Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060177	A. BUILDING: _____ B. WING _____	R 02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE HOUSE	9108-REAMES ROAD CHARLOTTE, NC 28216

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D 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an annual and follow-up survey with a complaint investigation on February 9, 2026 to February 11, 2026.	D 000		
D 237	10A NCAC 13F .0703 (e) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations (e) The result of the medical examination required in Paragraph (b) of this Rule shall be documented on the North Carolina Medicaid Adult Care Home FL-2 form which is available at no cost on the Department's Medicaid website at https://medicaid.ncdhhs.gov/media/6549/open. The Adult Care Home FL-2 shall be signed and dated by the physician or physician extender completing the medical examination. The medical examination shall include the following: (1) resident's identification information, including the resident's name, date of birth, sex, admission date, county and Medicaid number, current facility and address, physician's name and address, a relative's name and address, current level of care, and recommended level of care; (2) resident's admitting diagnoses, including primary and secondary diagnoses and dates of onset; (3) resident's current medical information, including orientation, behaviors, personal care assistance needs, frequency of physician visits, ambulatory status, functional limitations, information related to activities and social needs, neurological status, bowel and bladder functioning status, manner of communication of needs, skin condition, respiratory status, and	D 237	D 237- The Resident Care Director or designee checked ALL resident charts by 2/25/26 to ensure that medication names, times, and routes of administration are included when resident's exam results are recorded on FI2. The Resident Care Director/Executive Director/Designee will audit charts every 6 months ensure accuracy and updated information is on the FL2. DMS Ammendment per telephone conversation with the Administrator on 03/24/26 at 9:15am see page 9 of the SOD.	2/25/26

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Dara Neely — Executive Director — 3/20/26

TN 3/24/26
9:56am

Reviewed and acknowledged

by

DMS on 03/24/26

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D 237	Continued From page 1 nutritional status including orders for therapeutic diets; (4) special care factors, including physician orders for blood pressure, diabetic urine testing, physical therapy, range of motion exercises, a bowel and bladder program, a restorative feeding program, speech therapy, and restraints; (5) resident's medications, including the name, strength, dosage, frequency and route of administration of each medication; (6) results of x-rays or laboratory tests determined by the physician or physician extender to be necessary information related to the resident's care needs; and (7) additional information as determined by the physician or physician extender to be necessary for the care of the resident. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled residents (#5) medications included the frequency and route of administration of each medication were included when the results of the resident's medical examination was documented on the resident's current FL2. The findings are: Review of Resident #5's current FL2 dated 10/08/25 revealed: -Diagnoses included dementia, cerebral infarction (a type of stroke) and hypothyroidism (underactive thyroid gland). -There was an order for aspirin (a medication	D 237		

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D 237	Continued From page 2 used to reduce the risk of a stroke) 81mg. -The aspirin 81mg order did not indicate a frequency and route of administration. -There was an order for atorvastatin (a medication to treat high blood cholesterol) 40mg. -The atorvastatin 40mg order did not indicate a frequency and route of administration. -There was an order for citalopram HBR (a medication to treat depression) 10mg. -The citalopram HBR 10mg order did not indicate a frequency and route of administration. -There was an order for levothyroxine (a medication to treat hypothyroidism) 50mcg. -The levothyroxine 50mcg order did not indicate a frequency and route of administration. -There was an order for vitamin D3 (a supplement for immune, muscle, bone and teeth health) 5,000mcg. -The vitamin D3 5,000mcg order did not indicate a frequency and route of administration. -There was an order for vitamin B-12 (a supplement to support energy metabolism, brain health and red blood cell formation) 500mcg. -The vitamin B-12 order did not indicate a frequency and route of administration. -There was an order for anti-diarrheal medication 2 mg. -The anti-diarrheal medication 2 mg order did not indicate a frequency and route of administration. -There was an order for moisturizing cream. -The moisturizing cream order did not indicate a frequency and route of administration. -There was an order for ketoconazole 2% shampoo (an antifungal medication to treat scalp conditions). -The ketoconazole 2% shampoo order did not indicate a frequency or duration of administration. Review of Resident #5's Resident Register revealed he was admitted to the facility on	D 237		

