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
	FCL049-006	A. BUILDING: _____ B. WING _____	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANQUILITY ESTATE LIVING	111 N SHAYNA ROAD TROUTMAN, NC 28166

(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 conducted a complaint investigation on February 17, 2026.	C 000		
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 B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure staff were always awake in the facility for the safety and supervision of the residents(#1, #2 & #3) who had cognitive or physical deficits that required staff were awake to meet their need for supervision and personal care needs. The findings are: Review of the facility's license effective 08/13/26 revealed the facility was licensed as a family care home with a capacity of up to 3 non-ambulatory residents. Review of the current census dated 02/17/26 revealed there were 3 residents residing in the	C 188	Corrective Action for the Deficiency: Upon identification of the deficiency on February 17, 2026, the Administrator implemented corrective measures to ensure continuous awake supervision of residents. Beginning February 17, 2026, the administrator provided 8 hours of on-site coverage daily, allowing existing staff to receive uninterrupted off-duty rest periods while ensuring that an awake staff member was always present in the facility to supervise residents and respond to resident needs. Measures to Prevent Recurrence: Effective March 1, 2026, the facility implemented a revised staffing model. A third medication aide/supervisor-in-charge (MA/SIC) was hired. Staff schedules were restructured to eliminate 24-hour shifts. MA/SIC staff are now scheduled in rotating shifts not exceeding 16 hours, providing a minimum of 32 hours off between shifts. This schedule ensures continuous awake supervision of residents and prevents staff fatigue. Administrator continues to remain physically onsite for direct supervision five to eight hours a day Monday-Friday and is also available 24/7 for on call needs and/or emergencies. Monitoring of the Corrective Action: The Administrator reviews staffing schedules weekly to ensure that staff shifts do not exceed 16 hours and that continuous awake staff coverage is maintained at all times. Staffing schedules are maintained in the facility and available for review. Responsible Party: Administrator. Completion Date: March 1, 2026	

Reviewed and Acknowledged ER March 16, 2026

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C 188	Continued From page 1 facility. Review of the Administrator's staffing narrative notes dated January 2026 revealed: -The facility "utilized a two MA/SIC swing-shift staffing model to ensure continuous supervision and care for residents." -The MA/SIC staff are scheduled for overnight coverage from 7:00pm to 7:00am. -During overnight hours, the MA/SIC remains on site and is responsible for resident supervision, medication administration and care needs. " - "When residents are stable and care needs are met, MA/SIC staff may utilize permitted rest periods but must remain immediately available to respond to resident needs." -The Administrator "provides on-site daytime coverage Monday through Friday from 9:00am to 3:00pm". -Administrator coverage "was supplemental and does not replace MA/SIC coverage". -During the hours the Administrator was present, "MA/SIC coverage continues concurrently, providing overlapping supervision, resident assessments and operational support". -"This staffing structure ensures 24-hour MA/SIC availability, appropriate rest opportunities and continuous administrative oversight without gaps in care". -The staffing schedules "accurately reflect actual coverage and are reviewed regularly to ensure resident safety and compliance with North Carolina Family Care Home requirements." Review of the facility's January 2026 Staffing Calendar revealed: -The coverage model was for "overnight medication aide/Supervisor in Charge (MA/SIC) coverage (7:00pm to 7:00am) with permitted rest periods".	C 188		

