record and the facility's medication administration record (MAR) notebook on 02/05/26 revealed: -There was no January 2026 MAR for Resident #2. -There was no February 2026 MAR for Resident #2. Interview with the Administrator on 02/05/26 at 1:16pm revealed: -All residents' January 2026 and February 2026 MARs were mixed in with some other papers because she was working on changing to an electronic records system. -She accidentally shredded the residents' January 2026 and February 2026 MARs along with some other papers about 2 days ago in the middle of the night. -She requested new MARs from the pharmacy on the day before yesterday (02/03/26) and was waiting to receive the MARs in the mail. -She did not have a fax machine at the facility for the MARs to be faxed. Telephone interview with the Pharmacy Manager at the facility's contracted pharmacy on 02/10/26 at 4:32pm revealed: -The pharmacy dispensed 56 Hydrocodone/APAP 5/325mg tablets for Resident #2 on 01/05/26. -The supply dispensed on 01/05/26 was delivered to the facility early in the morning (did not see exact time documented) on 01/06/26. -The pharmacy dispensed 56 Hydrocodone/APAP 5/325mg tablets for Resident #2 on 01/27/26. -The supply dispensed on 01/27/26 was delivered to the facility on 01/28/26 at 2:29am. -The instructions for both supplies were to take 1 tablet every 6 hours as needed for pain.	C 367		

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C 367	Continued From page 194 Observation of Resident #2's medications on hand on 02/05/26 at 3:05pm revealed: -There was a supply of Hydrocodone/APAP 5/325mg dispensed on 01/27/26 with 56 tablets. -The instructions were to take 1 tablet every 6 hours as needed for pain. -There was a controlled substance record (CSR) attached to the bubble card with a rubber band. -There were 29 tablets sealed in bubbles numbered 1 - 29 on the bubble card. -There was a small plastic ziploc bag stapled to the back of the bubble card with 11 white tablets with the same imprint code as the Hydrocodone/APAP 5/325mg tablets sealed in the bubbles on the front of the bubble card. -There was nothing written on the ziploc bag and no medication label on the ziploc bag. -There was a total of 40 Hydrocodone/APAP 5/325mg tablets in and attached to the bubble card. Review of Resident #2's CSR kept with the bubble card for Resident #2's Hydrocodone/APAP 5/325mg dispensed on 01/27/26 revealed: -The CSR had a prescription label at the top for a supply of 56 Hydrocodone/APAP 5/325mg tablets dispensed on 01/27/26. -The first documented dose was on 01/28/26 at 5:00am leaving a balance of 55 tablets. -There was a second entry on 01/28/26 at 4:30pm with 1 tablet documented as administered declining the balance to 54 tablets. -There was a third entry on 01/29/26 at 5:00am with 1 tablet documented as administered declining the balance to 53 tablets. -There was a fourth entry on 01/29/26 at 12:00pm with 1 tablet documented as administered declining the balance to 52 tablets. -There was a fifth entry on 01/29/26 at 7:00pm	C 367		

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C 367	Continued From page 195 with 1 tablet documented as administered but the amount remaining was documented as 54 instead of 51. -The count continued to be declined from 54 on 01/29/26 at 7:00pm to 40 tablets on 02/02/26 at 11:45pm although 54, 53, and 52 for the remaining balance had been documented twice each on the CSR. -There was a total of 19 doses documented as administered on the CSR from 01/28/26 - 02/02/26 with a balance of 40 tablets but if 19 doses were administered, the remaining balance during that time frame should have been 37. -The documentation on the CSR did not accurately reflect the administration of Hydrocodone/APAP 5/325mg. Review of Resident #2's record and the facility's MAR notebook on 02/05/26 revealed there was no other CSR for Resident #2's Hydrocodone/APAP 5/325mg. Second interview with the Administrator on 02/06/26 at 3:05pm revealed: -She had not noticed the CSR for Resident #2's Hydrocodone/APAP 5/325mg dispensed on 01/27/26 was not documented correctly. -She did not know why she documented 54 as the remaining balance on 01/29/26 when it should have been 51 tablets. -She may have used some tablets from a previous supply and documented on the CSR for this supply, but she was not sure. -The tablets in the small plastic ziploc bag stapled to Resident #2's Hydrocodone/APAP 5/325mg bubble card were the same medication that was in the bubble card. -She had punched out and prepared the prn Hydrocodone/APAP tablets when preparing medications but if the resident did not need them,	C 367		

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C 367	Continued From page 196 she would put the tablet in the ziploc bag. -When asked why she prepared the prn medication in advance instead of preparing it only when it was needed, the Administrator raised her voice and repeated multiple times that was the way she did it. -She was unable to offer any other explanation for 11 Hydrocodone/APAP tablets being punched out and stored in a ziploc bag or for the CSR documentation being inaccurate. Observation of medication administration on 02/06/26 at 10:29am revealed: -The Administrator administered one Hydrocodone/APAP 5/325mg tablet crushed and put in an oral syringe with apple sauce to Resident #2. -The Administrator did not document the administration of the prn Hydrocodone on a MAR or CSR. Interview with Resident #2's hospice nurse on 02/06/26 at 11:10am revealed: -She usually checked controlled substance counts once a week for hospice residents. -On Wednesday, 02/04/26, Resident #2 had 40 Hydrocodone/APAP 5/325mg. -The 40 Hydrocodone/APAP 5/325mg tablets were all sealed in the bubble card. -There were no Hydrocodone/APAP 5/325mg tablets in a ziploc bag attached to Resident #2's bubble card. -She did not check any CSRs when she counted the controlled substances. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable. b. Review of Resident #2's physician's order	C 367		

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	FCL092-323	A. BUILDING: _____ B. WING _____	R 02/10/2026

