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	HAL036031	A. BUILDING: _____ B. WING _____	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON HOUSE	850 MAJESTIC COURT GASTONIA, NC 28054

(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 and the Gaston County Department of Social Services completed an annual survey on February 25 - 26, 2026.	D 000	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts in the statement of deficiencies corrective action report; the plan of	
D 056	10A NCAC 13F .0305 (f)(5) Physical Environment 10A NCAC 13F .0305 Physical Environment (f) The requirements for storage rooms and closets are: (5) the requirements for housekeeping storage are: (A) a housekeeping closet, with mop sink or mop floor receptor, shall be provided at the rate of one per 60 residents or portion thereof. In multi-level facilities, each resident floor shall have a housekeeping closet; and (B) there shall be separate locked areas for storing cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled, or handled. Cleaning supplies shall be monitored while in use; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure hazardous products were stored in a locked area resulting in a hazardous aerosol, hand sanitizer and personal care items being unattended and accessible to residents who resided in the Special Care Unit (SCU). The findings are: Review of the facility's undated Special Care Unit Accidental Ingestion safety policy revealed: -The community's program for accidental ingestion will include assessments to identify	D 056	Conduct mandatory training for all staff on identifying, securing, and monitoring hazardous materials. Emphasize the importance of routine room checks for hazardous items. Inform residents and families during admission about prohibited items and the need for locked storage. Provide written guidelines to families regarding acceptable personal care items. Implement daily room inspections to ensure compliance with storage policies. Document findings and corrective actions taken during inspections. DESIGNATED STAFF WILL CHECK WEEKLY Assign the Special Care Coordinator (SCC) to oversee compliance with hazardous material policies.	4/12/26

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shemika Bellamy, ED | TITLE: Executive Director | (X6) DATE: 3/27/2025

Reviewed and acknowledged by Milissa Hintz 2026-03-30

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D 056	Continued From page 1 potential ingestion risks, and interventions to reduce the risks. -Ingestion management program shall include assessment of the residents, periodic screenings, assessment of the environment for safety hazards, staff training and interventions to minimize the risks. -A periodic Screening of personal items that could be ingested are maintained by staff (all liquid personal items, aerosols, hearing aids, pins, buttons, clips etc.) in a secure location until needed for Resident use. -The Resident and the responsible party are notified of policy at admission. -Resident rooms/care areas were to be inspected regularly for unsafe items that could be accidentally ingested or harmful. (Glass items, pictures with glass covers, vases, etc.) -Staff were to routinely monitor the residents for possible hoarding of substances that could be ingested. -Staff training was to include assessing the residents for possible ingestion, initiating necessary emergency procedures by calling poison control center if necessary and the resident's physician. Observation of resident rooms #53 and #54 on 02/25/26 at 5:41pm revealed: -Room #53 and #54 were unlocked and easily assessable from the community day room. -Over the bathroom sink was an unlocked cabinet in the shared bathrooms. -In the unlocked cabinet there were two containers of petroleum jelly, 2 ounce tube of diaper rash skin protectant with zinc, 8 ounce tube of body and face lotion, 7 ounce tube of hair sculpting gel, 12 ounce can of air freshener and odor eliminator, dishwashing liquid, can of shaving cream, alcohol free mouthwash, 9 ounce	D 056		

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D 056	Continued From page 2 can of hair mousse, and an 8 ounce bottle of hand sanitizer. Observations of resident rooms #54 and #74 on 02/26/26 from 9:10am to 11:05am revealed: -There were four staff on the hall, including a medication aide (MA) passing medications to other residents. -There were 10 residents and one personal care aide (PCA) were in the dayroom across from rooms #53 and #54 and about 25 feet from room #74. -There was one resident wandering up and down the hall in front of rooms #53 and #54. -At 9:55am, both residents from room #54 left and locked their door. -There were several residents walking up and down the hall. -At 10:59am two residents returned to the room #54, unlocked the door and went in. Observation of resident's room #74 on 02/25/26 at 9:41pm revealed: -Room #74 was unlocked and easily assessable from the community day room. -On the counter of the bathroom sink was a 12fl oz container of hair gel conditioner, two-10fl oz containers of body lotion, a 15fl oz container of shampoo, a 5fl oz can of shaving cream, a 1.7fl oz tube of after shave cream, and a 2fl oz container of aloe vera skin moisturizer. -In the unlocked cabinet on the wall in the bathroom was a 12fl oz container of hair gel conditioner, a 5fl oz can of shaving cream, 10fl oz containers of body lotion, 2-2.4fl oz tubes of denture adhesive, and a 2.7fl oz box of denture adhesive powder. Telephone interview with the local poison control office on 02/26/26 at 10:40am revealed:	D 056		