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C 188	Continued From page 2 -Administrator coverage was from Monday to Friday from 9:00am to 3:00pm. -The Administrator was on call on weekends and after hours. -A coverage clarification stated "overnight MA/SIC staff remain on site and responsible for resident care and supervision until the next scheduled handoff." -Administrator daytime coverage was "supplemental and does not replace MA/SIC coverage". -"Coverage reflects overlapping supervision with no gaps in resident care." -A MA was scheduled to work a 24-hour shift on 01/01/26, 01/05/26, 01/06/26, 01/09/26, 01/10/26, 01/11/26, 01/14/26, 01/15/26, 01/20/26, 01/21/26, 01/23/26, 01/24/26, 01/25/26, 01/28/26, and 01/29/26. -A second MA was scheduled to work a 24-hour shift on 01/02/26, 01/03/26, 01/04/26, 01/07/26, 01/08/26, 01/12/26, 01/13/26, 01/16/26, 01/17/26, 01/18/26, 01/19/26,01/22/26, 01/26/26, 01/27/26, 01/30/26 and 01/31/26. Review of the facility's February 2026 Staffing Calendar revealed: -The coverage model was for "overnight MA/SIC Coverage (7:00am to 7:00am) with permitted rest periods". -Administrator coverage was from Monday to Friday from 9:00am to 3:00pm. -The Administrator was on call on weekends and after hours. -A coverage clarification stated "overnight MA/SIC staff remain on site and responsible for resident care and supervision until the next scheduled handoff." -Administrator daytime coverage was "supplemental and does not replace MA/SIC coverage".	C 188		

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C 188	Continued From page 3 -"Coverage reflects overlapping supervision with no gaps in resident care." -A MA was scheduled to work a 24-hour shift on 02/02/26, 02/03/26, 02/06/26, 02/07/26, 02/08/26, 02/11/26, 02/12/26, 02/16/26, 02/17/26, 02/20/26, 02/21/26, 02/22/26, 02/25/26, and 02/26/26. -A second MA was scheduled to work a 24-hour shift on 02/01/26, 02/04/26, 02/05/26, 02/09/26, 02/10/26, 02/13/26, 02/14/26, 02/15/26, 02/18/26, 02/19/26, 02/23/26, 02/24/26, 02/27/26 and 02/28/26. Observation of the facility on 02/17/26 from 8:30am to 5:00pm revealed: -There were three residents inside the facility. -One resident was ambulating with a walker. -A second resident was sleeping in a recliner chair in her room. -A third resident was awake and alert and resting in her bed in her room. -There was one MA/SIC inside the facility. -The Administrator, arrived at the facility at 9:23am. 1. Review of Resident #1's current FL2 dated 01/23/26 revealed: -Diagnoses included traumatic subdural hemorrhage, diabetes type II, migraines and hypertension. -She was intermittently disorientated. -She was continent of bowel and bladder. Review of Resident #1's Care Plan dated 01/23/26 revealed: -She was independent with eating, toileting, grooming and transfers. -She required supervision with ambulation. -She required limited assistance with bathing and dressing.	C 188		

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C 188	Continued From page 4 2. Review of Resident #2's current FL2 dated 12/29/25 revealed: -Diagnoses included hypertension and depression. -Her disorientation section was left blank. -She was incontinent of bowel and bladder. Review of Resident #2's Care Plan dated 12/29/25 revealed: -She was independent with eating. -She required extensive assistance with bathing, grooming, dressing and transfers. -She required total assistance with toileting and ambulation. 3. Review of Resident #3's FL2 dated 01/13/2 revealed diagnoses included dementia, hypertension (high blood pressure), type 2 diabetes mellitus (high blood sugar), congestive heart failure, atrial fibrillation (an irregular heartbeat) and glaucoma (an eye condition that can lead to vision loss). Review of Resident #3's Resident Register revealed: -She was admitted to the facility on 09/03/25. -She was discharged on 01/21/26. Review of Resident #3's Care Plan dated 11/08/25 revealed: -She was always disoriented with significant memory loss. -She required supervision for toileting and ambulation/locomotion. -She required limited assistance with dressing and grooming/personal hygiene. -She required extensive assistance with bathing. -She was independent with eating and transferring. -She used a rolling walker for ambulation.	C 188		

