| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| LEGACY HEIGHTS SENIOR LIVING COMMUNITY | 11230 BALLANTYNE TRACE COURT CHARLOTTE, NC 28277 |

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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an annual survey, follow-up survey and complaint investigations from 02/10/26 to 02/13/26.<br><br>The complaint investigations were initiated by the Mecklenburg County Department of Social Services on 02/05/26. | D 000 | | |
| D 067 | 10A NCAC 13F .0305 (h)(4) Physical Environment<br><br>10A NCAC 13F .0305 Physical Environment<br><br>(h) The requirements for outside entrances and exits are:<br>(4) in facilities with at least one resident who is determined by a physician or is otherwise observed by staff to be disoriented or exhibits wandering behavior, a continuously sounding device that is activated when the door is opened shall be located on each exit door that opens to the outside. The sound shall be audible in the facility. If a central system of remote sounding devices is provided, the control panel shall be powered by the facility's electrical system, and be in a location accessible by staff to operate the control panel. Notwithstanding the requirements of Rule .0301, the requirements of this Paragraph shall apply to new and existing facilities.<br><br>This Rule is not met as evidenced by:<br>TYPE A1 VIOLATION<br><br>Based on observations, interviews, and record | D 067 | 1. Community installed audible sounding devices on all exit doors.<br><br>2. Community installed automatic locking features on front entrance door. Door will automatically lock after posted reception hours.<br><br>3. Community will have receptionist staffed at front desk during hours front door is not not locked by the automatic door locking feature. | 1. 2/6/2026<br><br>2. 3/4/2026<br><br>3. Ongoing |



Reviewed and Acknowledged by SSD on 04/16/26 Sharon Dunton RN

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reviews, the facility failed to ensure 2 of 2 exterior exit doors were equipped with a sounding device that was audible throughout the facility when the door was opened and accessible to 1 of 1 sampled resident (#3) residing in the assisted living (AL) who had cognitive impairment and had current or history of occasional disorientation to person, place, time or situation even in familiar surroundings.

The findings are:

Review of the facility's Missing Resident policy revised on 12/15/25 revealed when a door alarm sounds or an exit door is found unsecured, an immediate head count would be conducted to ensure the presence of all residents.

Review of the facility's current license effective 01/01/26 revealed:
-The facility was licensed for 122 beds.
-There were 70 Assisted Living (AL) beds and 52 Special Care Unit (SCU) beds.

Review of the facility's census on 02/10/26 revealed there were 44 residents residing in the AL building of the facility.

Observation of the facility's main entrance on 02/05/26 at 3:01pm revealed:
-There was an unlocked main entry/exit door which led to a small vestibule.
-There was an interior, lockable door which led from the vestibule to the front desk.
-The interior entry/exit door included a lever handle with thumb turn lock; an electronic keypad beside the door to disengage the handicap door opening mechanism; and an electronic alerting device with a magnet on a short chain disengaged from the doorframe accessible from

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| D 067 | Continued From page 2<br>inside the facility.<br>-The door handle required the thumb turn lock to be turned from inside the facility for the door to unlock.<br>-The electronic alarming device was activated by manually attaching the magnet to the doorframe from inside the facility.<br>-When deactivated, the electronic alerting device alerted a computer screen in the copier room directly adjacent to the front door and to the facility's hand-held pager system.<br>-The electronic alerting device did not emit an audible sound alarm.<br>-A receptionist was sitting at the receptionist's desk at the front entrance of the facility.<br><br>Observation of the facility's C Hall exit on 02/05/26 at 3:53pm revealed:<br>-The C Hall consisted of three resident bedrooms.<br>-The C Hall had an interior exit door with a battery-operated audible alarm affixed to the top of the doorframe; the door led to a small vestibule with a stairway leading to the second story; and a fire exit door leading to the exterior of the facility at ground level.<br>-The battery-operated audible alarm did not sound when the door was opened.<br>-The C Hall fire exit door consisted of single action lever handle; a posted sign stated "Emergency exit only, Do not use this door as a passage. You will set off the alarm in the building."<br>-The C Hall fire exit door consisted of an electronic alerting device with a magnet on a short chain affixed to the doorframe accessible from inside the facility.<br>-The C Hall fire exit door magnetic alert device was armed. | D 067 | | |

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| D 067 | Continued From page 3<br><br>Review of Resident #3's current FL2 dated 06/17/25 revealed:<br>-Diagnoses included Parkinson's disease, type 2 diabetes, hypertension, diabetic retinopathy, cataract, and mild intermittent asthma.<br>-She was ambulatory with a rollator walker.<br>-She required assistance with bathing and dressing.<br>-Her level of care was assisted living.<br><br>Review of Resident #3's Resident Register revealed an admission date of 04/20/23.<br><br>Review of Resident #3's Care Plan dated 01/27/26 revealed:<br>-Resident #3's orientation was moderately impaired.<br>-Resident #3 had current or history of occasional disorientation to person, place, time or situation even in familiar surroundings.<br>-Resident #3 required supervision and oversight for safety.<br><br>Review of Resident #3's Level of Care assessment dated 12/12/25 revealed:<br>-Resident #3 was moderately confused and may have some unpredictable behavior or require moderate emotional support.<br>-Resident #3 had cognitive impairment.<br><br>Review of Resident #3's Physician's Notification form dated 01/19/26 revealed on 01/18/26 at 11:20pm Resident #3 was hallucinating, stating she was seeing a dead person who she later called and spoke with.<br><br>Review of the facility's communication log entry dated 01/16/26 at 7:00am revealed:<br>-Resident #3 was very agitated.<br>-Resident #3 refused her medications and insulin. | D 067 | | |

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| D 067 | Continued From page 4<br>-Resident #3 complained of not feeling well but did not specify what was bothering her.<br><br>Review of the facility's communication log entry dated 01/20/26 at 6:00pm revealed:<br>-Resident #3 was not her "normal self".<br>-Resident #3 wanted to leave the community.<br>-911 was called to transport Resident #3 to the Emergency Department (ED).<br>-Resident #3 refused to go to the hospital.<br><br>Review of the facility's communication log entry dated 01/28/26 at 5:00am revealed Resident #3 was up last night wandering the halls and going into other resident rooms.<br><br>Review of Resident #3's Nurse Practitioner's (NP) Progress Note dated 10/14/25 and 12/02/25 revealed:<br>-Resident #3 had history of Parkinson's disease.<br>-The resident reported occasional confusion and memory lapses.<br><br>Review of the facility's door Device Activity Report revealed:<br>-On 02/04/26 at 11:19pm the front door of the facility was opened and the device was reset after 20 minutes and 53 seconds.<br>-On 02/05/26 at 1:14am the front door of the facility was opened and the device was reset after 1 minute and 31 seconds.<br>-On 02/05/26 at 1:18am the front door of the facility was opened and the device was reset after 2 minutes and 43 seconds.<br>-On 02/05/26 at 2:11am the front door of the facility was opened and the device was reset after 36 minutes and 44 seconds.<br><br>Review of meteorological records revealed the low temperature on 02/05/26 between 12:00am | D 067 | | |

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and 6:00am was 34 degrees with wind speeds of 9 miles per hour (MPH).

Review of a Law Enforcement (LE) report dated 02/05/26 revealed:
-A law enforcement officer (LEO) was dispatched to do a welfare check on a person found on the sidewalk at the front door of the bank on 02/05/26 at 08:12am
-The subject was not moving.
-The subject was dressed in pajama pants, grey socks, no shoes and a blue jacket.
-The subjects clothes appeared wet as it was raining slightly at the time and had rained that morning.
-The subject appeared semi-conscious but unresponsive.
-The subject had scratches and blood around the knuckles of her left hand.
-When medics arrived they began conducting cardiopulmonary resuscitation (CPR) on the subject.
-The subject was transported to the hospital.
-Bank cameras captured the subject lying on the sidewalk around 6:00am that day (02/05/26).
-There was no further activity on the camera prior to 6:00am due to darkness.
-A missing person report from a nearby assisted living came in during the investigation.
-Through further investigation it was determined the subject found at the bank was Resident #3 from the facility.
-Resident #3 was pronounced deceased at the hospital on 02/05/26 at 9:55am.
-It was unclear how Resident #3 arrived at the bank due to mobility issues and her walker being located at the facility.

Review of Resident #3's Emergency Management Services (EMS) reported dated

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| D 067 | Continued From page 6<br><br>02/05/26 revealed:<br>-Dispatch was notified on 02/05/26 at 8:35am and arrived at the scene at 02/05/26 at 8:46am.<br>-Resident #3 was found lying on the sidewalk outside of a bank.<br>-The resident was extremely cold to the touch.<br>-Resident #3 was transported to the Emergency Department (ED).<br>-Resident #3 expired in the ED.<br><br>Review of Resident #3's Case Management ED Assessment note dated 02/05/26 revealed:<br>-Resident #3 presented to the ED due to cardiac arrest.<br>-Resident #3's time of death was 9:55am on 02/05/26.<br><br>Interview with a personal care aide (PCA) on 02/10/26 at 10:23am revealed:<br>-Resident #3 was hallucinating on and off recently.<br>-Resident #3 complained over the past couple of months that staff administered wrong medications to her.<br>-The previous week Resident #3 was agitated and told her it was because she got a letter that the facility was sold and "they" wanted the residents to leave.<br>-Resident #3 ambulated independently, almost always with a rollator walker.<br><br>Telephone interview with a second PCA on 02/11/26 at 2:07pm revealed:<br>-She worked third shift reporting for work on 02/04/26 at approximately 11:04pm and was scheduled until 7:00am on 02/05/26.<br>-She worked with the residents on the second floor and the medication aide (MA) worked with the residents on the first floor.<br>-She only worked with residents on the second | D 067 | | |

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floor unless there was a fall or other issue on the first floor.
-Resident #3's room was on the first floor.
-The process on third shift was to lock the front door and place the magnet on the sensor after all of second shift staff left the building.
-The back door had a key code and was locked all the time.
-If someone went out the front door, the magnet latch would drop and send a signal to staff pagers and to the computer near the front desk.
-The magnetic latch had to be replaced to clear the alert from the screen at the front desk.
-She did not have her pager third shift between 02/04/26 at 11:04pm and 02/05/26 at 7:00am because she left it at home.
-Because she did not have her pager she sat at the front desk monitoring the computer screen after completing her initial rounds which took her approximately 20 minutes.
-She replaced the magnet latch on 02/04/26 at approximately 11:40pm thinking second shift staff had caused it to be disconnected.
-She monitored the computer screen until about 1:00am on 02/05/26 at which time she went to the second floor of the facility.
-She was unsure of the time, but sometime after 1:00am on 02/05/26 she came down from the second floor and noticed the magnetic latch was not engaged and the door was not locked.
-She replaced the magnetic latch and relock the front door.
-She thought pharmacy may have delivered medications and that was why the front door was unlocked and the magnet was not engaged.
-She did not ask the MA if she had opened the door.
-She did not check on all the residents to ensure they were accounted for because they facility did not have confused residents that tried to leave

