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	HAL073018	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

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THE CANTERBURY HOUSE	1284 LEASBURG ROAD ROXBORO, NC 27573

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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on 02/03/26 - 02/05/26.	D 000		
D 225	10A NCAC 13F .0702 (c) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (c) The facility administrator or their designee shall assure the following requirements for written notice are met before discharging a resident: (1) The Adult Care Home Notice of Discharge with the Adult Care Home Hearing Request Form shall be completed and hand delivered, with receipt requested, to the resident on the same day the Adult Care Home Notice of Discharge is dated. These forms may be obtained at no cost from theDivision of Health Benefits, on the internet website https://policies.ncdhhs.gov/divisional/healthbenefits-nc-medicaid/forms. The Adult Care Home Notice of Discharge shall include the following: (A) the date of notice; (B) the date of transfer or discharge; (C) the reason for the notice; (D) the name of responsible person or contact person notified; (E) the planned discharge location; (F) the appeal rights; (G) the contact information for the long-term care ombudsman; and (H) the signature and date of the administrator. (2) A copy of the completed Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form shall be hand delivered, with receipt requested, or sent by certified mail to the resident's responsible person or legal representative and the individual identified upon	D 225	Responses to cited deficiencies do not constitute an admission or agreement by the facility of truth of facts alleged or conclusions set forth in the Statement of Deficiencies or the Corrective Action Report. The Plan of Correction is prepared solely as a matter of compliance with state laws. 10A NCAC 13F .0702 (c) Discharge of Residents ED, BOC and RCC have been in serviced on rule .0702 Discharge of residents by Regional Support. ED and/or Designee will have regional support review discharge paperwork for the next 60 days to ensure documentation and delivery of documentation is completed according to rule .0702.	02/27/26 04/06/26

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Sharon Ryder — Interim ED — 3-18-2026

Reviewed and acknowledged SW 03/19/26

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D 225	Continued From page 1 admission to receive a discharge notice on behalf of the resident on the same day the Adult Care Home Notice of Discharge is dated. For the purposes of this Rule "responsible person" means a person chosen by the resident to act on their behalf to support the resident in decision-making; access to medical, social, or other personal information of the resident; manage financial matters; or receive notifications. The Adult Care Home Hearing Request Form shall include the following: (A) the name of the resident; (B) the name of the facility; (C) the date of transfer or discharge; (D) the date of scheduled transfer or discharge; (E) the selection of how the hearing is to be conducted; (F) the name of the person requesting the hearing; and (G) for the person requesting the hearing, their relationship to the resident, address, telephone number, their signature, and date of the request. (3) Provide the following material in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to the resident and the resident's legal representative and the individual identified upon admission to receive a copy the discharge notice on behalf of the resident: (A) a copy of the resident's most current FL-2 form required in Rule .0703 of this Subchapter; (B) a copy of the resident's current physician's orders, including medication order; (4) Failure to use and simultaneously provide the specific forms according to Subparagraphs (c)(1) and (c)(2) of this Rule shall invalidate the discharge. (5) A copy of the completed Adult Care Home Notice of Discharge, the Adult Care Home	D 225		

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D 225	Continued From page 2 Hearing Request Form as completed by the facility administrator or their designee prior to giving to the resident and a copy of the receipt of hand delivery or the notification of certified mail delivery shall be maintained in the resident's record. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the requirements for written notice of discharge were met prior to discharging residents for ensuring a written discharge notice was hand delivered or sent by certified mail to the responsible party or legal representative for 1 of 2 sampled residents (#7) prior to discharge. The findings are: Review of the facility's Discharge and Transfer policy dated September 2021 revealed there was no process including the 30-day notice of discharge and appeal rights. Review of Resident #7's current FL-2 dated 01/16/26 revealed: -Diagnoses included adult failure to thrive, Alzheimer's disease with late onset, and atherosclerosis heart disease of native coronary. -Resident #7 was intermittently disoriented. -Resident #7 was ambulatory. -The level of care was skilled nursing facility. Review of Resident #7's previous FL-2 dated	D 225		

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D 225	Continued From page 3 06/28/25 revealed: -Diagnoses included adult failure to thrive, Alzheimer's disease with late onset, and atherosclerosis heart disease of native coronary. -Resident #7 was intermittently disoriented. -Resident #7 was ambulatory. -The level of care was domiciliary (rest home). Review of Resident #7's Resident Register revealed: -Resident #7 was admitted to the facility on 06/27/22. -Resident #7 had a Power of Attorney (POA). -Section G for Discharge/Transfer Information was blank. -Resident #7's POA had not signed the discharge portion of the Resident Register. Review of Resident #7's Notice of Transfer/Discharge form dated 01/06/26 revealed: -The transfer/discharge date was blank. -The reason for the notice was increased level of care. -Resident #7 was being transferred to a skilled nursing facility because the resident needed memory care. Telephone interview with Resident #7's POA on 02/03/26 at 3:43pm revealed: -Resident #7's had a decline in health. -The resident was being discharged from the facility on 02/06/26. -She was not given a written transfer/discharge notice and appeal form. -The Administrator told her verbally in January 2026, that the resident would be discharged in 30 days. Based on observations, interviews, and record	D 225		

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D 225	Continued From page 4 reviews, it was determined Resident #7 was not interviewable. Interview with the Business Office Manager (BOM) on 02/04/26 at 9:55am revealed: -She and the Administrator were responsible for discharging residents. -The Administrator was responsible for completing the discharge paperwork and she filed the paperwork. Interview with the Administrator on 02/05/26 at 3:14pm revealed: -He and the BOM were responsible for discharging residents. -He was aware that residents or their responsible party were supposed to receive a 30-day transfer/discharge notice and appeal form. -He could not recall how he provided the transfer/discharge notice to Resident #7's POA. -He was not aware there was issue with the discharge notice until the surveyor requested discharge records on 02/03/26. -He was not aware the date of transfer/discharge was required to be completed on the notice of discharge.	D 225	ED, BOC and RCC have been inserviced on rule .0702 Discharge of residents by Regional Support. ED and/or Designee will have regional support review discharge paperwork for the next 60 days to ensure documentation and delivery of documentation is completed according to rule .0702.	
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION The Type A2 Violation is abated. Non-compliance	D 273		

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D 273	Continued From page 5 continues. THIS IS A TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure health care referral and follow-up for 2 of 6 sampled residents (#1 and #8) related to physical therapy and occupational therapy referrals (#1 and #8) and a follow-up with the Primary Care Provider (PCP) from an Emergency Department (ED) visit (#1). The findings are: 1. Review of Resident #1's current FL-2 dated 01/12/26 revealed diagnoses included dementia, weakness, weight loss, gastro-esophageal reflux disease (GERD), and hypothyroidism. a. Review of Resident #1's accident/incident report dated 01/04/26 revealed: -At 10:50am, Resident #1 was found lying on her back in the doorway of her bedroom. -There were no injuries noted. Review of Resident #1's Primary Care Provider's (PCP) after visit summary dated 01/06/26 revealed: -Resident #1 was seen today, 01/06/26, for a follow-up visit from a fall on 01/04/26. -Resident #1 was found on her bottom in the doorway of her bedroom, without injury. -Resident #1 was ordered physical therapy (PT) and occupational therapy (OT) to evaluate and treat Resident #1's deconditioning and weakness due to dementia and gait instability. -PT and OT should increase Resident #1's strength and prevent falls. Review of Resident #1's record revealed there	D 273	10A NCAC 13F .0902(b) Health ED, Care Coordinator, Regional Clinical Director, PCP and Inhouse PT/OT met to review referral and order process. Regional clinical director and/or RVPO will audit no less than 5 resident records remotely and/or during on-site visits to ensure healthcare and follow up is properly conducted. ED, RCC and/or designee will notify provider of residents with incident reports requiring greater than first aide to be seen and assessed by PCP during weekly ED, Care Coordinator and/or designee will review PCP referral orders during daily stand up to ensure referrals to providers are being schedule.	02/10/26 and 02/17/26 03/20/26 03/17/26 03/22/26