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C 188	Continued From page 5 Interview with the MA on 02/17/26 at 4:52pm revealed: -She comes in for her shifts at 7am and works until 7am the following day. -Another MA relieves her at 7am and she goes home. -She believed they started the 24-hour shifts "about three weeks ago or so" but that the schedules for 24-hour shifts may also have started in January 2026. -She usually used a ride service to get to and from her workplace but occasionally would leave for a meal when a friend could pick her up. -The Administrator covered for her if she had to leave the facility or needed to rest during the day. -She never slept at the facility during the 7:00pm to 7:00am hours. -She would take rest periods when the Administrator was at the facility. -She checked on the residents every 2 hours during her 24-hour shifts unless they were "actively dying" when on hospice care, then she checked those residents every 30 minutes. -She had been employed at the facility since its opening in June of 2025 when she worked 8-hour shifts. Interview with a second MA/SIC on 02/17/26 at 4:50pm revealed: -She alternated 24-hour shifts with the other MA/SIC. -She would take "cat naps/power naps" that were about 20-25 minutes long in between her every 2-hour checks on the residents at night and when the residents were sleep during the day. -She would have to keep Resident #3 occupied during the day because Resident #3 was agitated more during the day. -At nighttime Resident #3 was up wandering into	C 188		

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C 188	Continued From page 6 other residents' rooms so she gave Resident #3 socks to fold and that kept Resident #3 busy for at least an hour. -The Administrator was there Monday-Friday usually 9:00am to 5:00pm and would let her rest some then as well. Interview with Resident #3's Power of Attorney (POA) on 02/27/26 at 12:46pm revealed: -There were two caretakers who worked at the facility at different times. -The caretaker was often "sitting at the desk" when she arrived. -The Administrator would often be at the facility when she visited during the day. -She was told that Resident #3 "often wasn't sleeping well" at night. Interview with the Administrator/Owner on 02/17/26 at 3:37pm revealed: -She is at the facility every Monday through Friday from 9:00am to 3:00pm and is on call on weekends. -She often comes into the facility for several hours on weekends. -Staff members could sleep or rest while she was in the facility. -She changed the staffing schedule's hours several months ago to accommodate staff transportation issues. -Each MA worked alternating 24-hour shifts. -Two MA staff were employed at the facility. _____ The facility failed to ensure there was awake staff at the facility to provide supervision to Resident #2 who required total assistance with ambulation and toileting and Resident #3 who had a diagnosis of dementia and was disoriented, and to provide supervision at all times for the safety of all the residents in the case of an emergency.	C 188		

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C 188	Continued From page 7 The facility's failure was detrimental to the 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 February 17, 2026 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 03, 2026.	C 188		
C936	10A NCAC 13G .1010(d) (e) Pharmaceutical Services 10A NCAC 13G .1010 (d) (e) Pharmaceutical Services (d) The facility shall assure the provision of medication for residents on temporary leave from the facility or involved in day activities out of the facility. The facility shall have written policies and procedures for a resident's temporary leave of absence. The policies and procedures shall facilitate safe administration by assuring that upon receipt of the medication for a leave of absence the resident or the person accompanying the resident is able to identify the medication, dosage, and administration time for each medication provided for the temporary leave of absence. The policies and procedures shall include at least the following provisions: (1) The amount of resident's medications provided shall be sufficient and necessary to cover the duration of the resident ' s absence. For the purposes of this Rule, sufficient and necessary means the amount of medication to be administered during the leave of absence or only	C936	Corrective Action for the Deficiency: Immediately upon identification of the deficiency the Administrator developed and implemented a medication release documentation form to be completed whenever a resident is discharged or leaves the facility with medications. The form documents the name of each medication, dosage, quantity released, administration instructions, and requires the signature of both facility staff and the resident or responsible party receiving the medications. Measures to Prevent Recurrence: Facility policy and procedure for resident discharge and medication release have been updated to require documentation of medication disposition at the time of discharge. Staff have been educated by the Administrator regarding proper documentation requirements for medications released from the facility. Monitoring of the Corrective Action: The Administrator will review all resident discharge documentation and medication records to ensure compliance with medication disposition requirements. Monitoring will occur for all discharges.	