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| D 067 | Continued From page 8<br>the facility.<br><br>A second telephone interview with a PCA on 02/12/26 at 10:35am revealed:<br>-She worked third shift reporting for work on 02/04/26 at approximately 11:04pm and was scheduled until 7:00am on 02/05/26.<br>-On 02/05/26 some time after 1:00am she came down from the second floor and noticed the door was not locked and the magnetic latch was not engaged.<br>-She looked outside but did not go outside to investigate.<br>-She relocked the door and replaced the magnetic latch.<br>-She said it was possible a resident could have left the building but she had never experienced it before.<br>-She was not trained to check on residents if a door was opened and she did not know the reason why it had been opened.<br><br>Telephone interview with a MA on 02/10/26 at 2:40pm revealed:<br>-Within the past two weeks Resident #3 started hallucinating.<br>-One morning, around 4:00am, Resident #3 was very upset saying her friend had died.<br>-She could not remember the exact date but another time recently Resident #3 was hallucinating and saying people were trying to kill her.<br><br>A second telephone interview with the MA on 02/12/26 at 9:49am revealed:<br>-She worked third shift in the Assisted Living from about 11:00pm on 02/04/26 until around 7:15am on 02/05/26.<br>-The facility doors did not have a continually sounding alarm when opened. | D 067 | | |

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-If a door was opened, the system would send a notice to staff pagers and to the computer at the front desk.
-The computer makes a sound if a door is opened but it was not continuous and not loud.
-If staff were in a resident's room, they would not hear the sound from the computer.
-She did not have a pager the night of 02/04/26-02/05/26.
-The only way she would know if a door had been opened that night would be if she saw it on the computer screen.
-She tried to check the computer every 30 minutes when she did not have a pager.
-She did not see on the computer screen any time that night that a door had been opened.

Interview with the previous Health and Wellness Director (HWD) on 02/11/26 at 2:50pm revealed:
-She was the HWD at the time of the incident involving Resident #3 on 02/04/26-02/05/26.
-She was involved in trying to locate Resident #3 the morning of 02/05/26 when Resident #3 was found on the ground outside of a bank.
-Each staff member were issued pagers and walkie-talkies upon hire.
-If a facility door was opened it would send a message to the staff's pagers and to the computer at the front desk.
-If a staff member forgot their pager, they were to sit at the front desk to monitor the computer screen for resident call bells.

Interview with the Administrator on 02/13/26 at 10:58am revealed:
-Prior to 02/05/26 there were no audible alarms on the facility doors.
-If a door opened, the magnetic latch would disengage and send a signal to staff pagers and to the computer at the front desk.

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| D 067 | Continued From page 10<br><br>-There was a receptionist at the front desk daily from 8:00am to 8:00pm.<br>-Between 8:00pm and 8:00am the door was to be locked, the magnetic latch engaged and the wheelchair push pad locked by entering a code in the keypad by the door.<br>-All staff were issued pagers and walkie talkies upon hire and were to bring them each time they arrived for work.<br>-He found out after Resident #3's death on 02/06/25 that the staff members on third shift the previous evening did not have their pagers.<br>-If a staff did not have their pagers, he expected staff to monitor the computer near the front desk.<br><br>[Refer to tag 338 10A NCAC 13F .0909 Resident Rights (Type A1 Violation)].<br><br>The facility failed to ensure 2 of 2 exit doors were alarmed with an audible sounding device when the door was opened allowing an assisted living resident who had cognitive impairment that had current history of occasional disorientation to person, place, time or situation even in familiar surroundings, and was documented wandering the halls to leave the building without staff knowledge and found hours later lying on the sidewalk outside a bank and cold to the touch, who later expired in the Emergency Department. This failure in resulted serious physical harm and neglect and constitutes a Type A1 Violation.<br><br>The facility provided a plan of protection in accordance with G.S. 131D-34 on February 11, 2026, for this violation.<br><br>THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 15, 2026. | D 067 | | |

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| D 259 | Continued From page 11 | D 259 | | |
| D 259 | 10A NCAC 13F .0802 (a) (c) Resident Care Plan<br><br>10A NCAC 13F .0802 Resident Care Plan<br><br>(a) The facility shall develop and implement a care plan for each resident based on the resident's assessment completed in accordance with Rule .0801 of this Section. The care plan shall be resident-centered and include the resident's preferences related to the provision of care and services. A copy of each resident's current care plan shall be maintained in a location in the facility where it can be accessed by facility staff who are responsible for the implementation of the care plan.<br>(c) The care plan shall include the following:<br>(1) a description of services, supervision, tasks, and level of assistance to be provided to address the resident's needs identified in the resident's assessment in Rule .0801 of this Section;<br>(2) frequency of the services or tasks to be performed;<br>(3) revisions of tasks and frequency based on reassessments in accordance with Rule .0801 of this Section;<br>(4) licensed health professional tasks required according to Rule .0903 of this Subchapter;<br>(5) a dated signature of the assessor upon completion; and<br>(6) a dated signature of the resident's physician or physician extender as defined in Rule .0102 of this Subchapter within 15 days of completion of the care plan certifying the resident is under this physician's care and has a medical diagnosis with associated physical or mental limitations warranting the provision of the personal care services in the above care plan in accordance with G.S. 131D-2.15. This shall not apply to residents assessed through the Medicaid State | D 259 | 1. Wellness Director or Designee will complete audit of all resident care plans for compliance and physician signature.<br><br>2. Wellness Director or Designee will obtain physician signature on current care plans<br><br>3. Wellness Director or designee will ensure that all future care plans are signed and dated by resident current physician within 15 days of being assessed. | 1. 3/5/2026<br><br>2. 3/20/2026<br><br>3.Ongoing |

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| LEGACY HEIGHTS SENIOR LIVING COMMUNITY | 11230 BALLANTYNE TRACE COURT CHARLOTTE, NC 28277 |

| (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 |
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| D 259 | Continued From page 12<br>Plan Personal Care Services Assessment for the portion of the assessment covering tasks needed for each activity of daily living of this Rule for which care planning and signing are directed by Medicaid.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to ensure 5 of 5 sampled residents (#1,#2, #3, #4 and #5) had a completed care plan that was signed by a physician or a physician's extender within 15 days of the resident being assessed.<br><br>The findings are:<br><br>1. Review of Resident #1's FL2 dated 03/05/25 revealed:<br>-Diagnosis included Parkinson's, pre-diabetes, hyperlipidemia, scoliosis and atrial fibrillation.<br>-She was non-ambulatory<br>-Her level of care was assisted living.<br><br>Review of Resident #1's Resident Register revealed an admission date of 03/31/25.<br><br>Review of Resident #1's care plan dated 12/11/25 revealed:<br>-She was non-ambulatory.<br>-She was cognitively intact.<br>-She required physical assistance with bathing, toileting and dressing and stand-by supervision with grooming. | D 259 | | |

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| D 259 | Continued From page 13<br>-The care plan was not signed by Resident #1's PCP.<br><br>Refer to interview with the Corporate Clinical Director on 02/12/26 at 4:20pm.<br><br>Refer to interview with the PCP on 02/11/26 at 2:40pm.<br><br>Refer to interview with the Administrator on 02/13/26 at 10:58am.<br><br>2. Review of Resident #2's current FL2 dated 07/08/25 revealed:<br>-Diagnoses included Alzheimer's disease, hypertension, hypothyroidism, acid reflux, and osteoporosis.<br>-Resident #2 was ambulatory.<br>-Resident #2 was constantly disoriented.<br>-Resident #2's level of care was Special Care Unit.<br><br>Review of Resident #2's Resident Registry revealed an admission date of 07/11/25.<br>Review of Resident #2's revised care plan dated 11/04/25 revealed:<br>-Resident #2 required standby assistance with bathing, dressing, grooming<br>-Resident #2 was a fall risk, had impaired vision, exit seeking behaviors and cognitive impairment.<br>-The care plan was not signed by the PCP.<br><br>Refer to interview with the Special Care Unit Coordinator (SCC) on 02/13/26 at 1:30pm.<br><br>Refer to interview with the Corporate Clinical Director on 02/12/26 at 4:20pm.<br><br>Refer to interview with the Administrator on 02/13/26 at 10:58am. | D 259 | | |

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| D 259 | Continued From page 14<br><br>3. Review of Resident #3's current FL2 dated 06/17/25 revealed:<br>-Diagnoses included type 2 diabetes, hypertension and Parkinson's disease.<br>-She was ambulatory with the use of a wheeled walker.<br>-Her level of care was assisted living.<br><br>Review of Resident #3's resident register revealed she was admitted to the facility on 04/20/23.<br><br>Review of Resident #3's care plan dated 01/23/26 revealed:<br>-Resident #3 had more than occasional disorientation to person, place, time or situation even in familiar surroundings.<br>-Resident #3 required supervision and oversight for safety.<br>-She was independent with transfers, toileting and grooming.<br>-Resident #3 was ambulatory with the use of a wheeled walker.<br>-She required moderate assistance with bathing.<br>-The care plan was not signed by Resident #3's Nurse Practitioner (NP).<br><br>Interview with Resident #3's NP on 02/11/26 at 4:34pm revealed she had not been asked to sign Resident #3's care plan.<br><br>Refer to interview with the Special Care Unit Coordinator (SCC) on 02/13/26 at 1:30pm.<br><br>Refer to interview with the Corporate Clinical Director on 02/12/26 at 4:20pm.<br><br>Refer to interview with the Administrator on 02/13/26 at 10:58am. | D 259 | | |

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| D 259 | Continued From page 15 | D 259 | | |

4. Review of Resident #4's current FL2 dated 07/08/25 revealed:
-Diagnoses included hypertension, hypothyroidism, acid reflux, and osteoporosis.
-Resident #4's level of care was Special Care Unit.

Review of Resident #4's revised care plan dated 12/14/25 revealed:
-Resident #4 required standby supervision with bathing, grooming, and dressing.
-Resident #4 was a fall risk, had exit seeking behaviors and cognitive impairment.
-Resident #4 ambulated independently with a cane.
-The care plan was not signed by the PCP.

Refer to interview with the SCC on 02/13/26 at 1:30pm.

Refer to interview with the Corporate Clinical Director on 02/12/26 at 4:20pm.

Refer to interview with the Administrator on 02/13/26 at 10:58am.

