STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL037002	A. BUILDING: _____ B. WING _____	R 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATES HOUSE	11 COMMERCE DRIVE GATESVILLE, NC 27938

(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
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey and complaint investigation on 02/24/26 through 02/26/26.	D 000		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure implementation of orders for 1 of 5 sampled residents (#1) related to daily dressing changes. The findings are: Review of Resident #1's current FL-2 dated 10/03/25 revealed: -Diagnoses included unsteady gait, frequent falls, transient ischemic attacks, osteoporosis, and type 2 diabetes mellitus. -The resident was intermittently disoriented. -Her level of care was assisted living. Review of a signed physicians order from Resident #1's hospice provider dated 01/09/26 revealed: -There was an order for wound care daily and as	D 276	D 276 Hospice nurse will provide in-service on dressing changes to all MA by 4/15/26. RCD, MCD, or ED will perform weekly spot checks of wound care to ensure completion of wound care per orders. Bandages will be dated and initialed after each wound care task is performed. ED or designee will provide resident rights in-service by 4/15/26.	

Reviewed and acknowledged by MB-04/01/26

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needed.
-Cleanse wound with normal saline and pat dry with gauze.
-Apply ABD pads (ABD pads are thick, highly absorbent, sterile medical dressing designed for wounds with heavy drainage) for drainage.
-Secure with tape.
-Wound care can be completed by facility staff in absence of skilled nurse.

Observation of Resident #1 on 02/26/26 at 9:32am revealed:
-The MA on the Assisted Living (AL) floor and the MA from the Special Care Unit (SCU) entered Resident #1's room after donning masks and gloves.
-Resident #1 was lying on her bed.
-The MA from the SCU retrieved dressing materials from Resident #1's closest which included normal saline, ABD pads, and tape.
-The SCU MA informed Resident #1 that she was going to change her dressing and both MAs repositioned Resident #1 in her bed.
-The SCU MA removed Resident #1's current dressing while instructing the AL MA and disposed of the old dressing.
-Resident #1's wound was large, raised with irregular edges, and contained areas of crusted black (necrotic) and yellow tissue over the left breast with reddish drainage.
-The SCU MA changed gloves and cleaned Resident #1's wound with normal saline on clean gauze and patted the wound dry with clean dry gauze while instructing the AL MA.
-The SCU MA applied fresh ABD pads to Resident #1's left breast wound and secured with tape while instructing the AL MA.

Review of Resident #1's January 2026 electronic medication administration record (eMAR)

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revealed:
-There was an entry to apply dry dressing to left breast every day.
-A dry dressing was documented as applied to Resident #1's left breast at 8:00am on 01/01/26 through 01/07/26.
-A dry dressing was documented as not applied to Resident #1's left breast at 8:00am on 01/08/26 and 01/09/26 with the exception documented as out of facility for both dates.
-A dry dressing was documented as applied to Resident #1's left breast at 8:00am on 01/10/26 through 01/31/26.

Review of Resident #1's initial hospice notes dated 01/09/26 revealed:
-The wound location was the left breast.
-The wound status was open and present on admission.
-The wound type was a skin lesion.
-The size was 7 centimeters (cm) and 8 cm wide.
-There was a moderate amount of bloody drainage.
-The surrounding tissue was intact.
-The patient response to treatment was tolerated well.

Review Resident #1's hospice skilled nursing visit notes dated 01/16/26 revealed:
-Staff member stated patient was under her bed this morning playing with the electrical wires of her hospital bed.
-This nurse educated staff on signs and symptoms of anxiety and hallucinations.
-This nurse also educated staff on as needed (PRN) medications available to treat symptoms.
-Patient did not recall being under the bed this morning.
-Patient stated she has a lot of pain to her left breast, and her dressing had not been changed

