STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL079053	A. BUILDING: _____ B. WING _____	R 02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE OF MAYODAN	6970 NC HWY 135 MAYODAN, NC 27027

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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-survey from 02/10/25 to 02/12/25.	D 000		
D 184	10A NCAC 13F .0605 (a) General Staffing Requirements for Adult Care 10A NCAC 13F .0605 General Staffing Requirements for Adult Care Homes (a) Adult care homes shall staff based on the facility's resident census and provide staffing to meet the care and supervision needs of the residents in accordance with the rules of this Subchapter. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure the minimum number of staff were present at all times to meet the needs of residents residing in the Special Care Unit (SCU) for 9 of 21 shifts sampled from 01/04/26 - 01/10/26. The findings are: Review of the facility's current license effective 12/31/2025 revealed the facility was an Adult Care Home with a capacity for 70, of which 31 were Special Care Unit (SCU) beds. Review of the SCU census dated 01/04/26 - 01/10/26 revealed a census of 28 residents,	D 184		

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D 184	Continued From page 1	D 184		

requiring 28 aide hours on first and second shift and 25.2 hours on third shift.

Review of the time punch cards for staff on 01/04/26 revealed:
-The SCU census was 28 on 01/04/26 and required 28 aide hours on first and second and 25.2 hours on third shift.
-There were 11 total aide hours provided on first shift leaving a shortage of 17 aide hours.
-There were 27.5 total aide hours provided on second shift leaving a shortage of 1.5 aide hours.
-There were 24.75 total aide hours provided on third shift leaving a shortage of .45 aide hours.

Review of the time punch cards for staff on 01/05/26 revealed:
-The SCU census was 28 on 01/05/26 and required 28 aide hours on first and second and 25.2 hours on third shift.
-There were 26.9 total aide hours provided on second shift leaving a shortage of 1.1 aide hours.
-There were 21.00 total aide hours provided on third shift leaving a shortage of 4.2 aide hours.

Review of the time punch cards for staff on 01/08/26 revealed:
-The SCU census was 28 on 01/08/26 and required 28 aide hours on first and second and 25.2 hours on third shift.
-There were 20.5 total aide hours provided on second shift leaving a shortage of 7.5 aide hours.
-There were 22.35 total aide hours provided on third shift leaving a shortage of 2.85 aide hours.

Review of the time punch cards for staff on 01/09/26 revealed:
-The SCU census was 28 on 01/09/26 and required 28 aide hours on first and second and 25.2 hours on third shift.

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D 184	Continued From page 2 -There were 24 total aide hours provided on second shift leaving a shortage of 4 aide hours. -There were 18.25 total aide hours provided on third shift leaving a shortage of 6.95 aide hours. Interview with the Special Care Unit Coordinator (SCUC) on 02/12/26 at 10:00am revealed: -She was aware there was a shortage of staff in the SCU. -The Business Office Manager (BOM) and the Administrator were responsible for scheduling the staff in the SCU. -She informed the Administrator about the staff shortages in January 2026, and the Administrator has been interviewing candidates to hire. -Her expectations would be for the SCU to be fully staffed to meet the required hours for all three shifts. Interview with the BOM on 02/12/26 at 10:20am revealed: -She was not aware of the required staffing hours for the SCU. -She had only been in this position for one month. -Both she and the SCUC were responsible for making staff schedules in the SCU. -She and the Administrator were trying to hire more staff to cover shift shortages. Interview with the Administrator on 02/12/26 at 11:00am revealed: -She was aware of the staffing shortages in the SCU and had been working on hiring more staff. -She and the BOM were responsible for scheduling staff for the SCU. -She notified the cooperate office about the need to hire more staff and they just allotted funds for her to hire. -Her expectations were to have enough staff to cover all required hours in the SCU.	D 184		

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D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult 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 record reviews and interviews, the facility failed to ensure 2 of 5 sampled residents (#4, #5) had completed the two-step tuberculosis (TB) testing in compliance with the control measures adopted by the Commission for Public Health. The findings are: 1. Review of Resident #4's current FL2 dated 08/03/25 revealed diagnoses included weakness, memory changes and dementia. Review of Resident #4's Resident Register revealed an admission date of 08/17/21. Review of Resident #4's record revealed: -She was enrolled in hospice services. -There was documentation that a 1st step TB skin test was administered on 07/27/21 and read on 07/29/21 with negative results.	D 234		