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D 237	Continued From page 3 09/23/24. Interview with a representative with the facility's contracted pharmacy on 02/10/26 at 10:00am revealed: -The pharmacy became the facility's new pharmacy provider in October 2025. -They profiled and provided medications for Resident #5 based on the signed physician orders provided by the facility dated 07/29/25. -The contracted pharmacy did not receive Resident #5's current FL2 dated 10/08/25. -If the facility had sent Resident #5's FL2 dated 10/08/25 to the pharmacy, the pharmacy would have reached out to the facility to clarify the medication orders. Interview with Resident #5's Nurse Practitioner (NP) on 02/10/26 at 10:45am revealed: -He usually added "See med list attached" when completing a resident's FL2. -He did not add "See med list attached" when he completed Resident #5's 10/08/26 FL2. -He did not know that Resident #5's current FL2 did not have a medication list attached to it. -The medication orders on Resident #5's current FL2 were not complete orders because they did not indicate a frequency or route of administration of the medications. Interview with the Administrator on 02/11/26 at 3:55pm revealed: -She did not know that Resident #5's current FL2 dated 10/08/25 did not indicate the medications' frequency and route. -Her expectation was that the NP who completed and reviewed Resident #5's current FL2 prior to signing it and at that time the NP ensured it had all the information on it. -The Special Care Director or Regional Nurse	D 237		

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D 237	Continued From page 4 were responsible for reviewing and filing all of the residents' FL2s in their charts. -The Special Care Director or Regional Nurse should have ensured Resident #5's current FL2 had complete medication orders that included their frequency and route of administration.	D 237		
D 259	10A NCAC 13F .0802 (a) (c) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (a) The facility shall develop and implement a care plan for each resident based on the resident's assessment completed in accordance with Rule .0801 of this Section. The care plan shall be resident-centered and include the resident's preferences related to the provision of care and services. A copy of each resident's current care plan shall be maintained in a location in the facility where it can be accessed by facility staff who are responsible for the implementation of the care plan. (c) The care plan shall include the following: (1) a description of services, supervision, tasks, and level of assistance to be provided to address the resident's needs identified in the resident's assessment in Rule .0801 of this Section; (2) frequency of the services or tasks to be performed; (3) revisions of tasks and frequency based on reassessments in accordance with Rule .0801 of this Section; (4) licensed health professional tasks required according to Rule .0903 of this Subchapter; (5) a dated signature of the assessor upon completion; and (6) a dated signature of the resident's physician or physician extender as defined in Rule .0102 of this Subchapter within 15 days of completion of	D 259	2/25/26 The Regional Director of Clinical Services audited resident care plan by 2/25/26 to ensure care plans will be updated to include a current list of medications, residents surgical or mental history and LHPS. The Executive Director/Resident Care Director or designee will audit care plans every 2 months to ensure the residents history is	

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D 259	Continued From page 5 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. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to complete care plans for 4 of 5 sampled residents (#1, #2, #3 & #4) to include a list of current medications, licensed health professional support (LHPS) tasks and social/mental health history. The findings are: 1. Review of Resident #1's current FL2 dated 08/18/25 revealed: -Diagnoses included chronic kidney disease, type 2 diabetes, cerebrovascular disease, cognitive communication deficit, hypertension and vascular dementia. -The recommended level of care was special care unit. -Resident #1 was semi-ambulatory.	D 259		

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D 259	Continued From page 6 Review of Resident #1's Resident Register revealed an admission date of 07/31/25. Review of Resident #1's record revealed there was a Special Care Unit (SCU) care plan completed on 12/08/25 with no current medications, social/mental health history or LHPS tasks listed. Refer to interview with the Special Care Unit Director (SCD) on 02/09/26 at 9:55am. Refer to interview with the Administrator on 02/11/26 at 3:56pm. 2. Review of Resident #5's current FL2 dated 10/08/25 revealed: -Diagnoses included dementia, muscle atrophy (the wasting or thinning of muscle mass), communication deficit, cerebral infarction (a type of stroke) and hypothyroidism (underactive thyroid gland). -The recommended level of care was Special Care Unit. -Resident #5 was ambulatory with a walker. Review of Resident #5's Resident Register revealed an admission date of 09/23/24. Review of Resident #5's record revealed there was an annual care plan completed 08/26/25 with no current medications, social/mental health history or LHPS tasks listed. Refer to interview with the Special Care Unit Director (SCD) on 02/09/25 at 9:55am. Refer to interview with the Administrator on 02/11/26 at 3:56pm.	D 259		