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since this nurse changed it earlier in the week.
-The nurse assisted patient from standing and pivoting from sofa into her wheelchair.
-The patient had become weaker and could not stand on her own.
-This nurse took the patient to her room via wheelchair.
-The nurse assisted patient from sitting in wheelchair to standing and pivoting to bed.
-This nurse completed wound care per the plan of care.
-Wound continuing to bleed.
-This nurse educated facility staff on changing the dressing daily.
-The facility was able to provide dry dressing changes as taught by this nurse, in the absence of skilled nurse.
-Facility staff verbalized understanding and stated she did not realize the dressing was not changed yesterday.
-The patient was comfortable in bed resting when this nurse ended the visit.
-This nurse met with the (named) Administrator to discuss the patient's current situation.
-The patient was well managed on the current plan of care.

Review of Resident #1's hospice skilled nursing visit notes dated 01/21/26 revealed:
-This nurse assisted the patient into a sitting position and assisted her to standing and pivoting into her bed for assessment and wound care.
-Wound was completed per plan of care.
-This nurse educated facility staff on changing dressings daily due to dressing that was currently on patient was from Monday of this past week.
-The wound continued to drain sanguineous fluid.
-Wound care supplies were left in the resident's closet.

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Interview with a medication aide (MA) on 02/26/26 at 8:39am revealed:
-Resident #1 had an order for daily dressing changes to her left breast.
-Resident #1 was on hospice service and the hospice nurse came on Monday, Wednesday and Friday and provided Resident #1's wound care.
-The MAs provided Resident #1's wound care on the days that hospice did not visit.
-She was going to change Resident #1's dressing today and another MA was going to come over from the SCU and help her.

Interview with a second MA from the SCU on 02/26/26 at 9:32am revealed:
-Resident #1 had orders for daily dressing changes and was under the care of hospice.
-When she worked on the assisted living hall, she changed Resident #1's dressing on the days that hospice did not come.

Second interview with the first MA on 02/26/26 at 11:26am revealed:
-There may have been some days that she did not change Resident #1's dressing.
-Resident #1's wound was a difficult wound to deal with because it was very large, had an odor, and the dressing changes were sometimes painful for Resident #1.
-There was a time when the MAs were not sure if they were allowed to change Resident #1's dressing.
-Resident #1's dressing should have been changed daily as ordered.

Interview with the Resident Care Coordinator (RCC) on 02/26/26 at 2:25pm revealed:
-If there was an order for dressing changes, the MAs were responsible to carry out those orders.
-There were some types of dressings the MAs

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were not allowed to perform but they could perform dry dressing changes.
-If Resident #1 did not receive a daily dressing change, it was possibly because the current dressing was clean, intact, not soiled, and with no drainage.
-She had never been approached by staff uncomfortable with changing Resident #1's dressing.
-If a resident had an order for a daily dressing change, she expected the order to be carried out.
-She was not aware that Resident #1's dressing had not been changed every day as ordered.

Interview with the Administrator on 02/26/26 at 3:25pm revealed:
-The MAs were responsible for dressing changes as ordered.
-There were certain dressings the MAs were not allowed to perform.
-For a while there was some confusion if facility staff were allowed to do Resident #1's dressing changes.
-He and staff were told by hospice and Resident #1's primary care provider (PCP) they could do dry dressings, and he wanted to clarify this with his corporate office.
-If there was an order for daily dry dressing changes for Resident #1 then he expected the dressing to be changed daily.
-Daily dressing changes were important to prevent wound infection.
-He had not been contacted by hospice that daily dressings had not always been performed on Resident #1.