5. Review of Resident #5's FL2 dated 07/07/25 revealed:
-Diagnoses included hyperlipidemia.
-She was intermittently disoriented
-She was ambulatory with the use of a wheeled walker.
-Her level of care was assisted living.

Review of Resident #5's resident register revealed she was admitted to the facility on 07/14/25.

Review of Resident #5's care plan dated 12/17/25

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| D 259 | Continued From page 16<br><br>revealed:<br>-She was moderately confused and may have some unpredictable behaviors or require moderate emotional support.<br>-She was independent with transfers and was ambulatory with the use of a wheeled walker.<br>-She required minimal assistance with bathing, grooming and dressing.<br>-The care plan was not signed by Resident #5's PCP.<br><br>Attempted interview with resident #5's Primary Care Physician (PCP) on 02/13/24 at 2:00pm was unsuccessful.<br><br>Refer to interview with the Corporate Clinical Director on 02/12/26 at 4:20pm.<br><br>Refer to interview with the Administrator on 02/13/26 at 10:58am.<br><br>Interview with the SCC on 02/13/26 at 1:30pm revealed:<br>-She and the Health and Wellness Director (HWD) were responsible for ensuring all care plans were completed and signed by the PCP.<br>-The facility was transitioning over to a new system and care plans were not always sent to the PCP for a signature.<br>-She did not know why care plans were not signed by the PCP, prior to the transitioning period.<br>-She expected all care plans to be signed by the PCP within 15 days of completion.<br><br>Interview with the Corporate Clinical Director on 02/12/26 at 4:20pm revealed:<br>-The SCC and the previous Wellness Director were responsible for care plans being sent out for physician's signature. | D 259 | | |

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| D 259 | Continued From page 17<br>-She expected all care plans generated by the assessment to be signed by the PCP despite when the facility began their transition to a different system on 12/18/25.<br><br>Interview with the PCP on 02/11/26 at 2:40pm revealed she had never been asked to sign care plans at this facility.<br><br>Interview with the Administrator on 02/13/26 at 10:58am revealed the HWD was responsible to ensure resident care plans were signed by the PCP. | D 259 | | |
| D 276 | 10A NCAC 13F .0902(c)(3-4) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(c) The facility shall assure documentation of the following in the resident's record:<br>(3) written procedures, treatments or orders from a physician or other licensed health professional; and<br>(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to the ensure the implementation of physician orders for 2 of 5 sampled residents (#1) related to orders to provide and use padded heel protectors and to check weekly blood pressures (#5).<br><br>The findings are: | D 276 | 1. Wellness Director or designee will audit all residents signed physician orders to confirm that orders are implemented appropriately on the MAR<br><br>2. Wellness Director or designee will in-service all medication aides and nurses on proper physician order transcription on resident MAR<br><br>3. Wellness Director or designee will conduct weekly audits of new medication orders for verification and | 1. 3/8/2026<br>2. 3/5/2026<br>3. Ongoing |

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| D 276 | Continued From page 18<br><br>1. Review of Resident #1's current FL2 dated 03/05/25 revealed diagnoses included Parkinson's disease, pre-diabetes, hyperlipidemia, scoliosis and atrial fibrillation.<br><br>Review of Resident #1's Resident Register revealed an admission date of 03/31/25.<br><br>Review of Resident #1's physician orders dated 06/18/25 revealed:<br>-An order to use padded heal booties.<br>-The order was initialed by the facility nurse with a note indicating it was faxed to pharmacy on 06/18/25 and noted on Medication Administration Record (MAR).<br><br>Review of Resident #1's Licensed Health Professional Support (LHPS) evaluation dated 08/16/25 and 11/04/25 revealed:<br>-There was documentation for applying and removing ace bandages, ted hose, binders, braces and splints.<br>-The health status narrative section documented Resident #1 had heel protectors to wear to bed.<br><br>Review of Resident #1's December 2025 MAR revealed:<br>-There was an entry for heel protectors wear at bedtime (8:00pm) and remove in morning for heel protection.<br>-The heel protectors were documented as applied from 12/01/25 through 12/31/25.<br><br>Review of Resident #1's January 2026 MAR revealed:<br>-There was an entry for heel protectors, use heel protectors as directed with the documented time of PRN (as needed).<br>-The heel protectors were not documented as not applied from 01/01/26 through 01/31/26. | D 276 | | |

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| D 276 | Continued From page 19 | D 276 | | |

Review of Resident #1's February 2026 MAR revealed:
-There was an entry for heel protectors, use heel protectors as directed with the documented time of (PRN as needed).
-The heel protectors were documented as not applied from 02/01/26 through 02/11/26.

Observation of Resident #1's room on 02/12/26 at 9:55am revealed two PCA's searched for heel protectors in her room and could not find any.

Interview with Resident #1 on 02/12/26 at 9:30am revealed:
-Staff had not applied her heel protectors in several months and thought maybe the last time was November 2025.
-The elastic was too tight and they were uncomfortable.
-Her husband used to put them on in such a way that it did not cause discomfort, but he had passed away.
-She would be willing to try a different type or size to see if they would be more comfortable.
-In regards skin assessments she did not think staff were looking at her heels, but they did help her get dressed by applying her socks and shoes.

Telephone interview with Resident #1's family member on 02/13/26 at 9:34am revealed:
-She remembered the heel protectors were in Resident #1's closet at one point.
-She could not recall if she removed them from the room but thought they could be in the wood cabinet by the bathroom.

Interview with a personal care aide (PCA) on 02/12/26 at 9:41am and 9:51am revealed:
-She assisted Resident #1 get up in the morning

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| D 276 | Continued From page 20<br>and the heel protectors had not been put on Resident #1 in several months.<br>-She did skin assessments when assisting Resident #1 with her shower by looking for skin tears, bruises, redness on her skin but did not really check her heels.<br>-She did apply Resident #1's socks and thought Resident #1 would tell her if she had any pain as she was very alert and communicated her needs well.<br><br>Interview with a medication aide (MA) on 02/13/26 at 2:25 pm revealed:<br>-She worked second shift and worked in all halls but could not recall if she had ever provided care to Resident #1.<br>-She had not recalled seeing or putting on heel protectors on Resident #1.<br>-If there is an item on the eMAR with directions for PRN she would always ask the residents if they needed that item or medication.<br>-If they did need the item or medication, it should be documented on the eMAR.<br><br>Interview with a second MA on 02/13/26 at 3:04pm revealed:<br>-She worked second shift and had worked with Resident #1.<br>-Resident #1 had refused the heel protectors in the past because it hurt her foot.<br>-Sometimes she would document on the eMAR as refused and she did the tell the HWD about this, but it was a couple of months ago.<br>-She stopped asking Resident #1 about the heel protectors when the eMAR documented to put them on as needed.<br>-She had not asked anyone about the heel protectors being PRN.<br>-Resident #1 would need to tell the MA if she would want the heel protectors on. | D 276 | | |

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| D 276 | Continued From page 21<br>-She did not know what happened to the heel protectors.<br><br>Interview with a facility nurse on 02/13/26 at 01:58pm revealed:<br>-The MAs were responsible for ensuring the orders were implemented on the eMAR.<br>-If a medication or therapeutic device was not available the MA should ask the nurse or Health and Wellness Director (HWD) to follow up on it.<br>-It should have been documented as not available or resident refusal on the eMAR.<br>-She was not aware the heel protectors were not being put on Resident #1.<br>-The MA should have let her or the HWD know so we could document this in the communication notebook for the PCP so they would be aware the heel protectors were not being applied to Resident #1.<br><br>Telephone interview with a representative with the facility's contracted pharmacy on 02/12/26 at 2:40pm revealed:<br>-There was an order dated 06/18/25 for heel protectors use as directed.<br>-Heel protectors were sent to the facility on 06/23/25.<br>-The pharmacy was responsible for adding the order to the eMAR and they added administration time as PRN.<br>-She had not sent over any additional heel protectors and usually this would be an item that would not be reordered.<br><br>Interview with Resident #1's PCP on 02/11/26 at 4:20pm revealed:<br>-Resident #1 has an order for heel protectors to prevent pressure ulcers.<br>-She would not have written an order to wear PRN due to Resident #1's immobility she is at risk | D 276 | | |

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| D 276 | Continued From page 22<br>for wounds and skin breakdown.<br>-She had not been made aware that she was not wearing the heel protectors.<br><br>Refer to interview with the Administrator on 02/13/26 at 2:45pm.<br><br>2. Review of Resident #5's FL2 dated 07/07/25 revealed:<br>Diagnoses included hyperlipidemia. Polymyalgia rheumatica, normal pressure hydrocephalus<br>-She was intermittently disoriented<br><br>Review of Resident #5's Resident Register revealed an admission date of 07/14/25.<br>Review of Resident #5's physician orders dated 08/12/25 revealed check blood pressures one time a week at 8:00am with no additional instructions or parameters.<br><br>Review of Resident #5's December electronic medication administration record (eMAR) revealed blood pressures were not checked from 12/01/25 through 12/31/25.<br><br>Review of Resident #5's January electronic medication administration record (eMAR) revealed blood pressures were not checked from 01/01/26 through 01/31/26.<br><br>Review of Resident #5's February electronic medication administration record (eMAR) revealed blood pressures were checked on 02/07/26 at 8:00am<br><br>Interview with a medication aide (MA) on 02/13/26 at 2:25 pm revealed:<br>-She had been assigned to Resident #5 in the past to administer medications.<br>-There had been a lot of changes when | D 276 | | |

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transitioning from eMARs to paper MARs.
-She would follow the eMAR but could not recall if she had taken Resident #5's blood pressure.
-She looked at the eMAR for December 2025 and January 2026 and said she was not sure why the blood pressure was not completed.

Interview with a second medication aide (MA) on 02/13/26 at 2:25 pm revealed:
-She had been assigned to Resident #5 in the past to administer medications.
-The blood pressure should have been written down and initialed on the paper MAR.
-She was not sure why it was not done.

Interview with a Facility Nurse on 02/13/26 at 01:58pm revealed:
-The MAs are to read the eMAR and to follow them.
-If something is on the eMAR such as weekly blood pressures this was expected to be done.
-She was not aware the blood pressures were not being completed.

Interview with the Corporate Clinical Director on 02/13/26 at 10:19am revealed:
-She could not locate any weekly blood pressure recordings for December 2025 or January 2026 for Resident #5.
-The MA's were responsible for taking blood pressure reading and charting it on the MAR.
-She thought it might be in a separate book where blood pressure readings were recorded but could not locate one.

Attempted interview with resident #5's Primary Care Physician (PCP) on 02/13/24 at 2:00pm was unsuccessful.