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D 056	Continued From page 3 -Dishwashing liquid in large amounts could be corrosive. -The hand sanitizer if ingested could lower the blood sugar in the elderly and overtime could cause alcohol poisoning. -Signs and symptoms of alcohol poisoning were vomiting, altered mental status, dizziness, drowsiness, slow breathing or loss of consciousness. -The aerosol air freshener could cause a chemical burn to the eyes, skin and oral mucosal. -The diaper rash ointment, petroleum jelly, hair sculpting gel, alcohol free mouthwash, shaving creme, lotion, denture adhesive, denture soak, shampoo, hair mouse and hair conditioner ingestion could cause nausea, vomiting and diarrhea. -She recommended to keep all household items out of reach of the cognitively impaired residents to prevent injuries. Interview with a resident who resided in room #54 on 02/26/26 at 11:00am revealed: -All of the products in the unlocked cabinet in the bathroom she shared with her roommate and a resident in room #53, belonged to her. -She did not know they were to be secured in a locked cabinet. Interview with a personal care aide (PCA) on 02/26/26 at 2:52pm revealed: -The residents in room #74, #53 and #54 were independent with personal hygiene tasks but she provided them with standby assistance in the shower room. -She was trained when she started working at the facility, Resident's were not allowed to have personal care supplies in their rooms/bathrooms. -All personal care supplies were to be kept locked up in the common bathroom.	D 056		

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D 056	Continued From page 4 -The residents in rooms #53, #54 and #74 were more cognitively impaired than the other residents in the SCU. -About three weeks ago, the SCC instructed her to go through each resident's room and remove "contraband" like personal care supplies and any items that was considered hazardous to the residents. -She removed the supplies and reported the findings to the Special Care Coordinator (SCC). Interview with a housekeeper on 02/26/26 at 3:12pm revealed: -Residents were only supposed to have toothpaste, toothbrush, hand towels and washcloths in their bathrooms. -Over the years it had changed drastically to where residents were bringing in items such as perfume, lotions and make up. -Residents have complained to management that they want their items back. -She had let the SCC know of residents with items in their rooms. -We do have residents that wander into other resident's rooms and when this happens she will let the PCA know about it to redirect the resident. Interview with a medication aide (MA) on 02/26/26 at 2:41pm revealed: -She was not aware of any hygiene products other than soap in resident's bathrooms. -The residents in room #74, #53 and #54 were independent with personal hygiene tasks but had provided them with standby assistance in the shower room. -She never noticed any hazardous products in the bathrooms in room #53, #54 or #74 and most supplies were in the shower room. -She was never told to complete resident room checks for hazardous products.	D 056		

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D 056	Continued From page 5 -She knew that hand sanitizer was dangerous and if she observed it in a resident room she would remove it and let the SCC know. -Family members would ask about bringing items in and she would let them know it would need to be locked up. -It had been a while since she had been trained regarding hazardous materials in resident rooms for a SCU, but thought it was common sense about what they can and can't have. Interview with the SCC on 02/26/26 at 3:30pm revealed: -She was not aware until yesterday 02/25/26 of residents not being allowed to have lotions, body wash or shaving cream as that was part of their daily routine and did not know it was a problem. -She knew mouth wash and hand sanitizer was not allowed. -She had noticed some personal care products in some resident rooms and those residents were independent with hygiene tasks. -She had not been made aware of personal hygiene products in resident room #53, #54 and #74. -She was aware that residents residing in a SCU maybe me more confused and may try and ingest items but had no reports of that. -She was not responsible for completing admissions with new family members as the Business Office Manager (BOM) would review the contract with family members. -She did speak with families know that items such as real flowers, valuable items, and refrigerators were not allowed in resident rooms. -The management team would be responsible for training staff on hazardous materials in resident rooms. -She supervised the MAs and PCAs. -She was not aware of staff being instructed to	D 056		