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D 259	Continued From page 7 3. Review of Resident #3's current FL2 dated 01/07/26 revealed: -Diagnoses included major neurocognitive disorder, active problems, urinary retention, aggression, altered mental status and agitation. -Resident #3 was ambulatory. -Resident #3 required assistance with bathing and toileting. Review of Resident #3's Resident Register revealed he was admitted on 12/30/25. Review of Resident #3's care plan dated 01/06/2026 revealed: -Resident #3 was ambulatory with aid or devices. -Resident #3 required assistance with toileting and bathing. -Resident #3 was sometimes disoriented and forgetful. -Resident #3 was currently receiving medications for mental illness and behavior. -The care plan was not complete with a current list of Resident #3 medications. -The care plan was not signed and dated by the assessor. Refer to interview with the Special Care Unit Director (SCD) on 02/09/26 at 9:55am. Refer to interview with the Administrator on 02/11/26 at 3:56pm. --- Interview with the SCD on 02/09/26 at 9:55am revealed: -She was responsible for completing and updating resident care plans upon admission, yearly and with a significant change. -She was responsible for obtaining the	D 259		

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D 259	Continued From page 8 physician's signature within 15 days after he completed the care plan. -She did not know she had to complete the current medications, social/mental health history or the LHPS tasks section. Interview with the Administrator on 02/11/26 at 3:56pm revealed: -Before 01/22/26 the SCD was responsible for updating care plans and after 01/22/26 the Area Nurse was responsible. -She did not know the care plans were not filled out completely because she did not review the care plans after completion.	D 259		
D 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on record reviews and interviews, the facility failed to respond immediately in the case of an incident involving a resident and in	D 271	Code status audit completed on for all residents, and code status is accurately reflected in the EMAR system On 2/9/2026 All team members are trained on emergency reporting procedures and required documentation by 2/20/2026. The Executive Director/Designee will conduct a weekly audit of code status to ensure the accuracy reflected on the MAR and Emergency Binder. DMS Ammendment per telephone conversation with the Administrator on 03/24/26 at 9:15am revealed: -Added to the above. -The Regional Nurse and the Administrator completed the audit on all residents to ensure their code status orders matched the eMAR system and Code book. -The Regional HWD completed training for all staff on emergency reporting procedures an required documentation. -The Administrator/Designee also will conduct audits on residents after returning from the hospital to make sure the code status orders were correct in their eMAR system and code book.	

TN 3/24/2026
9:56am

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D 271	Continued From page 9 accordance with the facility's established policy and procedures for 1 of 1 sampled residents (#1) who required cardiopulmonary resuscitation (CPR). The finding are: Review of the facility's CPR Policy dated 06/10/25 revealed: -Staff were to determine if the resident was unconscious (e.g. gently shake, call name, and check for pulse/breathing) and if no response, call for help. -Staff were to verify the residents' CPR status. -If the resident had a "CPR" status staff were to call 911 immediately and initiate CPR. -Staff were to continue CPR until emergency personnel arrived and took over. Review of Resident #1's current FL2 dated 08/18/25 revealed diagnoses included diabetes type 2, vascular dementia and cerebrovascular disease, cognitive communication deficit and hypertension. Review of Resident #1's Resident Register revealed Resident #1 was admitted on 07/31/25. Review of Resident #1's care plan dated 12/08/25 revealed: -Resident #1 required supervision with eating. -Resident #1 required extensive assistance with toileting, ambulation, transfers and bathing. -Resident #1 was totally dependent with dressing and grooming. Review of Resident #1's discharge summary from a local skilled nursing and rehabilitation facility dated 08/19/25 revealed Resident #1 was a full code.	D 271		

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D 271	Continued From page 10 Review of Resident #1's Medication Review Report dated 08/19/25 revealed Resident #1 was a full code. Review of Resident #1's record revealed there was no Do Not Resuscitate (DNR) directive. Interview with a personal care aide (PCA) on 02/09/26 at 4:00pm revealed the kiosk was where she documented daily task completed on resident #1 and Resident #1's profile picture had a green border around the picture which meant Resident #1 was a full code "do CPR". Review of local Emergency Medical Services (EMS) Report dated 12/13/25 revealed: -At 10:56am, EMS was dispatched to the facility for cardiac arrest. -At 11:03am, EMS arrived on scene. -Resident #1 was reported by staff to have a DNR. -EMS arrived to find Resident #1 pulseless, and apneic. -Staff reported Resident #1 went into cardiac arrest. -Staff reported there was no CPR attempted by staff and Resident #1 was a DNR. -At 11:10am, staff could not provide DNR documentation and CPR was administered by EMS personnel. -Resident #1 was found to be asystole (a severe, life-threatening cardiac arrest rhythm characterized by the cessation of electoral and mechanical activity in the heart). -Cardiac resuscitation medications were administered and during CPR copious amounts of emesis was coming out of Resident #1's airway. -After cardiac resuscitation medications and 11	D 271		