Telephone interview with the Case Manager and Registered Nurse with Resident #1's hospice provider on 02/26/26 at 2:02pm revealed:
-Hospice services were started for Resident #1

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D 276	Continued From page 6 on 01/09/26 for a presumed breast cancer diagnosis and comfort measures were chosen by the resident's Power of Attorney (POA) instead of medical or surgical treatment. -Resident #1 received hospice visits three days per week. -Resident #1 had a fungating mass (a fungating mass is a non-healing wound that occurs when a cancerous mass grows through the skin) on her left breast. -She wrote the order for daily dressing changes and that staff could change Resident #1's dressing in the absence of skilled nursing visits. -The daily dry dressing changes were important due to the large amount of drainage to keep the wound dry, to help prevent infection, and to help preserve the integrity of the surrounding tissues. -The wound was very stable at this point. -There had been a couple of times when she visited Resident #1 that she noticed the dressing had not been changed. -Facility staff were very receptive to education about the importance of Resident #1's daily dressing changes. Attempted telephone interview with Resident #1's PCP on 02/26/26 at 10:07am and 12:22pm were unsuccessful.	D 276		
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication	D 367	D 367 RCD or designee will provide in-serivce on 5 rights of medication administration including right documentation to all MA by 4/15/26. RCD or designee will audit documentation on scheduled wound care days and progress note that documentation has been completed.	

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administered;
(4) instructions for administering the medication or treatment;
(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;
(6) date and time of administration;
(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 1 of 5 sampled residents (#1) pertaining to documentation for daily dressing changes.

The findings are:

Review of Resident #1's current FL-2 dated 10/03/25 revealed:
-Diagnoses included unsteady gait, frequent falls, transient ischemic attacks, osteoporosis, and type 2 diabetes mellitus.
-The resident was intermittently disoriented.
-Her level of care was assisted living.

Review of a signed physicians order from Resident #1's hospice provider dated 01/09/26 revealed:
-There was an order for wound care daily and as

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needed.
-Cleanse wound with normal saline and pat dry with gauze.
-Apply ABD pads (ABD pads are thick, highly absorbent, sterile medical dressing designed for wounds with heavy drainage) for drainage.
-Secure with tape.
-Wound care can be completed by facility staff in absence of skilled nurse.

Review of Resident #1's January 2026 electronic medication administration record (eMAR) revealed:
-There was an entry to apply dry dressing to left breast every day.
-A dry dressing was documented as applied to Resident #1's left breast at 8:00am on 01/01/26 through 01/07/26.
-A dry dressing was documented as not applied to Resident #1's left breast at 8:00am on 01/08/26 and 01/09/26 with the exception documented as out of facility for both dates.
-A dry dressing was documented as applied to Resident #1's left breast at 8:00am on 01/10/26 through 01/31/26.

Review of Resident #1's initial hospice notes dated 01/09/26 revealed:
-The wound location was the left breast.
-The wound status was open and present on admission.
-The wound type was a skin lesion.
-The size was 7 centimeters (cm) and 8 cm wide.
-There was a moderate amount of bloody drainage.
-The surrounding tissue was intact.
-The patient response to treatment was tolerated well.

Review Resident #1's hospice skilled nursing visit

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notes dated 01/16/26 revealed:
-Staff member stated patient was under her bed this morning playing with the electrical wires of her hospital bed.
-This nurse educated staff on signs and symptoms of anxiety and hallucinations.
-This nurse also educated staff on as needed (PRN) medications available to treat symptoms.
-Patient did not recall being under the bed this morning.
-Patient stated she has a lot of pain to her left breast, and her dressing had not been changed since this nurse changed it earlier in the week.
-The nurse assisted patient from standing and pivoting from sofa into her wheelchair.
-The patient had become weaker and could not stand on her own.
-This nurse took the patient to her room via wheelchair.
-The nurse assisted patient from sitting in wheelchair to standing and pivoting to bed.
-This nurse completed wound care per the plan of care.
-Wound continuing to bleed.
-This nurse educated facility staff on changing the dressing daily.
-The facility was able to provide dry dressing changes as taught by this nurse, in the absence of skilled nurse.
-Facility staff verbalized understanding and stated she did not realize the dressing was not changed yesterday.
-The patient was comfortable in bed resting when this nurse ended the visit.
-This nurse met with the (named) Administrator to discuss the patient's current situation.
-The patient was well managed on the current plan of care.