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D 056	Continued From page 6 routinely check for hazardous items in resident rooms. Telephone interview with the facility's contracted Nurse Practitioner for the residents residing in rooms #74, #53 and #54 on 02/26/26 at 12:20pm revealed: -The residents in rooms #74, #53 and #54 were cognitively intact and he did not have concerns about them ingesting any personal hygiene items. -It would be possible residents could have an allergic reaction. -The facility should have a protocol in place for personal hygiene items in rooms because it is a SCU and there are concerns of other residents wandering into other resident rooms. -If families bring in items they should be made aware the items would need to be locked up. -If a resident ingests a personal hygiene item the facility should call poison control and send the resident to the hospital for an evaluation. -He had never had a report of a resident ingesting any personal hygiene items at the facility. -He comes to the facility every week. Interview with the Administrator on 02/26/26 at 10:30am and at 2:13pm revealed: -She was not made aware of the facility's policy and the process for routinely checking resident rooms for hazardous materials until she read the policy today 02/26/26. -She did not know the residents in rooms #53, #54 and #74 had hazardous items in their rooms that were not locked up. -All hazardous items were to be secured in the community bath area so that SCU resident did not accidentally ingest them. -Staff was expected to check rooms for hazardous materials. -The SCU had residents that wandered the	D 056		

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D 056	Continued From page 7 hallways. -The families were made aware upon admissions of items that are not allowed in resident rooms. -Staff were required to complete routine on-line training. -It was her responsibility to ensure that all staff are aware and trained on this policy and to ensure resident rooms are checked routinely.	D 056		
D 113	10A NCAC 13F .0311 (d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall supply hot water to the kitchen, bathrooms, laundry, housekeeping closets, and soiled utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F and shall not exceed 116 degrees F. Notwithstanding the requirements of Rule .0301 of this Section, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews the facility failed to ensure hot water temperatures at 4 of 9 fixtures accessible to residents (sinks in rooms 71, 72,73, and 74) on the Special Care Unit (SCU) were maintained between 100 degrees Fahrenheit (F) and 116 degrees F. The findings are:	D 113		

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D 113	Continued From page 8 Review of the American Burn Association Scald Injury Prevention dated 04/25/17 revealed: -Older adults have thinner skin so hot liquids cause deeper burns with even brief exposures. -Their ability to feel heat may be decreased due to certain medical conditions or medications so they may not realize water was too hot until the injury had occurred. -The elderly have poor microcirculation; heat was removed from the burned site rather slowly compared to younger adults. -Changes in a person's intellect, perception, memory, judgement or awareness may hinder the person's ability to recognize a dangerous situation or respond appropriately to remove themselves from danger. -A hot water temperature of 120 degrees F for 5 minutes was the time for a third degree burn to occur. -A hot water temperature of 124 degrees F for 2 minutes was the time for a second degree burn to occur. -A hot water temperature of 124 degrees F for 3 minutes was the time for a third degree burn to occur. -A hot water temperature of 140 degrees F for 5 seconds was the time for a third degree burn to occur. Review of the facilities midnight census dated 02/25/26 revealed there were 29 residents in the SCU. Review of the local Environmental Health Report dated 12/17/2025 revealed the inspectors observed hot water temperatures in room 71 at 121degrees F and room 74 at 123 degrees F at resident accessible handwashing sinks in the SCU.	D 113	Shut off water supply to affected rooms (71, 72, 73, and 74 Post "Out of Order" signs on bathroom doors and lock them until temperatures are corrected Relocate residents from affected rooms temporarily. Adjust the water heater to maintain temperatures between 100–116°F. Ensure the water heater settings comply with manufacturer instructions and safety guidelines. Implement daily water temperature checks at all resident-accessible fixtures for 14 days by designated staff. Use calibrated thermometers to ensure accurate readings. Train maintenance staff and other relevant personnel on proper water heater operation and temperature monitoring. Educate staff on the risks of scalding and the importance of maintaining safe water temperatures Educate residents on the risks of hot water and encourage them to report any issues. Ensure staff check water temperatures before assisting residents with hygiene tasks. Maintain detailed logs of water temperature checks and adjustments Report any temperature deviations to the Administrator immediately for corrective action. Conduct weekly audits to ensure water temperatures remain within the safe range by designated staff with issues being reported to ED Schedule regular inspections by the Maintenance Director and corporate special operations team.	4/12/2026

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D 113	Continued From page 9 Observations during the initial tour of the SCU on 02/25/26 between 9:28am and 9:39am revealed: -At 9:28am, the hot water temperature at the bathroom sink in resident room 71 was 116 degrees F. -At 9:39am, the hot water temperature at the bathroom sink in resident room 74 was 120 degrees F. Observation during a tour of the SCU on 02/25/26 between 4:14pm and 4:57pm revealed: -At 4:15pm, the hot water temperature at the bathroom sink in resident room 74 was 140 degrees F. -At 4:40pm, the hot water temperature at the bathroom sink in an unoccupied unlocked resident room 72 was 140 degrees F. -At 4:45pm, the hot water temperature at the bathroom sink in an unoccupied unlocked resident room 73 was 140 degrees F. - At 4:57pm, the hot water temperature at the bathroom sink in resident room 71 was 140 degrees F. -The water temperature at 140 degrees F showed notable steam. Interview with the resident residing in room 74 on 02/25/26 at 4:17pm revealed: -Sometimes the water did get hot, but he would just turn on the cold water to cool it down. -He only used the sink in his bathroom. Interview with a second resident residing in room 74 on 02/25/26 at 4:17pm revealed: -He thought the water was too hot. -He did tell someone about it and thought they would fix it. -He did not remember how long ago he told someone.	D 113		