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D 273	Continued From page 6 were no PT/OT notes available for review. Telephone interview with a representative from the facility's contracted therapy agency on 02/03/26 at 11:20am revealed: -The agency did not have an order for PT/OT services for Resident #1. -The agency had not seen Resident #1 since 2024. Telephone interview with a representative from the in-house therapy department on 02/03/26 at 11:27am revealed Resident #1 was not receiving and had not received PT/OT services from the in-house therapy department. Telephone interview with Resident #1's PCP on 02/05/26 at 9:30am revealed: -She saw Resident #1 on 01/06/26 for a follow-up visit from a fall that occurred on 01/04/26. -Resident #1 was ordered a PT/OT referral on 01/06/26 due to the fall. -She emailed Resident #1's PT/OT referral to the Administrator. -The Assisted Living Facility (ALF) had an in-house PT/OT department. -If the in-house PT/OT department could not accept Resident #1's therapy referral then the facility would refer Resident #1 to the facility's contracted agency outside the facility. -The in-house therapist told the PCP one day when she was in the facility that Resident #1 could not be seen by the in-house therapist because Resident #1 had a co-pay. -The in-house therapist told the Administrator that Resident #1 could not be seen by the in-house therapist; Resident #1 would have to be referred to the facility's contracted agency outside the facility. -She thought the Administrator had referred	D 273	ED, Care Coordinator and/or designee will review hospice and home health notes daily at stand up for 30 days, and then weekly thereafter. Regional Clinical Director and/or Care Coordinator and/or designee will review and exit with PCP for next 60 days. Care Coordinator and/or designee will review and exit with care coordinator thereafter. ED, Care Coordinator and/or designee are reviewing residents change in conditions, skin assessments during daily stand up for 30 days and then weekly for 90 days.	03/22/26 03/22/26 03/17/26

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D 273	Continued From page 7 Resident #1 to the facility's contracted agency outside the facility. -Resident #1 continued to decline after her fall on 01/06/26 and was hospitalized on 01/29/26 for altered mental status and the inability to ambulate. -She did not know Resident #1 had not started PT/OT services as ordered on 01/06/26 prior to her hospitalization on 01/29/26. -She expected the therapy orders to be implemented as least within a week of the orders being written. Telephone interview with a representative from the in-house therapy department on 02/05/26 at 10:22am revealed: -When the PCP wrote an order for PT/OT for a resident, the Administrator or the Resident Care Coordinator (RCC) would tell him. -The facilty wanted him to see Resident #1 for PT/OT. -He was unable to see Resident #1 for PT/OT related to a co-pay. -He told the Administrator that he was unable to see Resident #1, but he could not remember when. -The facility was responsible for notifying the outside provider for therapy services when the residents could not be seen in-house. Interview with the RCC on 02/05/26 at 10:49am revealed: -She started as the RCC a few weeks ago and her email was set up this week, the week of 02/02/26. -The PCP sent the after visit summaries to the Administrator's email. -She would scan the after visit summaries into the computer. -She would give a copy of the PT/OT referral to	D 273		

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D 273	Continued From page 8 the in-house therapist. -She was not sure if the in-house therapist was seeing Resident #1. -She did not recall seeing Resident #1 in therapy. -If the in-house therapy could not see Resident #1, she thought the therapist would tell the Administrator. Interview with the Administrator on 02/05/26 at 11:05am revealed: -The PCP had a folder that she would place PT/OT orders into. -He and the RCC were responsible for reviewing orders that were written by the PCP. -He or the RCC would give the in-house therapist the order. -If the in-house therapist could not see the resident, he would let the RCC or Administrator know and he or the PCP would send the order to the facility's outside provider. -He did not recall being told from the in-house therapist that Resident #1 could not be seen by the in-house therapist. -He should have been told that the in-house therapist could not see Resident #1 for therapy so he could have notified the outside contracted agency. b. Review of Resident #1's accident/incident report dated 01/06/26 revealed: -At 11:30am, Resident #1 was found lying on her bedroom floor by another resident's visitor. -Resident #1 was lying on her left side, holding the left side of her head. -Resident #1 was transported to the local hospital at 12:05pm. Review of Resident #1's Emergency Department (ED) discharge summary dated 01/06/26 revealed:	D 273		

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D 273	Continued From page 9 -Resident #1 was found on the floor and complained of a headache. -A computed tomography (CT) scan of her head showed a small left frontal subarachnoid hemorrhage. -The case was discussed with a neurosurgery department at a major hospital. -It was recommended to repeat the CT scan in 6 hours and if stable, discharge Resident #1 back to the ALF. -The second CT scan was stable with no expansion of the left frontal subarachnoid hemorrhage, and Resident #1 was discharged back to the Assisted Living Facility (ALF). -The neurosurgery department would contact Resident #1's caregivers to arrange a follow-up appointment. -Final diagnosis was traumatic subarachnoid hemorrhage without loss of consciousness. -Resident #1 was to follow-up with her PCP later that week, the week of 01/06/26. Review of Resident #1's accident/incident report dated 01/29/26 at 9:04am revealed Resident #1's PCP sent Resident #1 to the local hospital related to a change in condition. Review of Resident #1's Emergency Medical Services (EMS) report dated 01/29/26 revealed: -At 8:00am, EMS received a call regarding a lethargic resident. -Staff reported that Resident #1 was increasingly lethargic and weaker over the past three days. -Staff reported that Resident #1 was seen in the local hospital ED on 01/06/26 after a fall, with a diagnosis of a subarachnoid hemorrhage. -Staff denied any recent falls. Review of Resident #1's ED summary dated 01/29/26 revealed:	D 273		

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D 273	Continued From page 10 -Resident #1 was seen for altered mental status and inability to ambulate. -Resident #1 had increased weakness. -Resident #1 was seen on 01/06/26 with a subarachnoid hemorrhage. -A CT scan was ordered and the results were negative. -Resident #1 had a urinalysis which was positive for a urinary tract infection (UTI). -She was admitted to the hospital for a UTI and dehydration. Telephone interview with Resident #1's Power of Attorney (POA) on 02/03/26 revealed: -Resident #1 had a fall and hit her head on 01/06/26. -Resident #1 ambulated unassisted. -She was seen at the local ED and was diagnosed with a brain bleed according to the hospital staff. -She returned to the ALF after a second CT scan showed no additional bleeding. -The neurosurgeon's office called her and made an appointment for Resident #1 for 02/17/26. -She obtained her information from the local ED. -The facility called her to let her know Resident #1 was going to the hospital on 01/06/26 but they did not inform her about the brain bleed, the hospital staff informed her. -She received a call from the ALF on 01/29/26 stating Resident #1 had a change in her mental status and she could not walk, and Resident #1 was being sent to the local ED. -The facility voiced concerns about possible bleeding in the brain. -She spoke with the hospital personnel who stated Resident #1 had a severe UTI and she was dehydrated. -The hospital had done another CT scan and said there were no changes from the second CT scan	D 273		