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D 271	Continued From page 11	D 271		

rounds of compressions Resident #1 was found to be in asystole for 9 out of 11 rounds of compressions and pulseless electrical activity in 2 out of 11 rounds of compressions.
-At 11:31am, after 11 rounds of compressions, CPR efforts were discontinued.

Review of Resident #1's Accident/Incident Report dated 12/13/25 at 10:30am revealed:
-The report was completed on 12/15/25 by the Special Care Director (SCD).
-Resident #1 was a full code.
-CPR was initiated.
-EMS called time of death.
-A family member was on site at time of death.
-Resident #1's primary care physician was notified.
-Resident #1 was not sent to the emergency room.

Review of Resident #1's progress notes dated 12/13/25 at 3:00pm revealed:
-A PCA documented Resident #1 was observed not breathing or responding.
-EMS was called and Resident #1 was pronounced dead at the facility.
-Resident #1's family was onsite at the time of death.

Telephone interview with a PCA on 02/10/26 at 9:43am revealed:
-On 12/13/26, he worked from 7:00am to 3:00pm and had worked at the facility for about three months.
-Around 7:30am he gave Resident #1 a nutritional supplement, provided incontinent care and repositioned Resident #1.
-Around 10:00am, Resident #1's Power of Attorney (POA) came to visit Resident #1.
-Not long after Resident #1's POA arrived, the

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D 271	Continued From page 12 POA asked him for some water for Resident #1 and he provided a glass of water to the POA. -Quickly thereafter, the POA returned and stated she could not wake Resident #1 up. -He went to Resident #1's room and found Resident #1 laying on her back, her mouth was open and she was pale. -He called Resident #1's name and moved Resident #1's hand and there was no response. -He did not initiate CPR because he did not know if Resident #1 was a full code or not. -He went and got a MA and another PCA and all three of them returned to Resident #1's room. -The MA tried to wake Resident #1 up and there was no response from Resident #1. -He left Resident #1's room because the MA and other PCA were handling the situation and he to check on other residents. -It took "awhile" for emergency personnel to get there. -He did not know where to look to see if Resident #1 was a full code or not. Telephone interview with the MA on 02/10/26 at 11:28pm revealed: -On 12/13/26, a PCA reported to her that he and Resident #1's POA could not wake Resident #1 up. -She, the PCA and a second PCA went to Resident #1's room. -She checked to see if Resident #1 was breathing and Resident #1 was not and did not have a pulse. -She called 911 and was going to initiate CPR when the Business Office Manager came in the room after the 911 operator told her to start CPR. -The BOM took her phone away from her as she was on the phone with the 911 operator. -The BOM told her not to initiate CPR because Resident #1 was a "DNR".	D 271		

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D 271	Continued From page 13 -She had been full time up till about three weeks ago and now as needed and thought that Resident #1's DNR status had changed from full code as she knew it was before to DNR. -The BOM instructed her to not perform CPR and she did what she was told. -She did not look in the computer for the green border around Resident #1's profile picture, check Resident #1's record or the DNR book at the nurses station because the BOM was the manager in charge that day. -CPR was not initiated on Resident #1 until emergency personnel arrived and initiated CPR. Interview with the second PCA on 02/09/26 at 4:00pm revealed: -On 12/13/26 around 10:30am, a PCA came to the desk and told the MA and her to come and check on Resident #1. -She the MA and the other PCA went to Resident #1's room. -The other PCA stayed outside of Resident #1's room and she and the MA checked Resident #1's breathing and pulse. -Resident #1 did not have a pulse and was not breathing. -The MA went to the nurses station and got her phone and did something else before returning to Resident #1's room. -When the MA returned to Resident #1's room, the MA was on the phone with a 911 operator on speaker. -The 911 operator asked the MA if CPR had been initiated. -The MA told the operator that someone had told her Resident #1 was a DNR. -Within about 5 minutes the emergency personnel arrived and asked for the DNR paperwork. -No one could find the DNR paperwork so CPR	D 271		

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was initiated by the emergency personnel.
-She did not initiate CPR because the BOM told the MA Resident #1 was a DNR.
-If the MA had not been directed by the BOM, she would have looked in the computer and found a green border around Resident #1's profile picture, went to the nurses station and verified if Resident #1 was a DNR by looking on the DNR book.