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D 113	Continued From page 10 A review of the facility's water temperature logs dated 01/02/26 through 02/23/26 revealed: -The facility's water temperatures were checked weekly in a sample of resident bathroom sinks ranging from 100 to 122 degrees F. -On 01/09/2026, room 71, the hot water temperature was documented as 119 degrees F. -On 01/17/26, room 71, the hot water temperature was documented as 122 degrees F. -On 02/09/26, room 71 the hot water temperature was documented as 120 degrees F. -On 02/16/26, room 71 the hot water temperature was documented as 120 degrees F. -On 02/23/26, room 71 the hot water temperature was documented as 117 degrees F. Interview with the Administrator on 02/25/26 at 4:25pm revealed: -The former Maintenance Director walked with the environment health inspector during the inspection of the facility on 12/17/25. -She and the Maintenance Director were responsible for reviewing the reports from environmental health. -She reviewed the environment health report, and it was her understanding the Maintenance Director would be taking care of the water temperatures reported on the environmental report completed in December of 2025. -The facility hired a new Maintenance Director a couple of weeks ago. Interview with the Maintenance Director on 02/25/26 at 4:50pm revealed: -He started working at the facility two weeks ago. -He thought a safe water temperature should be about 106-107 degrees F. -He identified the 02-23-26 water temperature log as his signature and stated when he observed the water temperature in room 71 was at 117 degrees	D 113		

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D 113	Continued From page 11 F he adjusted the temperature down about 3 notches on the water heater to 115 degrees F. -He thought three notches on the water heater would be sufficient and had not yet re-tested it. Interview with the Business Office Manager (BOM) on 02/25/26 at 4:55pm revealed: -She started taking the water temperatures in the facility when there was not a Maintenance Director available for doing them. -The water temperatures were always done once a week. -She identified the water temperature logs from 01/02/26 through 02/26/26 were completed by her. -She was not exactly sure what a normal water temperature could be and thought 104 degrees F was sufficient. -She did not believe she had any training on hot water temperatures in healthcare facilities. -When she was done documenting the water temperatures on the log, she would give them to the Administrator. -She remembered when she completed the water temperature on 01/17/26 for room 71, she had walked away let it cool and tried it again and recorded a temperature of 122 degrees F. -She did not remember if she told anyone about the hot-water temperature but gave the log to the Administrator. Observation of the facility's gas water heater on 02/25/26 at 5:57pm revealed: -There were instructions posted on the gas water heater on how to adjust the water temperatures. -Above the knob had a sign reading; scalding risk increases with hotter water. -The knob to adjust the water temperatures ranged in order from low, hot, A, B, C and very hot.	D 113		

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D 113	Continued From page 12 -A danger label was on the water heater indicating 'water temperature over 125 degrees F can cause severe burns instant or death from scalds - children, disabled, or elderly are at highest risk of being scalded, see instruction manual before setting temperature at water heater'. -There was a diagram with lighting instructions off position, pilot position and on position. -There was an instructional label which indicated the time to produce serious burns on adult skin, 160 degrees F about a ½ second, 150 degrees F about 1 ½ seconds, 140 degrees F less than 5 seconds, 130 degrees F about 30 seconds, 120 degrees more than 5 minutes. -Under the chart for serious burns was a warning; 'the time to produce serious burns on the skin of infants, children and the elderly can be even shorter'. Interview with the Administrator on 02/25/26 at 5:57pm revealed: -She had already adjusted the temperature on the water heater because the surveyor told her about the temperature of 140 degrees in rooms 71 and 74 where residents were located. -She went outside and checked the water heater because the Maintenance Director had already left the facility. -She found the water heater setting in a "straight up position about slightly left to the "C" position. -She turned it down to slightly above the low position right before she had brought the surveyor out to observe the water heater. -She did not know why the Maintenance Director did not look at all the warnings and instructions on the water heater because it instructed how to set the water heater, and "hot" was 120 degrees F and 140 degrees took less than 5 seconds to burn.	D 113		