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D 273	Continued From page 11 from the ED visit on 01/06/26. Interview with a medication aide (MA) on 02/04/26 at 2:10pm revealed: -Resident #1 fell on 01/06/26 after being seen by her PCP earlier that morning. -Resident #1 was sent to the ED but returned the same day, 01/06/26, or the next day, 01/07/26. -A week or two after she returned from the ED, she began limping, as if her left leg hurt. -Resident #1 started dragging her left leg when she was trying to walk. -She was ambulating by herself prior to the fall on 01/06/26, but after she started limping and dragging her feet, Resident #1 needed someone to walk with her. -She told the RCC about Resident #1 limping and dragging her left leg. -She did not know if the RCC reached out to the PCP. -When she came to work on 01/27/26, Resident #1 was sitting in a wheelchair at the dining room table. -She told the RCC that Resident #1 could not walk and was in a wheelchair. -On 01/29/26, the PCP came for her weekly visit. -She told the PCP about the decline in Resident #1's ambulatory status and she showed the PCP the hospital discharge summary from 01/06/26. -The PCP stated she did not know Resident #1 had a brain bleed. -The PCP called the RCC and the Administrator, who were off on 01/29/26. -The PCP told the Administrator that she was finding out about the brain bleed today and that had she known about it she could have seen her the week of 01/13/26 for an acute visit regarding the brain bleed. -The PCP sent Resident #1 to the ED to be evaluated due to confusion and decline in	D 273		

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D 273	Continued From page 12 ambulatory status. Telephone interview with Resident #1's PCP on 02/05/26 at 9:30am revealed: -She was made aware of Resident #1's diagnosis of a subarachnoid hematoma on 01/29/26. -She saw Resident #1 on 01/06/26 for a follow-up visit from a fall on 01/04/26. -She was notified that Resident #1 had fallen and hit her head on 01/06/26, after her visit, and that Resident #1 was being sent to the ED. -She was not notified when Resident #1 returned to the facility or that Resident #1 had a subarachnoid hematoma. -She visited the facility weekly and she called the Administrator before each weekly visit to ask if there were any acute residents that needed to be seen. -She called the Administrator before her weekly visit on 01/13/26, and she was told there were no residents that required an acute visit on 01/13/26. -When she visited on 01/29/26, she was presented with Resident #1's ED discharge note from 01/06/26, which was when she found out about the subarachnoid hemorrhage. -She expected to be notified as soon as Resident #1 returned to the facility with a diagnoses of a subarachnoid hemorrhage. -She notified the Administrator on 01/29/26 when she was presented with the ED discharge summary and asked why she was seeing this on 01/29/26 for the first time when the subarachnoid hemorrhage occurred on 01/06/26. -The Administrator told her he did not know why; the discharge summary must have been misplaced. -On 01/29/26, she saw Resident #1; Resident #1 was not herself. -Resident #1 was ambulatory, but she was not walking and she was in a wheelchair.	D 273		

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D 273	Continued From page 13 -She was admitted to the hospital for a UTI and dehydration. Interview with the RCC on 02/05/26 at 10:49am revealed: -She did not prepare the acute list for the PCP for her weekly visit. -She thought the Administrator prepared the acute list of residents for the PCP to visit each week. -She did not see the ED discharge summary when Resident #1 returned to the facility. -She did not know the PCP was unaware of Resident #1's diagnosis of a subarachnoid hemorrhage on 01/06/26. -She did not know what happened the to the ED discharge summary and why it was not placed in the PCP's folder when Resident #1 was returned to the facility. -She did not recall the MA informing her that Resident #1 was having difficulty walking. Interview with the Administrator on 02/05/26 at 11:05am revealed: -The ED discharge summary should have been given to the PCP on the very next visit, 01/13/26. -The PCP texted him every week to see if there were any acute residents (residents with falls or ED visits) who needed to be seen. -He would text the PCP the names of the acute residents who needed to be seen. -He did not text Resident #1's name to the PCP to be added for her 01/13/26 visit for an acute visit because he was not aware that Resident #1 needed to be seen. -On 01/29/26 the discharge paper work was located and provided to the PCP. -On 01/29/26, the PCP called him; she was questioning Resident #1's subarachnoid hemorrhage.	D 273		

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D 273	Continued From page 14 -He found out about the subarachnoid hemorrhage on 01/29/26 when he received the call from the PCP. -He did not know when Resident #1's decline in health started. -He noticed Resident #1 was having difficulty standing and walking on 01/28/26 while she was in the dining room. -Resident #1 required assistance ambulating to her room from the dining room. -No one had reported to him regarding Resident #1's decline. Attempted telephone interview with Resident #1's neurosurgeon's office on 02/03/26 at 1:30pm was unsuccessful. 2. Review of Resident #8's current FL-2 dated 01/12/26 revealed diagnoses included Alzheimer's disease, unspecified fractures of upper end of right tibia, unspecified fall, malignant neoplasm of left kidney, hypertensive chronic disease stage I, chronic kidney disease stage, thyroid nodule, and acute respiratory failure with hypoxia. Review of Resident #8's accident/incident report dated 12/29/25 revealed: -At 1:15pm, Resident #8 was found lying on her bedroom floor. -Resident #8 denied any injuries. -Resident #8 stated her knee gave out and she lost her balance. -Resident #8 was transported to the local hospital per the family's request. Review of Resident #8's Emergency Department (ED) discharge summary dated 12/29/25 revealed: -Resident #8 was seen for bilateral knee pain and	D 273		

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D 273	Continued From page 15 a hematoma on the back of her head after a fall. -Resident #8 reported she was walking to the bathroom when her knees buckled and she fell. -Resident #8 reported her knees buckled from time to time. -Resident #8 had a CT (computed tomography) scan which showed no acute intracranial hemorrhage or abnormalities. Review of Resident #8's Primary Care Provider's (PCP) after summary visit dated 01/06/26 revealed: -Resident #8 was seen in the ED on 12/29/26 due to a fall. -Resident #8 was seen today, 01/06/26, for a hospital follow-up. -Resident #8 lost her balance and fell without injury. -There was an order for physical therapy (PT) and occupational therapy (OT) to evaluate and treat Resident #8's deconditioning and weakness due to dementia, gait instability and limited mobility to increase strength and prevent falls. Review of Resident #8's signed physician order dated 01/06/26 revealed there was an order for PT/OT related to falls. Review of Resident #8's record revealed there were no PT/OT notes to review. Review of Resident #8's accident/incident report dated 01/13/26 revealed: -At 12:55am, Resident #8 was found sitting on the bathroom floor. -Resident #8 denied any injuries. Interview with Resident #8 on 02/05/26 at 10:10am revealed: -She had fallen a few times going to the	D 273		