Refer to Interview with the Administrator on

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| LEGACY HEIGHTS SENIOR LIVING COMMUNITY | 11230 BALLANTYNE TRACE COURT CHARLOTTE, NC 28277 |

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| D 276 | Continued From page 24<br>02/13/26.<br><br>Interview with the Administrator on 02/13/26 at 2:45pm revealed:<br>- HWD was responsible for weekly eMAR audits to ensure orders were being followed.<br>-He was not aware orders were not being implemented as it should have been brought to his attention by the HWD. | D 276 | 1. Food & Beverage Director conducted a full cleaning of both freezers and coolers<br><br>2. Food & Beverage Director or Designee will follow daily and weekly cleaning logs to ensure compliance with sanitation rules. Logs will be uploaded to TELS ongoing. | |
| D 282 | 10A NCAC 13F .0904(a)(1) Nutrition and Food Service<br><br>10A NCAC 13F .0904 Nutrition and Food Service<br>(a) Food Procurement and Safety in Adult Care Homes:<br>(1) Facilities with a licensed capacity of 7 to 12 residents shall ensure food services comply with Rules Governing the Sanitation of Residential Care Facilities set forth in 15A NCAC 18A .1600 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving food and beverage under sanitary conditions.<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews, and interviews the facility failed to ensure food stored and served to all residents was protected from contamination related to foods stored that were not labeled or dated and the cleaning of the reach-in freezer that contained ice buildup and | D 282 | 3. Food & Beverage Director conducted a full audit of all food and drinks inside both freezers to ensure all items are correctly dated and labeled.<br><br>4. Food & Beverage Director will conduct ongoing visual checks of all food items to ensure proper labels and dates.<br><br>5. Food & Beverage Director will conduct weekly sanitation audit of kitchen using a sanitation checklist and documented on SOS<br><br>6. ED to review sanitation log monthly to ensure compliance<br><br>7. Food and beverage to conduct in-service with food service orientation manual with all culinary staff<br><br>8. ED inspected storage areas and coolers immediately to ensure proper food handling practices were corrected.<br><br>9. ED to conduct ongoing visual checks of food handling and sanitation of kitchen equipment. | 1. 2/17/2026<br>2. Ongoing<br>3. 2/28/2026<br>4. Ongoing<br>5. Ongoing<br>6. Ongoing<br>7. 3/20/2026<br>8. 2/16/2026<br>9. Ongoing |

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| D 282 | Continued From page 25<br>frozen food debris.<br><br>The findings are:<br><br>Review of the facility's undated Food Orientation Manual (Kitchen Sanitation section) revealed:<br>-Refrigerators and freezers should be periodically cleaned and sanitized.<br>-Any spills in the refrigerator should be cleaned up immediately and not left to sit.<br>-All leftovers should be labeled with date the item was placed in the refrigerator to ensure everyone knows how long the leftovers have been in storage.<br>-Elderly residents are susceptible to food-borne illness, therefore sanitation is very important.<br><br>Observation of the kitchen on 02/10/26 from 3:15pm to 3:45pm revealed:<br>-There were eleven large containers of condiments (salad dressing, barbecue sauce, tarter sauce, honey mustard) that were opened, stored in the refrigerator and not labeled with the date they were opened or placed in the refrigerator.<br>-There were three packages of shredded and sliced cheese that were opened, removed from their original packaging and located in the refrigerator that were not labeled with the date they were opened or placed in the refrigerator.<br>-There was loose food debris located on the reach-in freezer floor.<br>-There was ice buildup on the reach-in freezer floor and thick ice buildup on raw food located on the reach-in freezer floor.<br><br>Interview with the Dietary Manager (DM) on 02/10/26 at 3:35pm revealed:<br>-The kitchen staff were responsible for labeling open containers of food stored in the refrigerator. | D 282 | | |

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| D 282 | Continued From page 26<br>-The ice buildup in the freezer was concerning due to the constant digital reading of defrost and had not been reported to maintenance or the Administrator.<br>-She was ultimately responsible for ensuring food stored for resident consumption was properly labeled, oversight of kitchen sanitation and ensuring equipment was in working order.<br><br>Interview with the Administrator on 02/13/26 at 1:45pm revealed:<br>-The DM was responsible for ensuring opened foods stored in the kitchen were properly labeled, and oversight of kitchen staff to assure regular sanitation tasks were performed.<br>-He was not informed there were issues with the freezer defrost mechanism and ice buildup.<br>-His expectation was for all foods served to residents to be prepared and stored in a sanitary environment. | D 282 | | |
| D 309 | 10A NCAC 13F .0904(e)(3) Nutrition and Food Service<br><br>10A NCAC 13F .0904 Nutrition and Food Service<br>(e) Therapeutic Diets in Adult Care Homes:<br>(3) The facility shall maintain a current listing of residents with physician-ordered therapeutic diets for guidance of food service staff.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews, the | D 309 | | |

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| D 309 | Continued From page 27<br><br>facility failed to maintain a current listing of residents with physician-ordered therapeutic diets for guidance of food service staff for 2 of 3 sampled residents (#1 & #5) for diet orders for chopped meats (#1) and a regular diet with honey thickened liquids (#5).<br><br>The findings are:<br><br>Observation of the kitchen on 2/10/26 at 3:15pm and 2/11/26 at 2:40pm revealed there was no documentation of a list of residents receiving therapeutic diets that were available for kitchen staff preparing and plating resident meals.<br><br>Observation of the meal service on 02/11/26 at 12:00pm revealed:<br>-The dietary server was taking resident orders on a green restaurant style order pad and would take the order to the kitchen.<br>-There were no pictures of residents or diet orders on the order she took to the kitchen.<br><br>1. Review of Resident #1's current FL2 dated 03/05/25 revealed:<br>-Diagnosis included Parkinson's disease, pre-diabetes, hyperlipidemia, scoliosis and atrial fibrillation.<br>-There was an order for a regular diet.<br><br>Review of Resident #1's physician orders dated 05/28/25 revealed an order to change to a chopped diet.<br><br>Review of the facility's diet list provided upon entrance on 02/10/26 revealed Resident #1 had an order for a regular diet with cut up meat.<br><br>Review of a dietary notebook on 02/10/26 revealed a diet order for Resident #1 dated | D 309 | 1. Food & Beverage Director audited all resident therapeutic diet orders to ensure they match current signed physician diet order.<br><br>2. Food & Beverage Director in-serviced all dietary team members on community diet board and serving appropriate diets to residents with a signed therapeutic diet.<br><br>3. Wellness Director or designee will ensure that the culinary team has updated therapeutic diets upon change of signed diet order.<br><br>4. Current and completed list of therapeutic diets has been posted in kitchen for immediate access to food service staff<br><br>5. ED will review change of diet forms weekly during IDT meeting to ensure current diets match diets being served in dining | 1. 03/6/2026<br>2. 3/10/2026<br>3. Ongoing<br>4. 3/9/2026<br>5. Ongoing |

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| D 309 | Continued From page 28<br>03/05/25 documented as a regular diet with no specifications for chopped meats.<br><br>Interview with the facility's Nurse Practitioner (NP) on 02/11/26 at 4:20pm revealed she changed the order for Resident #1 to chopped meats because she would put large pieces of meat in her mouth.<br><br>Refer to interview with the cook on 02/11/26 at 2:40pm.<br><br>Refer to interview with the Dietary Manager (DM) on 02/10/26 at 3:20pm.<br><br>Refer to interview with the Regional Director of Operations on 02/11/26 at 2:45pm.<br><br>Refer to telephone interview with the Administrator on 02/13/26 at 2:45pm.<br><br>2. Review of Resident #5's current FL2 dated 07/07/25 revealed:<br>-Diagnoses included hyperlipidemia. polymyalgia rheumatica, normal pressure hydrocephalus<br>-She was intermittently disoriented<br>-She was ambulatory with the use of a wheeled walker.<br><br>Review of Resident #5's record revealed:<br>-A speech pathology modified barium swallow study dated 01/27/26 which included a diagnosis of dysphagia oropharyngeal phase and cough after eating.<br>-A diet order for a regular diet with mildly thick nectar liquids.<br>-There was a signed physician's order dated 02/03/26 to continue a regular diet and change to mildly thick nectar liquids.<br>-The bottom of the order was initialed by the facility nurse, dated 02/03/26 with a note; copy | D 309 | | |

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| D 309 | Continued From page 29<br><br>given to dietary.<br>-There was a second signed physicians order from a result of a swallow study completed on 02/06/26 with a diet order for honey thickened honey liquids.<br><br>Review of a dietary notebook on 02/10/26 revealed:<br>-A diet order for Resident #5 dated 07/07/25 documented as a regular diet with no specifications for thickened liquids.<br>-There were no updated orders in the diet notebook for Resident #5.<br><br>Refer to interview with the cook on 02/11/26 at 2:40pm.<br><br>Refer to interview with the DM on 02/10/26 at 3:20pm.<br><br>Refer to interview with the Regional Director of Operations on 02/11/26 at 2:45pm.<br><br>Refer to interview with the Administrator on 02/13/26 at 2:45pm.<br><br>_____<br>Interview with the cook on 02/11/26 at 2:40pm revealed:<br>-Personal care assistants (PCAs) or servers were responsible for preparing thickened liquids for residents who had thickened liquid orders.<br>-Servers were responsible for providing him with resident orders via a written order ticket as he was plating resident meals.<br>-A list of residents with therapeutic diets was not posted in the kitchen for his reference.<br>-He did not know a list of residents and their therapeutic diet should have been posted and available in the kitchen for reference.<br>-The DM usually informed him if a resident | D 309 | | |

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| D 309 | Continued From page 30<br>needed a specific food item that was not on the regular diet.<br><br>Interview with the DM on 02/10/26 at 12:30pm and 3:20pm revealed:<br>-There was not a therapeutic diet board or list posted and available for kitchen staff to reference.<br>-All resident diets were listed in a notebook near the DM's office.<br>-She obtained diet orders from the nurse and placed them in the diet order book as needed.<br>-The orders in the notebook were the most current list she had.<br>-She expected the cook to know from memory, what residents should receive for therapeutic diets.<br><br>Interview with the Regional Director of Operations on 02/11/26 at 2:45pm revealed the facility has a special diet board with photos of each resident which was given to the DM and the cooks have the listing close to the serving line for guidance.<br><br>Interview with the Administrator on 02/13/26 at 2:45pm revealed:<br>-The Health and Wellness director was responsible for providing the dietary department with any change in diets.<br>-The DM is responsible for making sure the list is available and updated for the staff in the kitchen. | D 309 | | |
| D 310 | 10A NCAC 13F .0904(e)(4) Nutrition and Food Service<br><br>10A NCAC 13F .0904 Nutrition and Food Service<br>(e) Therapeutic Diets in Adult Care Homes:<br>(4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be | D 310 | | |