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C 367	Continued From page 197 dated 07/31/25 revealed an order to increase Lorazepam to 1mg every 6 hours as needed for agitation. (Lorazepam is a controlled substance used to treat anxiety and agitation.) Review of Resident #2's December 2025 medication administration record (MAR) revealed: -There was an entry for Lorazepam 1mg 1 tablet every 6 hours as needed for agitation or restlessness. -Lorazepam 1mg was initialed as administered 24 times from 12/01/25 - 12/19/25. Review of Resident #2's record and the facility's MAR notebook on 02/05/26 revealed: -There was no January 2026 MAR for Resident #2. -There was no February 2026 MAR for Resident #2. Interview with the Administrator on 02/05/26 at 1:16pm revealed: -All residents' January 2026 and February 2026 MARs were mixed in with some other papers because she was working on changing to an electronic records system. -She accidentally shredded the residents' January 2026 and February 2026 MARs along with some other papers about 2 days ago in the middle of the night. -She requested new MARs from the pharmacy on the day before yesterday (02/03/26) and was waiting to receive the MARs in the mail. -She did not have a fax machine at the facility for the MARs to be faxed. Telephone interview with the Pharmacy Manager at the facility's contracted pharmacy on 02/10/26 at 4:32pm revealed: -The pharmacy dispensed 60 Lorazepam 1mg	C 367		

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C 367	Continued From page 198 tablets for Resident #2 on 08/01/25. -The pharmacy dispensed 60 Lorazepam 1mg tablets for Resident #2 on 08/28/25. -The pharmacy dispensed 60 Lorazepam 1mg tablets for Resident #2 on 09/22/25. -The pharmacy dispensed 60 Lorazepam 1mg tablets for Resident #2 on 10/31/25. -The pharmacy dispensed 60 Lorazepam 1mg tablets for Resident #2 on 12/11/25. Observation of Resident #2's medications on hand on 02/05/26 at 3:05pm revealed: -There was a supply of Lorazepam 1mg tablets dispensed on 12/11/25 with instructions to take 1 tablet every 6 hours as needed for agitation or restlessness. -There were 52 of 60 Lorazepam 1mg tablets remaining. Review of Resident #2's record and the facility's MAR notebook on 02/05/26 revealed there were no controlled substance records (CSRs) for any supplies of Resident #2's Lorazepam 1mg tablets. Second interview with the Administrator on 02/06/26 at 3:05pm revealed: -The CSRs for Resident #2's Lorazepam 1mg should be in the MAR notebook. -If the CSRs were not in the MAR notebook, they probably had been shredded when she accidentally shredded the MARs about 2 days ago. Interview with Resident #2's hospice nurse on 02/06/26 at 11:10am revealed: -She usually checked controlled substance counts once a week for hospice residents. -On Wednesday, 02/04/26, Resident #2 had 52 Lorazepam tablets on hand at the facility.	C 367		

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C 367	Continued From page 199 -She did not check any CSRs when she counted the controlled substances. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable. _____ The facility failed to maintain controlled substance records (CSRs) for 2 of 2 hospice residents with orders for controlled substances for moderate to severe pain and for anxiety and agitation. Resident #4 had 29 Oxycodone 5mg tablets as observed by the hospice nurse on 02/04/26. On 02/06/26, there were no Oxycodone 5mg tablets available for administration for Resident #4 and the last dose documented on the CSR was 01/29/26 and 47 tablets should have been remaining. The Administrator reported she had counted wrong on 02/04/26 and there were only 18 or 19 Oxycodone on hand which she stated she administered all 18 or 19 tablets to Resident #4 from 02/04/26 - 02/06/26 because she failed to document when she administered on the CSR and could not recall the time between dosages. Resident #5 had a card of 56 Hydrocodone/APAP 5/325mg tablets dispensed on 01/27/26 with 29 tablets sealed in the bubble card and a ziploc bag with 11 loose tablets stapled to the card and a CSR that was inaccurate. Resident #2 and Resident #4 were missing CSRs leaving no documentation to accurately reconcile the receipt, administration, and disposition of the medications. This failure of the facility put the residents at substantial risk of serious physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/05/26 for this violation.	C 367		

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C 367	Continued From page 200 THIS FACILITY WAS ISSUED A SUMMARY SUSPENSION ON 02/12/26.	C 367		
C 934	G.S.131D-4.5B (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure that 1 of 1 medication aides, the Administrator, completed the annual state approved infection control training course. The findings are: Review of the Administrator's personnel record on 02/05/26 at 10:30am revealed: -She was the Administrator and co-owner/operator of the facility. -She was hired as a medication aide (MA) on	C 934		

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C 934	Continued From page 201 10/24/23. -There was no documentation the Administrator completed the annual state approved infection control course. Observations of the Administrator on 02/06/26 from 08:58am - 9:21am and 9:56am - 10:01am revealed: -She prepared medications for 4 residents including punching oral medications into her ungloved, bare hands. -She crushed medications and mixed them in applesauce and fed the crushed medications to two residents. -She touched two residents' cups and straws and held the straws to their mouths with her bare, ungloved hands. -She did not wash her sanitize her hands prior to or after administering medications to any of the residents. Interview with the Administrator on 02/06/26 at 2:30pm revealed: -She was the only MA employed at the facility. -She was the only staff member required to complete the infection control training. -She completed the required infection control training; however, she was unable to access the training portal to obtain a certificate of completion. -All staff training documentation was maintained within the training portal, which she was unable to access. -She attempted to contact the training developer on 12/03/25, but was unsuccessful. [Refer to Tag 346, 10A NCAC 13G .1004 (n) Medication Administration.]	C 934		