Review of Resident #1's hospice skilled nursing

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D 367	Continued From page 10 visit notes dated 01/21/26 revealed: -This nurse assisted the patient into a sitting position and assisted her to standing and pivoting into her bed for assessment and wound care. -Wound care was completed per plan of care. -This nurse educated facility staff on changing dressings daily due to dressing that was currently on patient was from Monday of this past week. -The wound continued to drain sanguineous fluid. -Wound care supplies were left in the resident's closet. Interview with a medication aide (MA) from the Special Care Unit (SCU) on 02/26/26 at 9:32am revealed: -Resident #1 had orders for daily dressing changes and was under the care of hospice. -When she worked on the assisted living hall, she changed Resident #1's dressing on the days that hospice did not come. -The MAs documented on the eMAR when a treatment was carried out or a medication was administered. -If a dressing change was not carried out then it should be documented as such on the resident's eMAR. Interview with a second MA on 02/26/26 at 11:26am revealed: -There may have been some days that she did not change Resident #1's dressing. -Resident #1's wound was a difficult wound to deal with because it was very large, had an odor, and the dressing changes were sometimes painful for Resident #1. -There was a time when the MAs were not sure if they were allowed to change Resident #1's dressing. -She should not have documented on the eMAR that she changed Resident #1's dressing when	D 367		

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D 367	Continued From page 11 she did not. Interview with the Resident Care Coordinator (RCC) on 02/26/26 at 2:25pm revealed: -The MAs were to document on the resident's eMAR when a treatment was rendered. -If a treatment was not administered, the MA was expected to document on the eMAR that the treatment was not administered and a reason why. Interview with the Administrator on 02/26/26 at 3:25pm revealed: -The MAs were expected to document on the resident's eMAR if they did or did not perform an ordered treatment. -For a while there was some confusion about whether facility staff were allowed to do Resident #1's dressing changes. -The MAs had to click off Resident #1's wound care on the eMAR on the days hospice performed her wound care. -On the days that hospice did not perform Resident #1's wound care, the MAs were expected to do so and if they did not perform her wound care, he expected them to document on the eMAR that the wound care was not provided and why.	D 367		
D 463	10A NCAC 13F .1306 Admission To The Special Care Unit 10A NCAC 13F .1306 Admission To The Special Care Unit In addition to meeting all requirements specified in the rules of this Subchapter for the admission of residents to the home, the facility shall assure that the following requirements are met for admission to the special care unit:	D 463		

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D 463	Continued From page 12 (1) A physician shall specify a diagnosis on the resident's FL-2 that meets the conditions of the specific group of residents to be served. (2) There shall be a documented pre-admission screening by the facility to evaluate the appropriateness of an individual's placement in the special care unit. (3) Family members seeking admission of a resident to a special care unit shall be provided disclosure information required in G.S. 131D-8 and any additional written information addressing policies and procedures listed in Rule .1305 of this Subchapter that is not included in G.S. 131D-8. This disclosure shall be documented in the resident's record. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to document a pre-admission screening by the facility to evaluate the appropriateness of an individual's placement in the special care unit (SCU) for 2 of 2 sampled residents (Resident #2, #3). The findings are: 1. Review of Resident #1's current FL-2 dated 07/25/25 revealed: -Diagnosis included Alzheimer's disease. -The recommended level of care was Special Care Unit (SCU). Review of Resident #1's Resident Register revealed: -She was admitted to the facility on 08/09/24. -She was forgetful and needed reminders. -She required staff assistance with dressing, bathing, ambulation, toileting and getting in and out of bed.	D 463	D 463 BOM will conduct audit of all MC resident business files to ensure there is a MC disclosure for all residents on file and obtain any missing by 4/15/26. ED/BOM or designee will ensure all new residents have disclsure statement signed prior to physical move in. ED/RCD/MCD will conduct audit of all MC resident charts for pre-screen and complete any missing by 4/15/2026. ED/RCD/MCD will ensure all new move ins have SCU pre-screens complete prior to physical move in.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 463	Continued From page 13	D 463		

Review of Resident #1's current care plan dated 10/17/25 revealed:
-Resident #2 was completely dependent on the staff to meet all her activities of daily living (ADLs) needs.
-She required extensive assistance from staff for eating and toileting.
-She was totally dependent on staff for ambulation, bathing, dressing, grooming and transferring.