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| D 310 | Continued From page 31<br>served as ordered by the resident's physician.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observations, record reviews and interviews, the facility failed to ensure 1 of 5 sampled residents (Resident #5) was served a physician ordered therapeutic diet related to honey thickened liquids.<br><br>The findings are:<br><br>Review of Resident #5's FL2 dated 07/07/25 revealed:<br>-Diagnoses included hyperlipidemia. polymyalgia rheumatica, normal pressure hydrocephalus<br>-She was intermittently disoriented<br>-She was ambulatory with the use of a wheeled walker.<br><br>Review of Resident #5's Resident Register revealed an admission date of 07/14/25.<br><br>Review of Resident #5's record revealed:<br>-A speech pathology modified barium swallow study dated 01/27/26 included a diagnosis of dysphagia oropharyngeal phase and cough after eating.<br>-There was a signed physician's order dated 02/03/26 to continue a regular diet and change to mildly thick nectar liquids.<br>-The bottom of the order was initialed by the Facility Nurse, dated 02/03/26 with a note; copy given to dietary.<br>-There was a second signed physicians order dated 02/06/26 from a result of a swallow study with a diet order for honey thickened honey | D 310 | 1. Food & Beverage Director audited on 3/6/2026 all resident diet orders to ensure they match current signed physician diet order including nutritional supplements and thickened liquids.<br><br>2. Food & Beverage Director in-serviced all dietary team members on community diet board and serving appropriate diets to residents with a signed therapeutic diet<br><br>3. Wellness Director or designee will ensure that culinary team has updated therapeutic diets upon change of signed diet order.<br><br>4. Food & Beverage Director in-serviced on 3/6/2026 all culinary team members of proper service of therapeutic diets to residents and ongoing training is conducted to all culinary team members of changes to resident therapeutic diets | 1. 3/6/2026<br>2. 3/10/26<br>3. Ongoing<br>4. 3/6/2026 |

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| D 310 | Continued From page 32<br>liquids.<br><br>Observation of Resident #5 on 02/10/26 at 12:10pm revealed:<br>-She was served a glass of water that was not thickened.<br>-She did not drink the non-thickened water.<br><br>Observation of the service refrigerator in the service kitchen on 02/10/26 at 12:22pm revealed a carton of sweetened thickened tea and sweetened lemon-flavored water.<br><br>Review of a dietary notebook on 02/10/26 revealed:<br>-A diet order for Resident #5 dated 07/07/25 documented as a regular diet with no specifications for thickened liquids.<br>-There were no updated orders in the diet notebook for Resident #5.<br><br>Interview with the Dietary Manager (DM) on 02/10/26 at 12:30pm revealed:<br>-She placed the non-thickened water in front of Resident #5.<br>-She was not aware of the order for honey thickened beverages for Resident #5.<br>-The dietary servers are responsible for pouring the beverages but she was helping the dietary server.<br>-She had spoken to Resident #5's responsible party on 02/06/26 regarding Resident #5's diet order change to thickened liquids, however she needed to educate him that he needed to bring in a physician order for the diet change.<br>-The nurse was responsible for providing any diet order change to the DM and she had no updates for Resident #5.<br>-She said that as far as she knew Resident #5 was still on regular diet with no thickened | D 310 | | |

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| D 310 | Continued From page 33<br>beverages.<br><br>Interview with the dietary server on 02/11/26 at 12:05pm revealed:<br>-She was aware there was one person who had thickened beverages and pointed to Resident #5.<br>-She knew about the diet order change for Resident #5 because someone in the kitchen told her today 02/11/26.<br>-For dessert, residents could choose rice pudding or ice cream for dessert.<br><br>Observation of Resident #5 on 02/11/25 from 11:50am to 12:26pm during the lunch meal revealed:<br>-She was sitting in a chair at a dining table with other residents and staff nearby.<br>-She was served nectar thickened water and nectar thickened iced tea.<br>-She did not drink the nectar thickened water or nectar thickened iced tea.<br>-She was served barbeque chicken, cornbread and coleslaw.<br>-The staff took Resident #5's order for dessert on a resturant styled green notepad.<br>-Resident #5 was served a bowl of chocolate ice cream.<br>-She fed herself 100 percent of the ice cream without difficulty, without assistance and without coughing.<br><br>Interview with the dietary server on 02/11/26 at 12:26pm revealed:<br>-She pointed to the icecream and rice pudding for dessert.<br>-Due to a language barrier she did not understand the question about icecream being served to Resident #5.<br><br>Interview with the DM on 02/11/26 at 12:32pm | D 310 | | |

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| D 310 | Continued From page 34<br><br>revealed:<br>-To her knowledge if a resident was on thickened beverages they could still have ice cream.<br>-Resident #5 was on a regular diet and her beverages were either honey thickened or nectar thickened.<br>-We served Resident #5 nectar thickened beverages today as she was not sure which thickened liquid Resident #5 should have, nectar thickened or honey thickened.<br>-The facility nurse spoke with her about the thickened beverages yesterday 02/10/26 and she said that the new diet order was placed int the kitchen last week, but she did not have it.<br><br>Interview with the Facility Nurse on 02/12/26 at 11:15am revealed:<br>-She received the order for the nectar thickened liquids for Resident #5 on 02/03/26 and made a copy and put it in a mail shelf by the DM's office.<br>-She verbally informed the cook and the DM about the order.<br>-She obtained a case of nectar thickened liquid and put it on the medication cart.<br>-She spoke to Resident #5's family member and to Resident #5 so they were both aware of the new order.<br>-She did not have a copy of the new order for honey thickened liquids dated 02/06/26.<br><br>Interview with the Regional Director of Operations on 02/11/26 at 2:45pm revealed when there is a new diet order the receiving nurse was to initial and date the order at the bottom of the order and give a copy to dietary and fax to the pharmacy to ensure the order is placed on the electronic medication administration record (eMAR).<br><br>Telephone interview with a dietician on 02/12/26 at 2:20pm revealed: | D 310 | | |

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| LEGACY HEIGHTS SENIOR LIVING COMMUNITY | 11230 BALLANTYNE TRACE COURT CHARLOTTE, NC 28277 |

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| D 310 | Continued From page 35<br>-There were no extension menus for thickened liquids.<br>-There is a separate manual for thickened liquids which the facility has access to as well as consulting with the dietician for clinical needs.<br>-The menu system will print a ticket with each resident's diet and if the resident had an order for thickened liquids it would show up on the ordering ticket.<br>-A resident should not have ice cream if they had a physician order for thickened liquids as there would be risk of aspiration.<br>-A magic cup (a high protein frozen nutritional dessert used for swallowing difficulties), or pudding would be a good substitute in place of ice-cream.<br><br>Interview with the facility's Nurse Practitioner (NP) on 02/11/26 at 4:20pm revealed if a resident was on a thickened beverage they should not have ice-cream as the resident would be at risk for aspiration.<br><br>Interview with the Administrator on 02/13/26 at 2:45pm revealed:<br>-The previous Health and Wellness Director was responsible for providing the dietary department with any changes in diets.<br>-The DM is responsible for training all staff in the kitchen on the therapeutic diets.<br>-The DM is responsible for the menu and should be offering the correct alternatives to ensure the diets are being followed.<br><br>The facility failed to serve a Resident (#5) with an alternative dessert for a physcian ordered honey thickened liquid diet order and served the resident ice cream. The resident had a recent swallow study and was diagnosed with dysphagia. The DM had no knowledge that ice | D 310 | | |

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| D 310 | Continued From page 36<br>cream was not recommended for a honey thickened liquid. This failure increased the risk of aspiration and was detrimental to the health, safety and welfare of the resident which constitute a Type B violation.<br><br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/12/26 for this violation.<br><br>THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 30,2026 | D 310 | | |
| D 328 | 10A NCAC 13F .0906(f)(4) Other Resident Care and Services<br><br>10A NCAC 13F .0906 Other Resident Care and Services<br>(f) Visiting:<br>(4) If the whereabouts of a resident are unknown and there is reason to be concerned about his safety, the person in charge in the home shall immediately notify the resident's responsible person, the appropriate law enforcement agency and the county department of social services.<br><br>This Rule is not met as evidenced by:<br>TYPE A1 VIOLATION<br><br>Based on observations, interviews, and record reviews for 1 of 5 sampled residents the facility failed to immediately notify local law enforcement and the county Department of Social Services when a resident residing in the Assisted Living could not be immediately located (#3). | D 328 | 1. Facility will immediately notify both emergency services and DSS upon the notification of a missing resident from the community<br><br>2. Facility conducted in-service of reporting of missing residents for all team members on 2/14/2026<br><br>3. Wellness Director and Executive Director conducted elopement drill on 2/6/2026 for every shift<br><br>4. Community implemented daily resident checks to confirm that all residents are accounted for on all shifts, on 2/6/2026. ED to review weekly for compliance.<br><br>5. Community in serviced team members on frequency of rounding on their designated shift on 2/14/2026 | 1. Ongoing<br>2. 2/14/2026<br>3. 2/6/2026<br>4. 2/6/2026<br>5. 2/14/2026 |

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The findings are:

Review of the facility's Emergency Procedure: Elopement/Missing Resident policy dated 07/01/15 revealed:
-If a staff member noticed a resident was absent from the community, staff would immediately check the resident's room and common areas as well as the visitor sign out book.
-Staff were to notify the Administrator or Manager on Duty (MOD) if the resident was not found and was not signed out.
-The Administrator or MOD would assign staff to complete a room by room search as well as exterior search of the community and neighborhood area.
-If the resident was not found, the Administrator or MOD would notify the resident's family that the resident was missing and the results of the ongoing search as well as the next steps, i.e. contacting the police.
-If the searches did not yield any results, the Administrator or MOD would contact the police and the Department of Community Health within 30 minutes.

Review of the facility's Missing Resident policy revised on 12/15/25 revealed when a door alarm sounds or an exit door is found unsecured, an immediate head count would be conducted to ensure the presence of all residents.