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D 273	Continued From page 16 bathroom, but she did not remember when. -She knew she hit her head and went to the ED one time. -She did not remember anyone coming to see her to do exercises with her. Telephone interview with Resident #8's Power of Attorney (POA) on 02/05/26 at 2:00pm revealed: -Resident #8 had several falls in the past 6 months. -Resident #8 was seen in the ED a few times because Resident #8 hit her head when she fell. -Resident #8 fell mostly at night when she was going to the bathroom. -He did not know if Resident #8 had started PT/OT or not. Telephone interview with a representative from the facility's contracted therapy agency on 02/05/26 at 10:30am revealed: -The agency did not have an order for PT/OT services for Resident #8 in January 2026. -The agency had not seen Resident #8 since 2014. -Referrals from the facility were received via email of fax from the Administrator. -As the facility's contracted therapy agency, they accepted all referrals from the facility. Telephone interview with a representative from the in-house therapy department on 02/05/26 at 10:22am revealed: -When the PCP wrote an order for PT/OT for a resident, the Administrator or the Resident Care Coordinator (RCC) would tell him. -He was unable to see Resident #8 for PT/OT due to the resident's payor status. -He told the Administrator that he was unable to see Resident #8, but he did not remember when. -He thought the Administrator was responsible for	D 273	Regional clinical director and/or RVPO will audit no less than 5 resident records remotely and/or during on-site visits to ensure healthcare and follow up is properly conducted. ED, Care Coordinator, Regional Clinical Director, PCP and Inhouse PT/OT met to review referral and order process.	03/17/26 02/10/26 and 02/17/26

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D 273	Continued From page 17 referring residents to the outside provider for services. Telephone interview with Resident #8's PCP on 02/05/26 at 9:30am revealed: -She saw Resident #8 on 01/06/26 for a follow-up visit after being seen in the ED on 12/29/25. -Resident #8 was ordered a PT/OT referral on 01/06/26 due to falls. -She emailed Resident #8's PT/OT referral to the Administrator. -The facilty had an in-house PT/OT department. -If the in-house PT/OT department could not accept the resident for PT/OT, the facility would refer them to the facility's contracted agency outside the facility. -She did not know Resident #8 had not been seen for PT/OT as of 02/05/26. Interview with the RCC on 02/05/26 at 10:49am revealed: -She started as the RCC a few weeks ago and her email was set up this week. -The PCP sent the after visit summaries to the Administrator's email. -She would scan the after visit summaries into the computer. -She would give a copy of the PT/OT referral to the in-house therapist. -She was not sure if the in-house therapist was seeing Resident #8. -She did not recall seeing Resident #8 have therapy. Interview with the Administrator on 02/05/26 at 11:05am revealed: -The PCP had a folder that she placed orders into. -He and the RCC were responsible for reviewing orders that were written by the PCP.	D 273	ED, Care Coordinator and/or designee will review PCP referral orders during daily stand up to ensure referrals to providers are being schedule. ED, Care Coordinator and/or designee are reviewing residents change in conditions, skin assessments during daily stand up for 30 days and then weekly for 90 days. ED, Care Coordinator and/or designee will review hospice and home health notes daily at stand up for 30 days, and then weekly thereafter.	

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D 273	Continued From page 18 -He or the RCC would give the in-house therapist the order. -If the in-house therapist could not see the resident, he would let the RCC or Administrator know, and the order would be sent to the outside providers by the Administrator. -He did not know #8 had an order for PT/OT. _____ The facility failed to ensure health care referral and follow up for a resident (#1) who was seen in the Emergency Department on 01/06/26, diagnosed with a subarachnoid hemorrhage sustained from a fall, and was to follow up with her PCP within the week; however, the resident was not seen by the PCP until 01/29/26. Resident #1 had been ambulatory but declined to a non-ambulatory status and had not received PT and OT as ordered. Resident #8 also did not receive PT and OT as ordered, and had an additional fall after the PT/OT order was written. This failure 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. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 22, 2026.	D 273		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) Facilities with a licensed capacity of 13 or more residents shall ensure food services comply	D 283		

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D 283	Continued From page 19 with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions set forth in 15A NCAC 18A .1300 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure foods stored and prepared in the kitchen were free from contamination related to dirty food storage containers, opened foods, food that was not labeled or dated, expired food, dirty walls and shelves with food buildup, debris on the floors, a dirty microwave oven, and a dirty stove with a buildup of grease on the surrounding equipment. The findings are: Review of the Environmental Health Services (EHS) inspection report dated 10/31/25 revealed the kitchen sanitation score was 100. Review of the undated weekly cleaning log posted in the kitchen on 02/03/26 at 10:22am revealed: -On Monday, the stock room and storage room were to be cleaned, organized, swept, and mopped.	D 283	10A NCAC 13F .0904 Nutrition and Food Service Dietary manager attended ServSafe Course to receive proper education on food safety. DSM was in serviced by Regional Support on importance of cleanliness and adhering to cleaning schedule, proper storage and expiration dating of food. Cleaning schedule will be reviewed daily at standup by DSM and ED for 30 days to ensure completion of daily tasks. ED and/or designee will conduct daily walk throughs of kitchen, freezer, refrigerator and dry storage area to inspect cleanliness, proper storage and dating of food for 30 days. RVPO and/or other regional support will tour kitchen during random monthly onsite visits for the next 90 days.	02/25/26 03/10/26 03/22/26 03/10/26 05/06/26

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D 283	Continued From page 20 -On Tuesday, the equipment and appliances were to be deep cleaned and wiped down. -On Wednesday, the refrigerator and freezer were to be cleaned, expired foods removed and disposed of. -On Thursday, the kitchen surfaces and walls were to be scrubbed, prep tables and countertops wiped down, and the sinks were to be sanitized. -On Friday, the floors were to be deep cleaned and the trash cans were to be cleaned. -On Saturday and Sunday, prep areas and equipment were to be wiped down. -The kitchen was to be swept and mopped after each shift daily. Observation of the dry storage on 02/03/26 at 9:44am revealed: -There was an opened container of mashed potatoes that was dated 01/23. -There was a bag of brownish cabbages that were sitting on the floor. -There were multiple opened bags of dry foods that were not dated. Observation of the refrigerator and freezer on 02/06/26 at 9:59am revealed: -The doors of the refrigerator were covered in dirty stains. -There were spills inside of the refrigerator. -There was a pitcher of liquid that was uncovered, not labeled, or dated. -There was an opened bag of parmesan cheese that was not properly dated. -There was a large bag of tossed salad that was brown in color. -There was a container of soup that was partially covered with aluminum foil, that was not dated. -There were multiple pans of food that were partially covered with aluminum foil that were not dated.	D 283		