Telephone interview with a second MA on 02/10/26 at 10:41am revealed:
-On 12/13/25, she was assigned to Resident #1.
-She administered medications to Resident #1 that morning and there were no concerns about Resident #1 during that time.
-Around 8:30am she saw a PCA assisting Resident #1 with a supplemental drink.
-Around 10:15am she went on break and the other MA was looking after her residents.
-After a 15-minute break she returned to the floor when she noticed everyone running towards the dayroom.
-She went to gather towels and bath supplies to give a resident a bath.
-She went to Resident #1's room to see what was going on and she saw two PCAs.
-The PCAs told her that Resident #1 had died so she went to get the first MA.
-The first MA was at the nurses station, on the portable phone and headed back to Resident #1's room.
-No one asked her about Resident #1's DNR status.
-She was not sure if Resident #1 was a DNR or not but that was why there was a DNR book at the nurses station, computer and resident's records to find that information.
-The residents' DNR directive could change every day and that's why the staff had back-up ways to know for sure.

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D 271	Continued From page 15 -There was no CPR initiated until emergency personnel arrived because the BOM was arguing with the first MA about Resident #1's DNR status. Telephone interview with the BOM on 02/09/26 at 11:04am revealed: -On 09/07/25, she started working at the facility. -On 12/13/25, she was the manager on duty at the facility. -On 12/13/25, she was told by a MA that Resident #1 had died so she went to check on Resident #1. -She found Resident #1 laying in her bed with a sheet over her face. -A sheet over the face meant everything was done for the resident so she checked to see if Resident #1 was a DNR. -The MA informed her that Resident #1 was a DNR. -Within 30 minutes after being told that Resident #1 had died, a PCA told her Resident #1 was on hospice, speaking to Resident #1's POA finding out Resident #1 was not on hospice, a full code she called the Special Care Director (SCD) and was informed Resident #1 was a full code. -She also called the Administrator and was told Resident #1 was on palliative care and a DNR. -She could not locate a DNR, or DNR order in the book at the nurses station. -She checked the computer and a green border was around Resident #1's profile picture which indicated a full code but she thought the computer had not been updated since the staff were telling her Resident #1 was on palliative care and a DNR. -The DNR book at the nurses station had not been updated so since she could not locate a DNR or order for DNR she told the MA to call 911. -Staff were to check for pulse/breathing and if those were absent then find out if DNR and if not	D 271		

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call 911 and initiate CPR within 1-3 minutes.
-She and the staff did not initiate CPR because the staff could not find out Resident #1's code status.
-Emergency personnel-initiated CPR because the staff could not supply a DNR status.
-Thirty minutes was too long to take to find out Resident #1's code status.
-The SCD was responsible for updating the resident's record, computer and DNR book at the nurses station.

Telephone interview with the SCD on 02/09/26 at 9:55am revealed:
-On 12/13/25 around 11:00am, she was not at the facility but she received a call from the MA and BOM on the same phone stating Resident #1 had died.
-The MA and BOM were inquiring about the DNR status of Resident #1.
-She informed the MA and BOM Resident #1 was a full code and CPR was to be initiated.
-She was informed by the BOM, CPR was not initiated until shortly after their conversation on the phone, that the emergency personnel arrived and CPR was initiated by emergency personnel.
-She trained all staff upon hire when and how to determine the code of a resident.
-Staff were expected to know the code status of a Resident and/or to look in the resident's record, the DNR book at the nurses station or on the resident's computer profile picture.
-The DNR book at the nurses station contained copies of the DNR document for only residents who were a DNR only.
-The residents computer profile picture had a border of green indicating a full code or a red border indicating and a DNR status.
-A third option for DNR status was the resident's record which was labeled on the outside with a