Review of Resident #3's current FL2 dated 06/17/25 revealed:
-Diagnoses included Parkinson's disease, type 2 diabetes, hypertension, diabetic retinopathy, cataract, and mild intermittent asthma.
-She was ambulatory with a rollator walker.
-She required assistance with bathing and

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| D 328 | Continued From page 38<br>dressing.<br>-Her level of care was assisted living.<br><br>Review of Resident #3's Resident Register revealed an admission date of 04/20/23.<br><br>Review of Resident #3's Care Plan dated 01/27/26 revealed:<br>-Resident #3's orientation was moderately impaired.<br>-Resident #3 had current or history of occasional disorientation to person, place, time or situation even in familiar surroundings.<br>-Resident #3 required supervision and oversight for safety.<br><br>Review of Resident #3's Level of Care assessment dated 12/12/25 revealed:<br>-Resident #3 was moderately confused and may have some unpredictable behavior or require moderate emotional support.<br>-Resident #3 had cognitive impairment.<br>Observation while walking two routes to the bank utilizing GPS monitoring on 02/12/26 between 12:10pm and 1:30pm revealed:<br>-The bank was located 0.24-0.27 miles from the facility.<br>-The bank was up an incline from the facility.<br><br>Interview with a medication aide (MA) on 02/10/26 at 4:15pm revealed:<br>-She worked second shift on 02/04/26.<br>-She administered medications to Resident #3 between 7:30pm and 8:30pm on 02/04/26.<br>-She did not think Resident #3 was listed out of the facility in the communication log when she reviewed it on 02/04/26.<br>-She did not check the whiteboard for Resident #3's room number because she knew the resident was in the building. | D 328 | | |

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-Resident #3 was ambulatory with the aide of a rollator walker.
-She never saw Resident #3 in the hallway without her rollator walker.

Interview with a personal care aide (PCA) on 02/10/26 at 4:50pm revealed:
-She worked second shift on 02/04/26.
-Resident #3 had ordered in her dinner from an outside source.
-She assisted Resident #3 into her pajamas on 02/04/26 sometime after 8:30pm.
-Resident #3 used her call light after 9:00pm and requested some hot tea which she prepared in the resident's room.
-The last time she saw Resident #3 that night (02/04/26) was when the resident called her again after 10:00pm, and when asked what she wanted, Resident #3 stated she forgot.

Telephone interview with MA on 02/10/26 at 2:40pm revealed:
-She worked second shift on 02/04/26 in the Special Care Unit (SCU) and came to the Assisted Living (AL) on 02/04/26 at approximately 11:00pm to work as the third shift MA in the AL.
-She worked third shift in the AL from 11:00pm on 02/04/26 to approximately 7:15am on 02/05/26.
-She counted controlled substances with Resident #3's second shift MA on 02/04/26 at around 11:00pm before going to the second floor to count with the other second shift MA.
-The second shift MA assigned to Resident #3's floor did not usually give a verbal report requiring the on-coming MA to ask questions.
-The second shift MA did not say if any residents were out of the building.
-She did not ask Resident #3's second shift MA if any residents were out of the building.
-She went into Resident #3's room shortly after

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midnight on 02/05/26 and the resident was not in her room or bathroom.
-Resident #3 had ambulated independently with a rollator walker.
-Resident #3's rollator walker was in her room.
-She asked the third shift PCA if she received report that Resident #3 was out of the facility and she had not.
-She then looked at the whiteboard that staff documented on when residents went out of the facility.
-There was undated documentation on the white board that Resident #3 had called 911 on herself.
-It was not uncommon for Resident #3 to call 911 for herself.

Telephone interview with a PCA on 02/11/26 at 2:07pm revealed:
-She worked third shift in the AL from around 11:04pm on 02/04/26 to approximately 7:00am on 02/05/26.
-She usually worked the second floor on third shift and the MA usually worked on the first floor.
-Resident #3's room was on the first floor.
-When she began her shift that night (02/04/26) she reviewed the whiteboard and checked on the second-floor residents which took approximately 20 minutes.
-There was an undated note on the whiteboard indicating Resident #3 called an ambulance on herself.
-At around 5:00am on 02/05/26 the MA asked her where Resident #3 was and she responded the whiteboard said she was in the hospital.

Interview with a MA on 02/10/26 at 1:14pm revealed:
-She worked first shift on 02/05/26 and counted controlled substances on her cart with the third shift MA around 6:45am that morning (02/05/26).

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| D 328 | Continued From page 41<br><br>-Resident #3 had Parkinson's disease and ambulated independently with a rollator walker.<br>-She had not seen Resident #3 ambulate without her walker except occasionally in her room.<br>-The third shift MA told her Resident #3 was not in her room during third shift from 11:00pm on 02/04/26 to 7:00am on 02/05/26.<br>-The third shift MA told her Resident #3 was in the hospital during third shift from 11:00pm on 02/04/26 to 7:00am on 02/05/26.<br>-She questioned the third shift MA as to why Resident #3 was in the hospital and the third shift MA stated she did not know.<br>-The third shift MA left the facility around 7:15am on 02/05/26.<br>-After the third shift MA left, she looked in Resident #3's room and Resident #3's rollator walker was in her room but the resident was not.<br>-She was unsure of the time, but she then went to the second floor MA and asked her to contact the Health and Wellness Director (HWD) to inquire where Resident #3 was.<br>-While on the second floor she reviewed the communication log and did not see any documentation that Resident #3 was out of the facility.<br>-She thought the HWD arrived between 8:45am and 9:00am.<br>-After the HWD arrived staff began searching the facility and grounds for Resident #3.<br><br>Interview with a PCA on 02/10/25 at 10:23am revealed:<br>-She worked first shift on 02/05/26.<br>-She arrived at the facility for work on 02/05/26 around 7:05am.<br>-She went to Resident #3's room around 7:10am that day (02/05/26).<br>-Resident #3 was not in her room.<br>-Resident #3's bedding was pulled back as staff | D 328 | | |

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do on second shift, but the bedding was not disturbed.
-Resident #3 had difficulty walking and almost always used her walker outside of her bedroom.
-Around 7:15am-7:20am she went to the front desk where the first shift and third shift MAs were to ask them if Resident #3 was at the hospital.
-The MAs were to keep documentation on a piece of paper of which residents were at the hospital.
-The two MAs discussed if Resident #3 may have gone to the hospital on 02/04/26 during second shift.
-She resumed her rounds with her assigned residents around 7:25am on 02/05/26.
-Between 7:20am and 9:00am the MA was trying to determine Resident #3's location.
-Around 9:00am on 02/05/26 the previous Health and Wellness Director (HWD) instructed staff to search each room for Resident #3.

Review of meteorological records revealed the low temperature on 02/05/26 between 12:00am and 6:00am was 34 degrees with wind speeds of 9 miles per hour (MPH).

Review of a Law Enforcement (LE) report dated 02/05/26 revealed:
-A law enforcement officer (LEO) was dispatched to do a welfare check on a person found on the sidewalk at the front door of the bank on 02/05/26 at 08:12am
-The subject was not moving.
-The subject was dressed in pajama pants, grey socks, no shoes and a blue jacket.
-The subjects clothes appeared wet as it was raining slightly at the time and had rained that morning.
-The subject appeared semi-conscious but unresponsive.

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| D 328 | Continued From page 43<br><br>-The subject had scratches and blood around the knuckles of her left hand.<br>-When medics arrived they began conducting cardiopulmonary resuscitation (CPR) on the subject.<br>-The subject was transported to the hospital.<br>-Bank cameras captured the subject lying on the sidewalk around 6:00am that day (02/05/26).<br>-There was no further activity on the camera prior to 6:00am due to darkness.<br>-A missing person report from a nearby assisted living came in during the investigation.<br>-Through further investigation it was determined the subject found at the bank was Resident #3 from the facility.<br>-Resident #3 was pronounced deceased at the hospital on 02/05/26 at 9:55am.<br>-It was unclear how Resident #3 arrived at the bank due to mobility issues and her walker being located at the facility.<br><br>Review of Resident #3's Emergency Management Services (EMS) reported dated 02/05/26 revealed:<br>-Dispatch was notified on 02/05/26 at 8:35am and arrived at the scene at 02/05/26 at 8:46am.<br>-Resident #3 was found lying on the sidewalk outside of a bank.<br>-The resident was extremely cold to the touch.<br>-Resident #3 was transported to the Emergency Department (ED).<br>-Resident #3 expired in the ED.<br><br>Review of Resident #3's Case Management ED Assessment note dated 02/05/26 revealed:<br>-Resident #3 presented to the ED due to cardiac arrest.<br>-Resident #3's time of death was 9:55am on 02/05/26. | D 328 | | |

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| D 328 | Continued From page 44<br><br>Interview with the Manager of the bank on 02/12/26 at 12:16pm revealed:<br>-He arrived at the bank on 02/05/26 at 8:10am and observed Resident #3 lying on the concrete walk outside the front doors of the bank.<br>-He called 911 immediately.<br>-EMS did not respond, so he called 911 again at 8:35am.<br>-The fire department arrived at the bank first, followed by EMS.<br>-EMS arrived at the bank at about 8:42am on 02/05/26.<br>-The banks video recording revealed Resident #3 was on the concrete walk prior to 6:00am.<br>-The video recordings did not indicate when Resident #3 arrived out front of the bank because it was too dark prior to 6:00am for the video recording to pick up any activity.<br><br>Telephone interview with the previous HWD on 02/11/26 at 2:50pm revealed:<br>-She was the HWD at the time of the incident involving Resident #3 on 02/04/26-02/05/26.<br>-She was involved in trying to locate Resident #3 the morning of 02/05/26 when Resident #3 was found on the ground outside of a bank.<br>-The MAs were trained the last week of December 2025 to review the communication log and not the whiteboard for resident updates such as residents going to or returning from the hospital.<br>-She was not contacted by third shift staff on 02/04/26-02/05/26 that Resident #3 was not in the building.<br>-She received a text on 02/05/26 at 8:38am from a MA asking if Resident #3 went to the hospital overnight.<br>-She was pulling into the facility when she received the text on 02/05/26 at 8:38am and instructed the MA to check Resident #3's room, | D 328 | | |

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bathroom and check the communication log.
-When she walked into the facility at about 8:45am, she checked the resident's sign out log to see if Resident #3 had signed herself out and she had not.
-She then called the hospital that Resident #3 always requested to go to but got no answer.
-She texted the Administrator to inquire if he had any communication regarding Resident #3's location.
-She called Resident #3's Power of Attorney (POA) to determine if the resident was with her and she was not.
-She called 911 on 02/05/26 at 9:15am to report Resident #3 could not be located.

Interview with Resident's #3 Nurse Practitioner on 02/11/26 at 4:34pm revealed:
-She expected staff to give a shift to shift report of each resident's whereabouts each change of shift.
-She expected staff to check on all residents each shift and to know if they were in the facility or out of the facility.
-She expected staff to check on Resident #3 at least three times per night.
-She expected the facility to keep the residents safe.