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D 283	Continued From page 21 Observation of the freezer on 02/06/26 at 10:09am revealed: -There was a bag of food that was green in color, dated 01/23/26, that was not labeled. -There was a large, opened bag of green beans that was not dated. -There was a large, opened bag of mixed vegetables that was not dated. Observation of the kitchen on 02/03/26 at 10:16am revealed: -There were two opened bags of pasta on the countertop that was dated 12/09. -There was a dirty stainless-steel container that was labeled "iced tea". -There was a food cart that was dirty with spilled liquids and debris. -There was a buildup of food, debris and a black layer on the cast-iron burners on the stove. -There were spots of various sizes on the walls next to the stove. -There was a thick yellow buildup on the flat top grill. -There was a dirty storage bin that was labeled "sugar" beneath the prep table. -The floors were covered with food debris, spills, and dirt. -There were three white towels underneath the trashcan. -There was a bucket with a brownish liquid underneath the handwashing sink. Interview with the Dietary Manager (DM) on 02/04/26 at 3:25pm revealed: -She was responsible for creating the cleaning schedule. -The dietary staff were responsible for following the cleaning schedule posted in the kitchen. -The kitchen had not been cleaned since	D 283		

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D 283	Continued From page 22 01/30/26, because she was short staffed due to the snowstorm. -The kitchen was supposed to be cleaned after each meal service. -The storage bins had been cleaned last week and were usually cleaned once a week. -The floors were swept and mopped after each meal service. -She was not aware of the expired food. -The kitchen staff were responsible for checking for expired foods daily. -She labeled opened food with the month and day. -She was not aware food should be labeled and dated with the month, day, and year they were opened. -She was not aware that the opened food items were not dated. -She was not aware of the opened bags of food. -All food should be resealed. -She started using aluminum foil to cover food because there was no saran wrap in the facility. -She placed the bag of cabbages on the floor because she was going to throw them away. Interview with a cook on 02/05/26 at 12:21pm revealed: -Some days she worked as a dietary aide and other days she worked as a cook. -The days she worked as a dietary aide, she cleaned the dishes the residents used and swept and mopped the kitchen closest to the sink. -When she was responsible for cooking, she only cleaned the side of the kitchen where the cooking appliances were; and swept and mopped that area. -The cleaning schedule did not indicate which dietary staff was responsible for cleaning the different areas of the kitchen. -The DM trained her to clean the kitchen that way	D 283	Dietary manager attended ServSafe Course to receive proper education on food safety. RVPO and/or other regional support will tour kitchen during random monthly onsite visits for the next 90 days. Cleaning schedule will be reviewed daily at standup by DSM and ED for 30 days to ensure completion of daily tasks. ED and/or designee will conduct daily walk throughs of kitchen, freezer, refrigerator and dry storage area to inspect cleanliness, proper storage and dating of food for 30 days.	

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D 283	Continued From page 23 when she was hired. -She could not recall the last time she cleaned the kitchen. -There were mornings when she arrived to work and the kitchen had not been cleaned from the previous day. -There were pots and pans in the sink from the breakfast and lunch meal service. -There was food that was being prepped that was left uncovered on the steam table. -She reported it to the DM and the Administrator. -She used aluminum foil to cover foods in the refrigerator because there was no saran wrap. -She was taught to label opened food with the month and day. -She looked in the refrigerator once a week for expired foods to throw away. Interview with the Administrator on 02/05/26 at 3:14pm revealed: -He toured the kitchen daily during the lunch meal service. -The kitchen was always clean when he toured the kitchen. -He knew there was a cleaning schedule in the kitchen but was not sure if it was being followed. -He never opened the refrigerator, freezer, or looked in the dry storage room. -The dietary staff should not be using aluminum foil to cover food. -He expected the dietary staff to use saran wrap to cover open food. -He expected the DM to look at the walk-in cooler and freezer daily, upon arrival, to ensure all foods were labeled, dated and not expired. -He expected the dietary staff to follow the cleaning schedule. Attempted telephone interview with the Environmental Health Specialist from the Local	D 283	DSM was inserviced by Regional Support on importance of cleanliness and adhering to cleaning schedule, proper storage and expiration dating of food.	

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D 283	Continued From page 24 Department of Environmental Health on 02/05/26 at 3:10pm was unsuccessful.	D 283		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult 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: Based on observations and interviews, the facility failed to treat the residents with respect and dignity as evidenced by serving food that was cold, undercooked and burnt and not serving alternate foods as requested by residents. The findings are: Observation of the lunch meal service on 02/04/26 at 12:12pm revealed: -Two residents were served burnt meatballs on their plates. -The meatballs were black with a thick crust on one side. Interview with a resident on 02/03/26 at 9:20am revealed: -Sometimes the food was not cooked enough. -She had been served undercooked beans that were crunchy and undercooked meat that was red in the middle. -She had been served meatballs that had been burnt. -The facility served spaghetti and meatballs several times a week. -She had requested navy beans or pinto beans,	D 338	10A NCAC 13F .0909 Resident Resident rights were reviewed by ED and AED during all staff RVPO and DSM reviewed dietary platform for training and understanding of meal quality, proper recipe following and cook times per dish served. ED and/or designee will conduct random temp checks on food before served for 30 days. Manager on Duty on schedule created to ensure that at minimum one meal service is watched during weekend rotations for 90 ED and/or designee will randomly monitor meal services to ensure proper quality of food being served for the 90 days.	02/17/26 03/09/26 03/10/26 05/06/26 05/06/26

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	HAL073018	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

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D 338	Continued From page 25 but the facility had not served those. Interview with a second resident on 02/03/26 at 9:23am revealed: -The butterbeans were not cooked well; they were undercooked. -She could not eat the butterbeans because they were not done. -She told the kitchen staff during the meal that the butterbeans were not done; the residents were not served anything in place of the butterbeans. -Sometimes the meat and bread would be burnt; she would not eat the meat and bread if it was burnt. -The kitchen staff did not do anything about the burnt food; the residents were not offered an alternate food to replace the burnt food. Interview with a third resident on 02/03/26 at 9:38am revealed: -Sometimes the food was undercooked and cold. -Sometimes the meat was overcooked and burnt. -There were a few times she did not know what the meat was. -The facility needed to hire a chef to cook the meals. -She had complained to the kitchen staff about cold, undercooked, and burnt food but there had been no improvement. Interview with a fourth resident on 02/04/26 at 8:00am revealed: -The meals were always being served cold. -He was served eggs, oatmeal, and sausages for breakfast today 02/04/26, and they were cold. -He complained to the Administrator two weeks ago and was told the Administrator would take care of it. -The food continued to be served cold.	D 338		

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D 338	Continued From page 26 Interview with a fifth resident on 02/04/26 at 2:40pm revealed: -Last week he requested a salad for dinner, because he was tired of eating chicken. -The cook told him she could not make him a salad but did not tell him why. -About 30 minutes later, the cook served him a salad. Interview with the medication aide (MA)/Resident Care Coordinator (RCC) on 02/05/26 at 2:51pm revealed: -Several residents had complained to her about being served the same food; they would like something different. -Several residents complained of overcooked food such as chicken tenders. -She told the Dietary Manager (DM) and the Administrator about the residents' concerns. Interview with a cook on 02/05/26 at 12:45pm revealed: -She was responsible for cooking, plating the food, and serving the food. -She would prepare enough plates for one table, and then serve the residents at that table their food. -She would push the cart to the kitchen door and a personal care aide (PCA) or MA would serve the plates. -There was one resident who said her food was cold and wanted it re-heated. -She re-heated the resident's plate of food. -She was told one day that the pizza crust was burnt. -The residents had complained that chicken tenders were cooked too long and they were tough. -No one complained to her about undercooked beans.	D 338		