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C936	Continued From page 8 a current dose pack, card, or container if the current dose pack, card, or container has enough medication for the planned absence; (2) Written and verbal instructions for each medication to be released for the resident's absence shall be provided to the resident or the person accompanying the resident upon the medication ' s release from the facility and shall include at least: (A) the name and strength of the medication; (B) the directions for administration as prescribed by the resident's physician; (C) any cautionary information from the original prescription package if the information is not on the container released for the leave of absence; (3) The resident's medication shall be provided in a capped or closed container that will protect the medications from contamination and spillage; and (4) Labeling of each of the resident's individual medication containers for the leave of absence shall be legible, include at least the name of the resident and the name and strength of the medication, and be affixed to each container. The facility shall maintain documentation in the resident's record of medications provided for the resident's leave of absence, including the quantity released from the facility and the quantity returned to the facility. The documentation of the quantities of medications released from and returned to the facility for a resident's leave of absence shall be verified by signature of the facility staff and resident or the person accompanying the resident upon the medications ' release from and return to the facility. (e) The facility shall assure that accurate records of the receipt, use, and disposition of medications are maintained in the facility and available upon request for review.	C936	Responsible Party: Administrator Completion Date: March 10, 2026.	

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C936	Continued From page 9 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure accurate records of the receipt, use and disposition of medications were provided at discharge for 1 of 3 sampled residents (#3). The findings are: Review of Resident #3's current FL2 dated 01/13/26 revealed: -Diagnoses included dementia, hypertension, congestive heart failure, atrial fibrillation and hyperthyroidism. -An order for amiodarone (used to treat cardiac dysrhymias) 100mg daily. -An order for donepezil (used to treat dementia) 10mg at bedtime. -An order for Eliquis (a blood thinner) 2.5mg two times daily. -An order for furosemide (used to treat fluid excess) 40mg two times a week on Wednesdays and Saturdays. -An order for jardiance (used to treat heart failure) 10mg daily. -An order for lumigan 0.01% (used to treat glaucoma) instill one drop in each eye daily. -An order for methimazole (used to treat hyperthyroidism) 10mg daily. -An order for omeprazole (used to treat increased stomach acid) 40mg daily at least thirty minutes before breakfast. -An order for quetiapine fumarate (used to treat anxiety) 50mg twice daily.	C936		

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C936	Continued From page 10 -An order for valsartan (used to treat high blood pressure) 40mg daily. -An order for acetaminophen (used to treat pain/fever) 500mg every six hours as needed. -An order for an anti-diarrheal (used to treat diarrhea) 2mg four times daily as needed. -An order for ondansetron (used to treat nausea) 4mg every eight hours as needed. -An order for polyethylene glycol (used for constipation) 3350 powder, dissolve 17gm in 8oz of fluid daily as needed. -An order for quetiapine fumarate (used to treat agitation) 50mg daily as needed. -An order for solonpas 3-10% (used to treat pain) twice daily as needed. Review of Resident #3's resident register revealed Resident #3 was discharged on 01/21/26. Review of Resident #3's record revealed there was no documentation showing the resident's disposition of her medications when she was discharged from the facility on 01/21/26. Telephone interview with Resident #3's Power of Attorney (POA) on 02/17/26 at 12:44pm revealed: -Resident #3 was given an immediate discharge from the facility on 01/21/26. -Resident #3's medications were in bubble packs and put in "garbage bags". -She did not receive instructions on when Resident #3 last received her medications, when she would administer the next dose or what medications required refills. -She did not sign any documents stating she received Resident #3's medications from the facility with instructions about the medications. -There was no document listing each medication, instructions or count of the medications at	C936		

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C936	Continued From page 11 discharge. Interview with the Administrator on 02/17/26 at 9:28am revealed: -She did not know she was responsible to have a receipt of the medication sent home with Resident #3 on discharge. -She did not know she was responsible to fill out a list of all of Resident #3's medications, administration instructions and how many of each medication was taken with Resident #3 when Resident #3 was discharged home from the facility.	C936		