Interview with the Administrator on 02/13/26 at 10:58am revealed:
-He saw Resident #3 on 02/04/26 at around 6:30pm.
-He expected staff to frequently check on all residents every shift depending on the resident's needs.
-Staff were not required to document resident checks.
-The previous HWD notified him on 02/05/26 at approximately 8:50am that Resident #3 was not

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| D 328 | Continued From page 46<br><br>in the facility.<br>-He was aware law enforcement (LE) should be contacted immediately if a resident could not be located but he was not notified Resident #3 could not be located until the HWD notified him at about 8:50am that morning (02/05/26).<br>-He did not know if the HWD had contacted LE but he instructed her to contact them.<br><br>Attempted telephone interviews with the Detective on 02/11/26 at 2:05pm and on 02/12/26 at 1:14pm were unsuccessful.<br><br>Attempted telephone interview the reporting officer indicated on the LE report dated 02/05/26 on 02/13/26 at 8:32am was unsuccessful.<br><br>[Refer to tag 338 10A NCAC 13F .0909 Resident Rights (Type A1 Violation)].<br><br>The facility failed to notify local law enforcement and the county Department of Social Services immediately after staff found Resident #3 who had cognitive impairment with a current history of disorientation to person, place, time or situation even in familiar surroundings was missing from her room during a routine staff check shortly after midnight on 02/05/26 which resulted in the Resident #3 being found lying on a concrete sidewalk outside of a bank for an unknown length of time after walking approximately 0.24 miles away from the facility without her rollator walker between midnight and 8:10am at which time the bank manager arrived and called 911, the bank video surveillance showing her on the side walk at 6:00am when the sun came up for the camera to reveal the outside of the front of the bank. This failure resulted in serious physical harm and neglect and constitutes a Type A1 Violation. | D 328 | | |

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| LEGACY HEIGHTS SENIOR LIVING COMMUNITY | 11230 BALLANTYNE TRACE COURT CHARLOTTE, NC 28277 |

| (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 |
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| D 328 | Continued From page 47<br>The facility provided a plan of protection in accordance with G.S. 131D-34 on February 11, 2026, for this violation.<br><br>THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 15, 2026. | D 328 | | |
| D 338 | 10A NCAC 13F .0909 Resident Rights<br><br>10A NCAC 13F .0909 Resident Rights<br>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.<br><br>This Rule is not met as evidenced by:<br>TYPE A1 VIOLATION<br><br>Based on observations, record reviews, and interviews, the facility failed to ensure 1 of 5 sampled resident (Resident #3) who had a cognitive impairment was protected from neglect relating to not having audible door alarms, not investigating an opened door on third shift, conducting a facility search or contacting law enforcement and the county Department of Social Services when a resident's location was unknown<br><br>The findings are:<br><br>Review of the facility's Missing Resident policy revised on 12/15/25 revealed when a door alarm sounds or an exit door is found unsecured, an immediate head count would be conducted to ensure the presence of all residents.<br><br>Review of Resident #3's current FL2 dated | D 338 | 1. Facility conducted immediate resident rights training for team members on 2/14/2026<br><br>2. Team members are trained on Resident Rights upon hire and annually thereafter.<br><br>3. Community installed audible sounding devices on all facility exit doors. – 2/6/2026<br><br>4. Community installed automatic locking feature on front entrance door on 3/5/2026. Door will automatically lock after posted reception hours.<br><br>5. Community will have receptionist staffed at front desk during hours front door is not locked. | 1. 2/14/2026<br>2. Ongoing<br>3. 2/6/2026<br>4. 3/5/2026<br>5. Ongoing |

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06/17/25 revealed:
-Diagnoses included Parkinson's disease, type 2 diabetes, hypertension, diabetic retinopathy, cataract, and mild intermittent asthma.
-She was ambulatory with a rollator walker.
-She required assistance with bathing and dressing.
-Her level of care was assisted living.

Review of Resident #3's Resident Register revealed an admission date of 04/20/23.

Review of Resident #3's Care Plan dated 01/27/26 revealed:
-Resident #3's orientation was moderately impaired.
-Resident #3 had current or history of occasional disorientation to person, place, time or situation even in familiar surroundings.
-Resident #3 required supervision and oversight for safety.

Review of Resident #3's Level of Care assessment dated 12/12/25 revealed:
-Resident #3 was moderately confused and may have some unpredictable behavior or require moderate emotional support.
-Resident #3 had cognitive impairment.

Review of Resident #3's Physician's Notification form dated 01/19/26 revealed on 01/18/26 at 11:20pm Resident #3 was hallucinating, stating she was seeing a dead person who she later called and spoke with.

Review of the facility's communication log entry dated 01/16/26 at 7:00am revealed:
-Resident #3 was very agitated.
-Resident #3 refused her medications and insulin.
-Resident #3 complained of not feeling well but

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| D 338 | Continued From page 49<br>did not specify what was bothering her.<br><br>Review of the facility's communication log entry dated 01/20/26 at 6:00pm revealed:<br>-Resident #3 was not her "normal self".<br>-Resident #3 wanted to leave the community.<br>-911 was called to transport Resident #3 to the Emergency Department (ED).<br>-Resident #3 refused to go to the hospital.<br><br>Review of the facility's communication log entry dated 01/28/26 at 5:00am revealed Resident #3 was up last night wandering the halls and going into other resident rooms.<br><br>Review of Resident #3's Nurse Practitioner's (NP) Progress Notes dated 10/14/25 and 12/02/25 revealed:<br>-Resident #3 had history of Parkinson's disease.<br>-The resident reported occasional confusion and memory lapses.<br><br>Review of Resident #3 NP's Progress Note dated 01/20/26 revealed:<br>-Resident #3 was seen for follow up to ED visits and reported hallucinations.<br>-Resident #3 was diagnosed with Parkinson's disease in January 2025.<br>-Resident #3 reported occasional confusion and memory lapses.<br>-The resident had episodes of anxiety that also portrayed some hallucinations and confusion that may be related to Parkinson's disease.<br><br>Review of the facility's door Device Activity Report revealed:<br>-On 02/04/26 at 11:19pm the front door of the facility was opened and the device was reset after 20 minutes and 53 seconds.<br>-On 02/05/26 at 1:14am the front door of the | D 338 | | |

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| D 338 | Continued From page 50<br>facility was opened and the device was reset after 1 minute and 31 seconds.<br>-On 02/05/26 at 1:18am the front door of the facility was opened and the device was reset after 2 minutes and 43 seconds.<br>-On 02/05/26 at 2:11am the front door of the facility was opened and the device was reset after 36 minutes and 44 seconds.<br><br>Review of meteorological records revealed the low temperature on 02/05/26 between 12:00am and 6:00am was 34 degrees with wind speeds of 9 miles per hour (MPH).<br><br>Review of a Law Enforcement report dated 02/05/26 revealed:<br>-A law enforcement officer (LEO) was dispatched to do a welfare check on a person found on the sidewalk at the front door of the bank on 02/05/26 at 08:12am<br>-The subject was not moving.<br>-The subject was dressed in pajama pants, grey socks, no shoes and a blue jacket.<br>-The subjects clothes appeared wet as it was raining slightly at the time and had rained that morning.<br>-The subject appeared semi-conscious but unresponsive.<br>-The subject had scratches and blood around the knuckles of her left hand.<br>-When medics arrived they began conducting cardiopulmonary resuscitation (CPR) on the subject.<br>-The subject was transported to the hospital.<br>-Bank cameras captured the subject lying on the sidewalk around 6:00am that day (02/05/26).<br>-There was no further activity on the camera prior to 6:00am due to darkness.<br>-A missing person report from a nearby assisted living came in during the investigation. | D 338 | | |

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-Through further investigation it was determined the subject found at the bank was Resident #3 from the facility.
-Resident #3 was pronounced deceased at the hospital on 02/05/26 at 9:55am.
-It was unclear how Resident #3 arrived at the bank due to mobility issues and her walker being located at the facility.

Review of Resident #3's Emergency Management Services (EMS) report dated 02/05/26 revealed:
-Dispatch was notified on 02/05/26 at 8:35am and arrived at the scene at 02/05/26 at 8:46am.
-Resident #3 was found lying on the sidewalk outside of a bank.
-The resident was extremely cold to the touch.
-Resident #3 was transported to the Emergency Department (ED).
-Resident #3 expired in the ED.

Review of Resident #3's Case Management ED Assessment note dated 02/05/26 revealed:
-Resident #3 presented to the ED due to cardiac arrest.
-Resident #3's time of death was 9:55am on 02/05/26.

Review of an accident/incident report dated 02/05/26 revealed:
-Resident #3 was last seen by facility staff at approximately 10:30pm on 02/04/26.
-A medication aide (MA) went to administer Resident #3's medications at 8:30am (02/05/26) and noticed the resident was not present in her room.
-911 was contacted around 9:00am about a missing resident.
-Resident #3 was earlier located outside a bank and the bank manager called 911.

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| D 338 | Continued From page 52<br>-Resident #3 passed away at the hospital.<br><br>Observation of the facility's main entrance on 02/05/26 at 3:01pm revealed:<br>-There was an unlocked main entry/exit door which led to a small vestibule.<br>-There was an interior, lockable door which led from the vestibule to the front desk.<br>-The interior entry/exit door included a lever handle with thumb turn lock; an electronic keypad beside the door to disengage the handicap door opening mechanism; and an electronic alerting device with a magnet on a short chain disengaged from the doorframe accessible from inside the facility.<br>-The door handle required the thumb turn lock to be turned from inside the facility for the door to unlock.<br>-The electronic alarming device was activated by manually attaching the magnet to the doorframe from inside the facility.<br>-When deactivated, the electronic alerting device alerted a computer screen in the copier room directly adjacent to the front door and to the facility's hand-held pager system.<br>-The electronic alerting device did not emit an audible sound alarm.<br><br>Observation while walking two routes to the bank utilizing GPS monitoring on 02/12/26 between 12:10pm and 1:30pm revealed:<br>-The bank was located 0.24-0.27 miles from the facility.<br>-The bank was up an incline from the facility.<br><br>Interview with the Manager of the bank on 02/12/26 at 12:16pm revealed:<br>-He arrived at the bank on 02/05/26 at 8:10am and observed Resident #3 lying on the concrete walk outside the front doors to the bank. | D 338 | | |

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| D 338 | Continued From page 53 | D 338 | | |

-He called 911 immediately.
-EMS did not respond, so he called 911 again at about 8:35am.
-The fire department arrived at the bank first, followed by EMS.
-EMS arrived at the bank at about 8:42am on 02/05/26.
-The banks video recording revealed Resident #3 was on the concrete walk prior to 6:00am.
-The video recordings did not indicate when Resident #3 arrived out front of the bank because it was too dark prior to 6:00am for the video recording to pick up any activity.

Interview with a personal care aide (PCA) on 02/10/26 at 10:23am revealed:
-Resident #3 was hallucinating on and off recently.
-Resident #3 complained over the past couple of months that staff administered wrong medications to her.
-The previous week Resident #3 was agitated and told her it was because she got a letter that the facility was sold and "they" wanted the residents to leave.