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D 338	Continued From page 27 -Beans should be cooked on the stove, not the steam table. -On 02/03/26, the meatballs were placed on the steam table to cook. -After two hours on the steam table it was not hot enough to cook the meatballs. -She was instructed by the DM to place the meatballs in the oven to finish cooking the meatballs. -The meatballs began to burn on the bottom; she was instructed to take them out of the oven and place them on the stove top. Interview with the DM on 02/04/26 at 3:25pm revealed: -No residents had complained to her about undercooked, overcooked, burnt food, or food served cold. -The butterbeans should be cooked on the stove and not on the steam table. -Meatballs were cooked on the steam stable but all other meats were cooked in the oven. -The food was kept warm on the serving table until plated. -The staff would serve one table at a time. -The food would be plated for 4 to 6 residents and then served. -As the food was plated, it would be placed on a cart; after 4 to 6 plates were prepared, depending on the number of residents at the table, the plates would be taken to the dining room and served. -A few residents had complained about food preference. -She told the residents there was a main menu to follow. -She offered an alternate menu the residents could choose from if they did not want what was served. -There were a few residents who would choose from the alternate menu.	D 338	Resident rights were reviewed by ED and AED during all staff meeting. Manager on Duty on schedule created to ensure that at minimum one meal service is watched during weekend rotations for 90 days. ED and/or designee will randomly monitor meal services to ensure proper quality of food being served for the 90 days.	

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D 338	Continued From page 28 -The alternate menu consisted of sandwiches, soups, and salads. -She recently added more food to the alternate menu. Interview with the Administrator on 02/05/26 at 3:10pm revealed: -The only complaint he received about the food was that the pizza that was served several weeks ago was burnt on the bottom. -The Adult Home Specialist visited, he did not recall when and said some residents had complained about the food being cold. -He had discussed these issues with the DM. -He expected the food to be cooked well and served hot.	D 338	RVPO and DSM reviewed dietary platform for training and understanding of meal quality, proper recipe following and cook times per dish served.	
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B was not abated. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 5 sampled	D 358	10A NCAC 13F .1004 (a) Medication Administration RCD held in service with aide staff on the rule area .1004 Medication Administration to include infection control, order process, missing medication and process to correct missing medication orders. RCD/RN reviewed order process system with Care Coordinator. Care Coordinator has been provided with training on order process, visit summary reviews, cart audits, and chart audits by regional support team.	02/17/26 02/17/26 02/17/26, 02/24/26, 03/10/26, 03/11/26 and 03/17/26

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D 358	Continued From page 29 residents (#3) including a medication for diabetes. The findings are: Review of Resident #3's current FL-2 dated 10/30/25 revealed there was a diagnosis of diabetes mellitus. Review of Resident #3's signed physician orders dated 12/23/25 revealed there was an order for finger stick blood sugar (FSBS) checks before meals and at bedtime. Review of Resident #3's signed physician order dated 01/13/26 revealed there was an order to increase Mounjaro 2.5mg/0.5ml (used to improve blood sugar) to 5mg/0.5ml every 7 days. Review of Resident #3's January 2026 electronic medication administration record (eMAR) from 01/13/26 to 01/31/26 revealed: -There was no entry for Mounjaro 5mg/0.5ml inject every 7 days from 01/13/26 to 01/31/26. -There was no documentation Mounjaro 5mg/0.5ml was administered every 7 days from 01/13/26 to 01/31/26. -There was an entry for FSBS checks before meals and at bedtime with FSBS readings ranging from 114-338 from 01/13/26 to 01/31/26. Review of Resident #3's February 2026 eMAR 02/01/26 to 02/05/26 revealed: -There was no entry for Mounjaro 5mg/0.5ml inject every 7 days from 02/01/26 to 02/05/26. -There was no documentation Mounjaro 5mg/0.5ml was administered from 02/01/26 to 02/05/26. -There was an entry for FSBS checks before meals and at bedtime with FSBS readings ranging from 156-322 from 02/01/26 to 02/05/26.	D 358	Weekly MAR reviews for no less than 5 residents by RCD will be conducted onsite and/or during visit for 30 days. RCC will exit with PCP to review any acute issues and new orders. RCD/RN reviewed order process system with Care Coordinator. ED and RCC will review new PCP orders during daily stand up for 30 RCD/RN will provide weekly onsite visits with PCP for no less than 30 days to review visit summary. Weekly EMAR to Cart to Physician Order's audits will be conducted by RCC and/or designee and reviewed at daily stand up for 30 days and then weekly for the next quarter.	03/17/26 03/17/26 03/17/26 03/17/26 06/17/26

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D 358	Continued From page 30 Telephone interviews with a representative from the facility's contracted pharmacy on 02/05/26 at 8:42am and 2:15pm revealed: -Resident #3 had an order for Mounjaro 5mg/0.5ml inject 0.5ml every 7 days dated 01/13/26. -The pharmacy dispensed 4 Mounjaro 5mg/0.5ml pens on 01/13/26. -The pharmacy technician would enter the order into the computer system. -The pharmacist would verify the order was entered correctly. -Once the pharmacist verified the order was entered correctly, the facility would be able to see the order and approve the order for administration. Observation of Resident #3's medications on hand on 02/05/26 at 9:17am revealed: -There was one box of Mounjaro 5mg/0.5ml syringes in the refrigerator in the medication room. -The prescription label read, inject 0.5ml weekly for diabetes mellitus 2. -There were 3 of 4 Mounjaro 5mg/0.5ml syringes in the box available for administration with a dispensed date of 01/13/26. Interview with Resident #3 on 02/05/26 at 9:15am revealed: -She was a diabetic and received injections for her diabetes. -Some mornings she received one injection and some mornings she received two injections. -She was not sure when she received two insulin injections in one morning. Interview with the medication aide (MA) on 02/05/26 at 2:13pm revealed:	D 358	RCC will exit with PCP to review any acute issues and new orders. Weekly MAR reviews for no less than 5 residents by RCD will be conducted onsite and/or during visit for 30 days. Weekly EMAR to Cart to Physician Order's audits will be conducted by RCC and/or designee and reviewed at daily stand up for 30 days and then weekly for the next quarter.	