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D 234	Continued From page 4 -There was no documentation a 2nd step TB skin test was administered. Interview with the Administrator on 02/11/26 at 9:25am revealed: -She was responsible for making sure 2-step TB skin tests were completed. -A representative from the facilities contracted on-site medical care company completed TB test audits. -A representative from the facilities contracted on-site medical care company asked her if they were to complete Resident #4's 2nd step TB skin test or was the hospice provider going to complete the 2nd step TB skin test. -She did not give the representative from the facilities contracted on-site medical care company an answer so the 2nd step TB skin test was not completed. -She expected 2-step TB skin tests to be completed. Based on observations, interviews and record reviews, it was determined that Resident #4 was not interviewable. 2. Review of Resident #5's current FL2 dated 08/25/25 revealed diagnoses included anxiety, major depressive disorder, and hypertension. Review of Resident #5's Resident Register revealed an admission date of 09/08/23. Review of Resident #5's record revealed: -There was no documentation that a 1st step TB skin test was administered for Resident #4. -There was no documentation that a 2nd step TB skin test was administered for Resident #4. Interview with the Administrator on 02/11/26 at	D 234		

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D 234	Continued From page 5 9:25am revealed: -She was responsible for making sure 2-step TB skin tests were completed. -Resident #5 had been transferred to the facility from a skilled nursing facility (SNF). -She had contacted the SNF to obtain Resident #5's 1st and 2nd step TB skin test results. -She had not received Resident #5's 1st and 2nd step TB skin test results from the SNF. Based on observations, interviews and record reviews, it was determined that Resident #5 was not interviewable.	D 234		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents (#5), including a medication used to treat generalized anxiety disorder. The findings are: Review of Resident #5's current FL2 dated 08/25/25 revealed diagnoses included anxiety, major depressive disorder, and hypertension.	D 358		

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D 358	Continued From page 6 Review of Resident #5's signed physician orders dated 10/28/25 revealed there was an order for buspirone 5mg take one-half tablet two times daily at 6:00am and at bedtime. Review of Resident #5's electronic medication administration record (eMAR) for December 2025 revealed: -There was an entry for Buspirone 5mg take one-half tablet with a scheduled administration time of 6:00am. -Buspirone 5mg was documented as administered one time daily for 28 of 31 opportunities. Review of Resident #5's eMAR for January 2026 revealed: -There was an entry for Buspirone 5mg take one-half tablet with a scheduled administration time of 6:00am. -Buspirone 5mg was documented as administered one time daily for 30 of 31 opportunities. Review of Resident #5's eMAR for February 2026 from 02/01/26 through 02/10/26 revealed: -There was an entry for Buspirone 5mg take one-half tablet with a scheduled administration time of 6:00am. -Buspirone 5mg was documented as administered one time daily for 10 of 10 opportunities.from 02/01/26 to 02/10/26. Observation of Resident #5's medications on hand on 02/11/26 at 10:10am revealed: -There was a punch card dispensed on 02/04/26 for buspirone 5mg take one-half tablet once daily at 6:00am -There were 19 of 25 one-half tablets of	D 358		

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buspirone 5mg remaining on the punch card.

Based on observations, interviews and record reviews, it was determined that Resident #5 was not interviewable.

Telephone interview with Resident #5's primary care provider (PCP) on 02/11/26 at 10:54am revealed:
-She signed Resident #5's physician orders dated 10/28/25.
-She intended for the facility to administer Resident #5's buspirone 5mg one-half tablet two times daily at 6:00am and at bedtime.
-She was not aware the facility was administering Resident #5's buspirone 5mg one-half tablet once a day.
-She had not assessed any adverse effects in Resident #5 due to not receiving the buspirone 5mg as she had ordered.
-It was possible Resident #5's hospice provider changed the buspirone 5mg order.

Interview with a Medication Aide (MA) on 02/11/26 at 1:00pm revealed:
-She was not aware Resident #5 was supposed to be administered buspirone 5mg one-half tablet twice a day.
-She had spoken with Resident #5's hospice provider and they were not aware of the buspirone 5mg order.
-She had not noticed any behavior issues in Resident #5.

Interview with the Administrator on 02/11/26 at 12:39pm revealed:
-A registered nurse (RN) from the facilities contracted pharmacy conducted audits of medication carts monthly.
-A RN from the facilities contracted pharmacy

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D 358	Continued From page 8 conducted audits of resident records and eMARs every 2 to 3 months. -Resident #5's buspirone 5mg order administration error was an "oversight". -She expected medications to be administered as ordered.	D 358		