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WELLINGTON HOUSE	850 MAJESTIC COURT GASTONIA, NC 28054

(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 113	Continued From page 13 Observation on 02/25/26 at 6:45pm revealed the Administrator placed out of order signs on room 71's-bathroom door. Interview with the Administrator on 02/25/26 at 6:45pm revealed she was putting up signs on all bathroom doors on hall 70, would lock the bathroom doors, move the residents out of the rooms and lock bedrooms doors until the temperatures were fixed. Interview with the technician from the facility's corporate special operations department on 02/26/26 at 9:13am revealed: -The water heater that was being adjusted and it controlled only the 70 hall which had residents in two rooms. -The water heater did not have a circulating electric pump but was a gas water heater which would recover faster to temperature adjustments. -The temperature had been testing at 110 degrees F in room 71 this morning 02/26/26. -The facility had been using the thermometer from the kitchen. Observation during a tour of the SCU with a representative from the facility's special operations on 02/26/26 between 9:34am and 11:20am revealed: -At 9:34am, the hot water temperature at the bathroom sink in resident room 74 was 117 degrees F using the facility thermometer and 114 degrees F using the surveyors thermometer. -At 9:54am the hot water temperature at the bathroom sink in resident room 71 was 124 degrees F using the facility thermometer and 122 degrees F using the surveyors thermometer. Interview with the technician from the facility's	D 113		

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D 113	Continued From page 14 corporate special operations department on 02/26/26 revealed: -He had shut off the water to rooms 71, 72, 73 and 74 and adjusted the water heater and waited for it to heat back up. -This method would allow for true and accurate water temperature readings. On 02/26/26 at 11:15am the technician from the facility's corporate special operations department and the surveyor calibrated both of their thermometers in the facility kitchen using a wet ice calibration procedure. Observation of water temperatures in the facility on 02/26/26 at 11:20am revealed all rooms on the 70-hall ranged from 108 to 111 degrees F. Interview with a medication aide (MA) on 02/26/26 at 2:41pm revealed: -She was not aware of any residents mentioning to her that their water was too hot. -She had not observed water being too hot in resident's rooms when she had the water on in the resident rooms. -If she did notice water to be too hot she would report it to the Maintenance Director.. Interview with a personal care aide (PCA) on 02/26/26 at 2:52pm revealed: -She was not aware of any residents mentioning to her that their water was too hot. -She always would check the water in the shower rooms by feeling the water first before assisting a resident in the shower. -She thought that 120 degrees F was good for water temperature. Interview with a housekeeper on 02/26/26 at 3:12pm revealed:	D 113		

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D 113	Continued From page 15 -She had not noticed the water being too hot in resident bathroom sinks but wore gloves. -If she did notice it she would let the Administrator or Maintenance Manger know. Interview with the Special Care Coordinator (SCC) on 02/26/26 at 3:30pm revealed she had not been made aware of any water temperatures being too hot but knew that any water temperature over 116 degrees F was too hot for a SCU and could burn a resident. Interview with the Administrator on 02/26/26 at 4:32pm revealed: -She started her role with this facility in December 2025 as the interim Administrator. -She knew that water temperatures had been checked weekly by the previous Maintenance Director. -She received the water temperature logs that were being completed by the BOM but had not reviewed them. -She thought the BOM would have told her some of the water temperatures exceeded 116 degrees F in resident rooms. -She would have told the Maintenance Director to investigate why the temperatures were high, fix it and check them daily to ensure they were within range of 100 to 116 degrees F. -She knew that any temperature over 116 degrees F could cause burns and 140 degrees F could cause severe burns. Based on observations and interviews, it was determined the resident from room 71 in the SCU on 02/25/26 at 9:35am was not interviewable. Attempted telephone interview with the previous Maintenance Director on 02/26/26 at 4:44pm was	D 113		

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D 113	Continued From page 16 unsuccessful. Attempted telephone interview with the Maintenance Director on 02/26/26 at 4:46pm was unsuccessful. The facility failed to ensure hot water temperatures were maintained between 100 and 116 degrees F at the 4 out of 9 sinks resulting in hot water temperatures between 118 degrees F and 140 degrees F in the Special Care Unit. Hot water temperatures at 120 degrees could result in a second degree burn in 2 minutes and a third degree burn in 5 minutes. Hot water temperatures above 124 degrees F could result in a second degree burn within 2 minutes and a third degree burn within 3 minutes. Hot water temperatures above 140 degrees F could result in a second degree burn within 5 seconds and a third degree burn within 10 seconds. This failure placed the residents at risk for burns, which 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 02/25/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 12, 2026.	D 113		