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D 358	Continued From page 31 -The representative from the pharmacy would enter the new order into the computer. -The Administrator would have to approve the new order before it could be administered. -The MAs could see when there was a new order to be approved on the eMAR. Telephone interview with a representative from Resident #3's Primary Care Provider's (PCP) office on 02/05/26 revealed: -The PCP wrote an order for Mounjaro 5mg/0.5ml inject 0.5ml daily on 01/13/26. -Mounjaro helped lower the A1C in residents with diabetes. (The hemoglobin A1C measures the average level of blood sugar over the previous 3 months. The normal A1C for a diabetic is less than 7.0%) -Resident #3's last A1C was 10 on 12/15/25. -The PCP expected the medication to be administered as ordered to help lower Resident #3's A1C. Interview with the MA/Resident Care Coordinator (RCC) on 02/05/26 at 2:20pm revealed: -New medication orders were faxed to the pharmacy by the facility staff or electronically sent to the pharmacy by the PCP and the pharmacy staff entered the new order into the computer. -The order had to be approved by the Administrator before it would show up on the eMAR and could be administered. -She had administered medications to Resident #3 the week of 02/03/26. -Resident #3 was receiving the Mounjaro injection every 7 days on Tuesday before the medication was increased on 01/13/26. -She did not give Resident #3 her injection on Tuesday, 02/03/26, because it was not on the eMAR. -If the medication had not been approved to be	D 358		

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D 358	Continued From page 32 administered, it could not be seen on the eMAR. -She was going to look into it, but she had gotten busy and forgot. -She did not recall giving Mounjaro 5mg/0.5ml to Resident #3 at anytime since it was ordered on 01/13/26. Interview with the Administrator on 02/05/26 at 3:10pm revealed: -He would expect the MAs to realize the medication was not appearing on the eMAR and investigate why the medication was not on the eMAR. -He was concerned because Resident #3 did not get a medication that was ordered by her PCP. -He did not know what complications could occur by Resident #3 missing this medication; he did not know what the medication was used for. -The order for Mounjaro may need to be approved so the order would show up on the eMAR for administration. -He was responsible for approving new medication orders for administration. The facility failed to administer medications as ordered for a resident (#3) who had a diagnosis of diabetes mellitus and was ordered but did not receive a medication used to lower blood sugar readings and lower the A1C, resulting in her having blood sugar readings as high as 338. This failure was detrimental to the health, safety, and welfare of the resident and constitutes an Unabated Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/15/26.	D 358		
D 371	10A NCAC 13F .1004 (n) Medication Administration	D 371		

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D 371	Continued From page 33 10A NCAC 13F .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. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure infection control measures were implemented during the morning medication pass as evidenced by the medication aide (MA) not sanitizing her hands prior to donning and doffing gloves when administering eye drops, injections, and checking finger stick blood sugar (FSBS). The findings are: Review of the facility's hand hygiene policy dated September 2021 revealed: -Wash hands before and after putting on disposable gloves. -Wash hands before assisting a resident with medications. -An alcohol-based hand rub may be used to obtain hand hygiene instead of handwashing. -The use of gloves did not replace handwashing or the use of an alcohol-based rub. Observation of the morning medication pass on 02/04/26 between 7:18am and 7:37am revealed: -At 7:18am, the MA put on gloves and checked a resident's FSBS reading. -The MA prepared the insulin for administration and administered the insulin to a resident. -The MA removed and disposed of the gloves and	D 371	10ANCAC 13F .1004(n) Medication Administration Medication aide staff was in serviced by RCD/RN on infection control on 2/17/26. RCD/RN, ED, RCC and/or designee will conduct random med pass observations to ensure proper infection control techniques are being adhere to by medication staff for 30 days. Infection control training for care and non-care staff was held by LHPS nurse on 03/18/26.	02/17/26 03/17/26 03/18/26

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D 371	Continued From page 34 documented on the electronic medication administration record (eMAR). -The MA did not sanitize her hands prior to putting on or removing the gloves. -The MA donned a second set of gloves, administered eye drops to the same resident, then removed the gloves. -The MA looked through the medication cart for hand sanitizer, which she could not find. -The MA did not sanitize her hands after removing the 2nd set of gloves. -The MA secured the medication cart to retrieve hand sanitizer for the medication cart. -At 7:37am, the MA sanitized her hands prior to putting on a third set of gloves. -The MA checked another resident's FSBS reading, removed her gloves, and documented the FSBS reading onto the eMAR. -The MA did not sanitize her hands after she removed the 3rd set of gloves. Interview with the MA/Resident Care Coordinator (RCC) on 02/05/26 at 2:20pm revealed: -She checked a resident's FSBS, administered insulin, and administered eye drops without sanitizing her hands. -She put on gloves before the FSBS check, then changed her gloves before administering the insulin and put on new gloves before administering the eye drops. -She thought she changed gloves before administering the insulin; she did not know she used the same pair of gloves to check the FSBS and administer the insulin to the resident. -She looked for the sanitizer on the medication cart after she had finished administering medication to the resident, but there was no sanitizer on the medication cart. -She had to leave the medication cart to get the hand sanitizer.	D 371		

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D 371	Continued From page 35 -She sanitized her hands when she returned to the medication cart before administering medication to the next resident. -She did not realize she did not sanitize her hands after she checked the second resident's FSBS and removed her gloves. -She knew to sanitize her hands between residents but she did not know she should sanitize her hands after removing gloves. Interview with the Administrator on 02/05/26 at 3:10pm revealed: -The MA should sanitize her hands between each resident, before putting gloves on, and after taking gloves off. -He was concerned about the spread of infection when hand sanitization was not done.	D 371		
D 406	10A NCAC 13F .1009 (b) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to follow up on a pharmacy review recommendation for 1 of 1 sampled residents (#3). The findings are: Review of Resident #3's current FL-2 dated	D 406		

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D 406	Continued From page 36 10/30/25 revealed: -Diagnoses included diabetes mellitus, hypertension, gastro-esophageal reflux disease, and developmental delay. -There was an order for metoclopramide 10mg (used to treat heartburn) three times daily before meals. Review of Resident #3's medication drug review revealed: -There were two medication drug reviews, dated 09/09/25 and 12/17/25, each with the same recommendation to decrease metoclopramide to 5mg three times daily before meals. -The reason for the decrease in metoclopramide was Resident #3 had an increased risk of developing tardive dyskinesia (a drug induced involuntary movement) with metoclopramide. -There was no documentation the recommendations on the medication drug review dated 09/09/25 or 12/17/25 had been addressed by the PCP. Observation of Resident #3 on 02/04/26 at 8:15am revealed Resident #3 did not have any involuntary movements. Review of Resident #3's January 2026 electronic medication administration record (eMAR) revealed: -There was an entry for metoclopramide 10mg three times daily before meals with a scheduled administration time of 7:00am, 11:30am and 5:00pm. -There was documentation that metoclopramide 10mg was administered with meals 91 of 93 opportunities from 01/01/26 to 01/31/26. Review of Resident #3's February 2025 eMAR from 02/01/26 to 02/05/26 revealed:	D 406		

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	HAL073018	A. BUILDING: _____ B. WING _____	R-C 02/05/2026

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D 406	Continued From page 37 -There was an entry for metoclopramide 10mg three times daily before meals with a scheduled administration time of 7:00am, 11:30am and 5:00pm. -There was documentation that metoclopramide 10mg was administered with meals 14 of 14 opportunities from 02/01/26 to 02/04/26. Observation of Resident #3's medication on hand on 02/04/26 at 9:26am revealed: -Metoclopramide 10mg was dispensed in a 7-day multi-dose pack and available for administration. -There was no metoclopramide 5mg tablets available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 02/05/26 at 8:42am revealed: -Resident #3 had an order for metoclopramide 10mg three times daily before meals. -The pharmacy dispensed metoclopramide 10mg three times daily in a 7 day multi-dose pack every week. -The pharmacy did not have an order to decrease metoclopramide to 5mg three times daily before meals. Interview with Resident #3 on 02/05/26 at 9:15am revealed: -She took a bunch of pills. -She did not know the names of all of them or what they were used for. -She took what the medication aide (MA) gave her. Telephone interview with a representative from Resident #3's PCP's office on 02/05/26 revealed: -The PCP's office received a medication drug review dated 09/09/25 from the facility; she did not know when the medication drug review was	D 406		