Review of Resident #2's Special Care Unit profile dated 06/30/25 revealed she was always disoriented, totally dependant on staff for ADLs, had significant memory loss and required direction from staff.

Review of Resident #2's resident record revealed there was no Special Care Unit pre-screening.

Observation of Resident #2 on 02/24/26 at 8:35am revealed she was sitting in a wheelchair in the common area of the Special Care Unit and did not respond when questions were asked.

Attempted telephone interview with Resident #2's primary care provider (PCP) on 02/26/26 at 10:07am and 12:22pm were unsuccessful.

Based on observation, record review and interviews with staff, it was determined that Resident #2 was not interviewable.

Refer to interview with the Special Care Coordinator (SCC) on 02/26/26 at 2:24pm.

Refer to interview with the Administrator on 02/26/26 at 3:04pm

2.Review of Resident #3's current FL-2 dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL037002	A. BUILDING: _____ B. WING _____	R 02/26/2026

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D 463	Continued From page 14 07/25/25 revealed: -Diagnoses included Alzheimer's disease and history of stroke. -The recommended level of care was Special Care Unit (SCU). Review of Resident #3's Resident Register revealed: -She was admitted on 06/21/23. -She was forgetful and needed reminders. -She required staff assistance with bathing, nail care and mouth care. Review of Resident #3's current care plan dated 10/08/25 revealed: -Resident #3 required assistance from staff to meet her activities of daily living needs (ADLs). -She required limited assistance from staff for eating. -She required extensive assistance from staff for bathing,dressing and transferring. -She required total assistance from staff for toileting, ambulation and grooming. Review of Resident #3's Special Care Unit profile dated 06/23/25 revealed she was sometimes disoriented, totally dependant on staff for ADLs, had significant memory loss and required direction from staff. Observation of Resident #3 on 02/24/26 at 8:30am revealed she was sitting in a wheelchair in the dining room of the Special Care Unit, was assisted by staff to eat and responses to questions were limited and somewhat inappropriate to the questions. Review of Resident #3's resident record revealed there was no Special Care Unit pre-screening.	D 463		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL037002	A. BUILDING: _____ B. WING _____	R 02/26/2026

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D 463	Continued From page 15 Attempted telephone interview with Resident #3's primary care provider (PCP) on 02/26/26 at 10:07am and 12:22pm were unsuccessful. Based on observation, record review and interviews with staff, it was determined that Resident #2 was not interviewable. Refer to interview with the Special Care Coordinator (SCC) on 02/26/26 at 2:24pm. Refer to interview with the Administrator on 02/26/26 at 3:04pm Interview with the Special Care Coordinator (SCC) on 02/26/26 at 2:24pm revealed: -Special Care Unit (SCU) pre-screenings were to be completed prior to admission to the Special Care Unit and assess the appropriateness of placement in a SCU. -She took on the SCC role a few months prior and planned to do audits of the resident records but had not yet had the opportunity do conduct the audits. -She was finding documents that were not filed by the previous SCC in various places. -She did not know why the SCU pre-screenings were not in the residents' records for Resident #2 and Resident #3. Interview with the Administrator on 02/26/26 at 3:04pm revealed: -Special Care Unit (SCU) pre-screenings were screenings to determine an appropriate level of care. -He and the SCC were responsible for ensuring the Special Care Unit pre-screenings were completed prior to admitting a resident to the SCU. -He was sure the SCU pre-screenings were	D 463		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 463	Continued From page 16 completed for Resident #2 and Resident #3 but he was unable to locate them. -Some documents had been thinned from the residents' records and were in storage. SCU pre-screenings should be left on the chart.	D 463		