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D 271	Continued From page 17 DNR sticker and the DNR document to indicate the resident was a DNR. -She was responsible for updating the computer, resident's record and the DNR book when the resident's DNR status changed. -Resident #1 was a full code and she expected the staff to perform CPR once the staff noticed Resident #1 was not breathing and had no pulse. Telephone interview with Resident #1's POA on 02/10/26 at 12:07pm revealed: -On 12/13/25, she entered the facility around 10:00am. -She went to Resident #1's room and Resident #1 had her eyes closed and breathing normally. -She lead over and kissed Resident #1 and sat down beside Resident #1. -She began talking to Resident #1 about her family member which Resident #1 loved to hear about. -She touched Resident #1's hand and Resident #1 began breathing rapidly. -Within 15-20 minutes, she used her cell phone to call a friend when she noticed Resident #1 taking a deep breath and then Resident #1 stopped breathing. -She called Resident #1's name and when there was no response, she went and got the PCA to come and help. -The PCA directed her to get the MA and the PCA went to Resident #1's room. -When she and the MA and other staff returned to Resident #1's room she was asked to step out of the room while the staff handled the situation. -No one asked her about Resident #1's code which was a full code. -She went outside to call family while the staff attended Resident #1. -She thought the staff were doing CPR and she did not know who initiated CPR.	D 271		

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D 271	Continued From page 18 Telephone interview with Resident #1's Physician's Assistant (PA) on 02/10/26 at 10:08am revealed: -Resident #1 was a full code. -She expected the staff to call 911 and initiate CPR when they found Resident #1 not breathing and no pulse. -When someone was in cardiac arrest, CPR was needed to circulate the blood to the brain and the other organs which could increase the chance of survival. Interview with the Administrator on 02/09/26 at 12:00pm revealed: -On 12/13/25, she was not in the building. -On 12/13/25, at 10:54am she received a text from the BOM that Resident #1 had died. -She replied to the text and asked if the staff began CPR and the BOM answered no. -The BOM texted staff were asked on the phone if the resident had a DNR and the staff told the 911 operator that there was a DNR. -Later, during her investigation, the BOM checked the DNR book and there was no DNR in the book for Resident #1 and CPR was not initiated by the staff. -When emergency personnel arrived and after the staff were not able to produce the DNR, CPR was initiated by the emergency personnel. -She expected the staff to know if a resident was an DNR and/or be able to find out fast in an emergency. -The SCD was responsible to update the resident's record, computer profile picture border and the DNR book with the DNR status immediately after a DNR status change. -Resident #1's record did not contain the DNR document and did not have a DNR sticker on it. -Resident #1's computer profile picture was	D 271		

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D 271	Continued From page 19 contained a green border which meant Resident #1 was a full code and CPR should have been initiated by staff when Resident #1 was found not breathing and no heartbeat. --- The facility failed to respond immediately in the case of an incident involving a resident and in accordance with the facility's established policy and procedures when staff failed to begin CPR and call EMS for Resident #1 when she was found unresponsive and CPR was not started until EMS arrived at the facility. This failure resulted in neglect and constitutes a Type A1 Violation. --- The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/10/26 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 9, 2026.	D 271		
D 464	10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan 10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan In addition to the requirements in Rules .0801 and .0802 of this Subchapter, the facility shall: (1) Within 30 days of admission to the special care unit and quarterly thereafter, develop a written resident profile containing assessment data that describes the resident's behavioral patterns, selfhelp abilities, level of daily living skills, special	D 464		

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D 464	Continued From page 20 management needs, physical abilities and disabilities, and degree of cognitive impairment. (2) Develop or revise the resident's care plan required in Rule .0802 of this Subchapter based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 5 sampled residents (#1) had a Special Care Unit (SCU) resident profile updated on a quarterly basis. The findings are: Review of Resident #1's current FL2 dated 08/18/25 revealed diagnoses included diabetes type 2, vascular dementia and cerebrovascular disease, cognitive communication deficit and hypertension. Review of Resident #1's Resident Register revealed Resident #1 was admitted on 07/31/25. Review of Resident #1's record revealed: -A SCU resident profile was completed on 11/07/25. -There was no SCU resident profile completed in August 2025. Telephone interview with the Special Care Director (SCD) on 02//09/26 at 12:57pm revealed: -The resident profiles were to be completed within 30 days of admission and quarterly thereafter. -Resident #1 should have had one completed in	D 464	ALL Special Unit Profile audited and completed. The Executive Director/Resident Care Director or Designee will review Special Care Profiles within the first 30 days of admission, then audit them quarterly.	2/25/2026