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D 406	Continued From page 38 faxed to the PCP's office. -The request was to decrease the dosage of metoclopramide from 10mg to 5mg three times daily before meals. -The PCP signed the medication drug review on 10/21/25 and agreed with the pharmacist's suggestion. -The medication drug review was faxed to the facility on 10/21/25. -Today, 02/05/26, the facility faxed a medication drug review dated 12/17/25 to the PCP's office with the same recommendation to change metoclopramide from 10mg to 5mg three times daily. -She returned the medication drug review dated 12/17/25 with a hand written note that read, the order to decrease metoclopramide to 5mg three times a day was faxed to the facility on 10/21/25. -She also faxed the medication drug review dated 09/09/25 that was signed on 10/21/25 by the PCP that the PCP was in agreement with the recommendation. -The PCP expected orders to be implemented as ordered. -A side effect of long-term usage of metoclopramide could be tardive dyskinesia. -Resident #3 had not experienced any signs of involuntary movement. Interview with the MA/Resident Care Coordinator (RCC) on 02/05/26 at 2:51pm revealed: -She thought she sent some of the medication drug reviews to the PCP. -She made a copy of the medication drug reviews that she sent to the PCPs. -If the medication drug review had not been returned in a week, she would refax the medication drug review to the PCP. -She did not recall faxing Resident #3's medication drug review to the PCP.	D 406		

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D 406	Continued From page 39 -She had not followed up on Resident #3's medication drug review. Interview with the Administrator on 02/05/26 at 3:10pm revealed: -He was responsible for printing and sending the medication drug reviews to the PCP for recommendations made by the pharmacist. -When the medication drug review was returned to the facility from the PCP, the medication drug review would be faxed to the pharmacy by the staff who retrieved the new order from the fax machine. -There was no process in place to follow up on the medication drug reviews that were sent to the PCP and to ensure they were returned to the facility timely. -He faxed the medication drug review dated 12/17/25 to the PCP's office today, 02/05/26. -The PCP's office returned the 12/17/25 medication drug review with a note that read, this medication drug review was signed on 10/21/25 to decrease metoclopramide to 5mg three times daily, along with the medication drug review dated 09/09/25 that was signed by the PCP on 10/21/25 that the PCP agreed with the pharmacist to decrease metoclopramide to 5mg three times daily. -He did not know who faxed the medication drug review dated 09/09/25 to the PCP. -There was no process in place to follow-up with the medication drug review that were sent to the PCP's office. -He did not know what metoclopramide was used for and the complications the medication could cause Resident #3.	D 406	10F NCAC 13F .1009 (b) Pharmaceutical Care RCD, ED and RCD met with PCP to review process for pharmacy reviews. RCC received training from Regional support on ensure pharmacy reviews were properly reviewed by PCP and updated on EMAR. ED, RCC and/or designee will conduct EMAR audit upon completion of pharmacy review to ensure recommendations have been properly recorded per PCP and Pharmacy suggestions.	02/17/26 03/10/26 06/17/26
D 430	10A NCAC 13F .1106 (d) Settlement Of Cost Of Care	D 430		

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D 430	Continued From page 40 10A NCAC 13F .1106 Settlement Of Cost Of Care (d) When a resident gives notice of leaving the facility, as may be required by the facility according to Rule .0702(i) of this Subchapter, and leaves at the end of the notice period, the facility shall refund the resident the remainder of any advance payment within 14 days from the date of notice. If notice is not required by the facility, the refund shall be made within 14 days after the resident leaves the facility. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 1 sampled resident (#6) who left the facility was refunded the remainder of payment 14 days after leaving the facility. The findings are: Review of the facility's Discharge, Transfer and Refunds policy dated September 2021 revealed the facility would refund any monies paid for the cost of services and care from the date of discharge or transfer through the end of the month of discharge or transfer, and the refund would be issued within 14 days from the date of discharge or transfer. Review of Resident #6's current FL-2 dated 04/11/25 revealed: -Diagnoses included dementia, anxiety, and	D 430	10A NCAC 13F .1106 Settlement of Cost of Care Refund process reviewed with AED by regional support. AED conducted audit on outstanding refunds to notify support center on missing funds. Refunds have been issued for residents that have been discharged as of 03/13/26.	02/20/26 02/20/26 03/13/26

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D 430	Continued From page 41 hypertension. -The discharge plan indicated skilled nursing facility. Review of Resident #6's Resident Trust Fund Account revealed: -There was a credit balance of $367.32. -There was a withdrawal on 02/01/26 for $367.32. Review of Resident #6's Resident Register revealed: -The resident was admitted to the facility on 04/08/24. -Resident #6 had a Power of Attorney (POA). -Section G for Discharge/Transfer Information was blank. -Resident #6's POA had not signed the discharge portion of the Resident Register. Telephone interview with Resident #6's POA on 02/04/26 at 9:01am revealed: -Resident #6 had not received a refund from the facility since being discharged on 01/03/26. -She requested a refund from the Business Office Manager (BOM) in January 2026. -The BOM told her that the $367.32 credit on the resident's account would be used to pay for the 3 days (01/01/26, 01/02/26, and 01/03/26) the resident was in the facility. Interview with the BOM on 02/04/26 at 9:55am revealed: -Resident #6 was discharged from the facility on 01/03/26. -On 02/01/26, she processed the refund for Resident #6 in the facility's accounting system. -A check number was generated when she processed the refund. -She emailed the facility's corporate office about the refund on 02/01/26.	D 430		

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D 430	Continued From page 42 -The corporate office would write the check on 02/15/26 and send it to the facility. -She would call the POA to pick up the check or send the check certified mail. -She did not recall telling the POA that the credit was being used to pay for the resident's stay in the facility in January 2026. -She was aware that the refund was past the 14-day requirement. -She did not send the refund within 14 days of discharge because she had other things going on. Telephone interview with a corporate accounts payable representative on 02/04/26 at 11:04am revealed: -Resident #6 was discharged on 01/03/26. -The BOM submitted a refund request on 02/01/26 for $367.32. -Resident #6 received a deposit of $473.00 from Special Assistance in January 2026. -The prorated amount for the resident living in the facility for January 2026 was $93.13. -Resident #6 would receive a refund in the amount of $750.19; the check would be mailed to the facility. -The check would be mailed to the facility on 02/06/26, because it should have been sent in January 2026. Interview with the Administrator on 02/05/26 at 3:14pm revealed: -He was aware of the facility's policy to refund a resident within 14 days of discharge. -He and the BOM were responsible for ensuring residents received a refund within 14 days of discharge. -He was unaware that Resident #6 needed a refund for money owed until yesterday (02/04/26), when the surveyor requested Resident #6's	D 430	Refund process reviewed with AED by regional support. AED conducted audit on outstanding refunds to notify support center on missing funds.	

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D 430	Continued From page 43 account information.	D 430		