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D 464	Continued From page 21 August 2025 but she cannot recall why there was not one completed. Interview with the Administrator on 02//11/26 at 3:56pm revealed: -The SCD was responsible to complete the Resident Profile within 30 day of admission and quarterly there after. -She did not know the resident profile had not been completed on Resident #1 and she did not complete audits to check to see if they were completed.	D 464		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure there was adequate staff working in the Special Care Unit (SCU) on second shift for 2 out 48 shifts and on third shift for 2 out 48 shifts. The findings are: Review of the facility's SCU census for 12/13/25 revealed there were 37 residents. -Based on a census of 37 residents, the SCU	D 465	Executive Director, Resident Care Director, or Designee will review schedules/timecard punches to ensure adequate staffing is assigned to the schedule weekly.	

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D 465	Continued From page 22 required a minimum of 37 hours of staff hours for second shift. -Review of the employee time punches for 12/13/25 revealed there was documentation of 32.55 staff hours worked for second shift. Review of the facility's SCU census for 02/06/26 revealed there were 39 residents. -Based on a census of 39 residents, the SCU required a minimum of 39 hours of staff hours for second shift. -Review of the employee time punches for 02/06/26 revealed there was documentation of 33.13 staff hours worked for second shift. Review of the facility census documentation for 02/03/26 for the SCU revealed there were 39 residents. -Based on a census of 39 residents, the SCU required a minimum of 31.20 hours of staff hours for third shift. -Review of the employee time punches for 02/03/26 revealed there was documentation of 23.79 staff hours worked for third shift. Review of the facility census documentation for 02/11/26 for the SCU revealed there were 39 residents. -Based on a census of 39 residents, the SCU required a minimum of 31.20 hours of staff hours for third shift. -Review of the employee time punches on 02/11/26 revealed there was documentation of 22.25 hours worked for third shift. Interview with a Personal Care Aide (PCA) on 02/11/26 at 10:05am revealed: -She worked first and second shifts at the facility. -The facility was short twice a week.	D 465		

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D 465	Continued From page 23 Interview with a Personal Care Aide (PCA) on 02/11/26 at 10:00am revealed: -She worked at a PCA most days at the facility. She was also a medication aide (MA). -The Administrator has been completing the schedule. -The facility was short staffed due to other staff members who called out. Interview with an MA on 02/11/26 at 10:15am revealed: -She worked as an MA on 3rd shift since November 2025 at the facility. -The SCD was responsible for completing the schedule, but the Administrator is doing it now. -In December and January, the facility was short staffed on 3rd shift due to staff calling out. -The staff were calling out to SCD but there were no staff to replace the other staff. -She had to work alone until other staff members came to work. -The SCD would assist with resident care when the facility was short staffed. Interview with a 2nd MA on 02/11/26 at 10:18am revealed: -She worked 1st shift as an MA. -The facility was short on the 3rd shift. Telephone interview with the SCD on 02/09/26 at 9:55am: -Up until 01/22/26, she was responsible for completing the schedule and making sure the shifts were covered according to the census and resident's care plan needs. -On 2nd shift she scheduled three PCAs and two MAs. -On 3rd shift she scheduled three PCAs and one MA. -After 01/22/26, the Administrator was	D 465		

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D 465	Continued From page 24 responsible for completing the schedule. -In December 2025 and January 2026 staff would call out and other staff would be called into work. -There may have been a few shifts that were not covered but she could not recall. Interview with the Administrator on 02/11/26 at 3:56pm revealed: -The SCD was responsible for completing the schedule before 01/22/26 and she was responsible after 01/22/26. -The schedule was to have enough staff to cover the census and meet the resident's needs. -On 1st and 2nd shifts there were to be at least five MAs/PCAs and on 3rd at least four MAs/PCAs scheduled. -Call outs were an issue because staff were to call her with the number she provided for them but they called the facility and there was no answer so staff on the next shift did not know until after the staff did not show up. -When staff did not show up, staff on duty called the manager on duty and additional staff were called in. -There were an occasion or two when a shift was short but she could not recall when.	D 465		

Daanuely, Executive Director 3/20/26