Interview with a second PCA on 02/10/26 at 4:50pm revealed:
-She worked second shift on 02/04/26.
-Resident #3 had ordered in her dinner from an outside source.
-She assisted Resident #3 into her pajamas on 02/04/26 sometime after 8:30pm.
-Resident #3 used her call light after 9:00pm and requested some hot tea which she prepared in the resident's room.
-The last time she saw Resident #3 that night (02/04/26) was when the resident called her again after 10:00pm, and when asked what she wanted, Resident #3 stated she forgot.

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Telephone interview with a third PCA on 02/11/26 at 2:07pm revealed:
-She worked third shift reporting for work on 02/04/26 at approximately 11:04pm and worked until around 7:00am on 02/05/26.
-There were two staff on duty on third shift, herself and a MA.
-She worked with the residents on the second floor and the medication aide (MA) worked with the residents on the first floor.
-She only worked with residents on the second floor unless there was a fall or other issue on the first floor.
-Resident #3's room was on the first floor.
-The process on third shift was to lock the front door and place the magnet on the sensor after all of second shift staff left the building.
-If someone went out the front door, the magnet latch would drop and send a signal to staff pagers and to the computer near the front desk.
-The magnetic latch had to be replaced to clear the alert from the screen at the front desk.
-She did not have her pager the third shift between 02/04/26 at 11:04pm and 02/05/26 at 7:00am because she left it at home.
-Because she did not have her pager she sat at the front desk monitoring the computer screen after completing her initial rounds which took her approximately 20 minutes.
-She replaced the magnet latch on 02/04/26 at approximately 11:40pm thinking second shift staff had caused it to be disconnected.
-She monitored the computer screen until about 1:00am on 02/05/26 at which time she went to the second floor of the facility.
-She was unsure of the time, but sometime after 1:00am on 02/05/26 she came down from the second floor and noticed the magnetic latch was not engaged and the door was not locked.

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-She replaced the magnetic latch and relocked the front door.
-She thought pharmacy may have delivered medications and that was why the front door was unlocked and the magnet was not engaged.
-She did not ask the MA if she had opened the door that night.
-She did not check on all the residents to ensure they were accounted for because the facility had never had an issue of a confused resident leaving the building before.

A second telephone interview with a PCA on 02/12/26 at 10:35am revealed:
-She worked third shift reporting for work on 02/04/26 at approximately 11:04pm and was scheduled until 7:00am on 02/05/26.
-On 02/05/26 some time after 1:00am she came down from the second floor and noticed the door was not locked and the magnetic latch was not engaged.
-She looked outside but did not go outside to investigate.
-She relocked the door and replaced the magnetic latch.
-She said it was possible a resident could have left the building, but she had never experienced it before.
-She was not trained to check on residents if a door was opened and she did not know the reason why it had been opened.

Telephone interview with a MA on 02/10/26 at 2:40pm revealed:
-Within the past two weeks Resident #3 started hallucinating.
-One morning, around 4:00am, Resident #3 was very upset saying her friend had died, who had not.
-She could not remember the exact date but

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another time recently Resident #3 was hallucinating and saying people were trying to kill her.
-She worked second shift on 02/04/26 in the Special Care Unit (SCU) and came to the Assisted Living (AL) on 02/04/26 at approximately 11:00pm to work as the third shift MA in the AL.
-She worked third shift in the AL from 11:00pm on 02/04/26 to approximately 7:15am on 02/05/26.
-She counted controlled substances with Resident #3's second shift MA on 02/04/26 at around 11:00pm before going to the second floor to count with the other second shift MA.
-The second shift MA assigned to Resident #3's floor that night did not usually give a verbal report requiring the on-coming MA to ask questions.
-The second shift MA assigned to Resident #3's floor did not say if any residents were out of the facility.
-She did not ask Resident #3's second shift MA if any residents were out of the facility.
-She went into Resident #3's room shortly after midnight on 02/05/26 and the resident was not in her room or bathroom.
-Resident #3's rollator walker was in her room.
-Resident #3 had ambulated independently with a rollator walker.
-She asked the third shift PCA if she received report that Resident #3 was out of the facility and she had not.
-She then looked at the whiteboard that staff documented on when residents were out of the facility.
-There was undated documentation on the white board that Resident #3 had called 911 on herself.
-It was not uncommon for Resident #3 to call 911 for herself.

A second telephone interview with a MA on 02/12/26 at 9:49am revealed:

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| D 338 | Continued From page 57<br>-She worked third shift in the Assisted Living (AL) from about 11:00pm on 02/04/26 until around 7:15am on 02/05/26.<br>-If a door was opened or a resident used their call light, the system would send a notice to staff pagers and to the computer near the front desk.<br>-She did not have a pager the night of 02/04/26-02/05/26.<br>-The only way she would know if a door had been opened that night would be if she saw it on the computer screen that was located near the front desk.<br>-She checked the computer located near the front desk approximately every 30 minutes when she did not have a pager.<br>-She did not see on the computer screen any time that night that a door had been opened.<br>-If the computer screen had indicated a door had been opened she would have checked on all residents.<br><br>Interview with Resident #3's Power of Attorney (POA) on 02/12/26 at 10:14am revealed:<br>-She had scheduled a care plan meeting for 02/05/26 with the facility because she noticed Resident #3 was having some confusion.<br>-Resident #3 called her several times recently saying she had not gotten her medications when in fact she had.<br>-She scheduled the care plan meeting so she and Resident #3 could sit down with facility staff to discuss her care.<br><br>Interview with Resident #3's NP on 02/11/26 at 4:34pm revealed:<br>-Resident #3 was diagnosed with Parkinson's disease in January 2025 but had symptoms prior to her diagnosis.<br>-Resident #3 had very mild dementia related to her Parkinson's disease. | D 338 | | |

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| LEGACY HEIGHTS SENIOR LIVING COMMUNITY | 11230 BALLANTYNE TRACE COURT CHARLOTTE, NC 28277 |

| (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 |
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| D 338 | Continued From page 58<br><br>-Resident #3 could be manipulative, lie and change her story at times.<br>-She never observed Resident #3 ambulate without her rollator walker.<br>-She expected staff to check on all residents several times each shift.<br>-Staff should have checked on Resident #3 at least three times during third shift.<br>-She expected staff to give report at shift change including where each resident was.<br>-If facility staff were uncertain of Resident #3's location, they should have contacted the Health and Wellness Director (HWD) immediately.<br><br>Interview with the former HWD on 02/11/26 at 2:50pm revealed:<br>-She was the HWD at the time of the incident involving Resident #3 on 02/04/26-02/05/26.<br>-She was involved in trying to locate Resident #3 the morning of 02/05/26 when Resident #3 was found on the ground outside of a bank.<br>-If a facility door was opened it would send a message to the staff's pagers and to the computer near the front desk.<br>-Each staff member were issued pagers and walkie-talkies upon hire.<br>-If a staff member forgot their pager, they were to sit at the front desk to monitor the computer screen for resident call bells.<br>-The facility transitioned from using a whiteboard to a communication log for staff communication the last week of December 2025 and all staff were trained on the new system at that time.<br>-PCAs and MAs were to review the communication log, not the whiteboard, each shift for any significant resident changes or residents going out of or returning to the facility.<br>-If staff had seen documentation on the whiteboard but not in the communication log, they should have questioned it because of the recent | D 338 | | |

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| D 338 | Continued From page 59<br>switch to documenting in the communication log.<br>-During shift change, staff were to report off to the on-coming shift and physically observe their assigned residents.<br>-Staff were to physically observe each resident every two hours.<br>-No staff member contacted her during the third shift between 11:00pm on 02/04/26 and 7:00am on 02/05/26.<br>-She received a text message on 02/05/26 at 8:38am from a MA asking if Resident #3 was sent out of the facility.<br>-She responded Resident #3 should be in the building if the communication log did not indicate she was out of the facility or if the resident had not signed herself out.<br>-The third shift MA told her that when she entered Resident #3's room around 11:30pm on 02/04/26 and the resident was not in her room that she assumed the resident went back to the hospital because the resident frequently went to the hospital.<br>-If a door had been opened and staff did not know why, she expected the staff to do a wellness check and physically observe all residents.<br><br>Interview with the Administrator on 02/13/26 at 10:58am revealed:<br>-Prior to 02/05/26 there were no audible alarms on the facility doors.<br>-If a door opened, the magnetic latch would disengage and send a signal to staff pagers and to the computer at the front desk.<br>-Between 8:00pm and 8:00am the door was to be locked, the magnetic latch engaged and the wheelchair push pad locked by entering a code in the keypad by the door.<br>-All staff were issued pagers and walkie talkies upon hire and were to bring them each time they arrived for work. | D 338 | | |

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| D 338 | Continued From page 60<br><br>-He found out after Resident #3's death on 02/06/25 that the staff members on third shift the previous evening did not have their pagers.<br>-If a staff did not have their pagers, he expected staff to monitor the computer at the front desk.<br>-If a door was opened and staff did not know why, he expected staff to check on every resident immediately.<br>-Staff were expected to check on all residents frequently throughout their shift depending on their care needs.<br><br>Attempted telephone interviews with the Detective on 02/11/26 at 2:05pm and on 02/12/26 at 1:14pm were unsuccessful.<br><br>Attempted telephone interview the reporting officer indicated on the LE report dated 02/05/26 on 02/13/26 at 8:32am was unsuccessful.<br><br>[Refer to Tag 67 10A NCAC 13F .0305(h)(4) Physical Environment (Type A1 Violation)]<br><br>[Refer to Tag 328 10A NCAC 13F .0906(f)(4) Other Resident Care and Services (Type A1 Violation)].<br><br>The facility failed to ensure Resident #3 was free from neglect when the audible alarms on facility doors did not prevent the resident who had a cognitive impairment from leaving the facility without staffs knowledge and delayed contacting law enforcement and the county Department of Social Services when a resident's location was unknown after staff checked on Resident #3's shortly after midnight and she was not in her room, and failed to investigate why a door to the facility was opened during the night shift which resulted in a resident leaving the facility without her shoes when outdoor temperatures were 34 | D 338 | | |

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| LEGACY HEIGHTS SENIOR LIVING COMMUNITY | 11230 BALLANTYNE TRACE COURT CHARLOTTE, NC 28277 |

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| D 338 | Continued From page 61<br><br>degrees and found 0.24 miles from the facility lying on a concrete walk, cameras placing her on the ground prior to 6:00am, wet and extremely cold to the touch and found at 8:10am with law enforcement and emergency medical services (EMS) arriving to the scene after 8:35am, EMS beginning CPR and the resident being pronounced deceased in the emergency department at 9:55am on 02/05/26. This failure resulted in serious neglect and death of Resident #3 and constitutes a Type A1 Violation.<br><br>The facility provided an acceptable plan of protection in accordance with G.S. 131D-34 on February 13, 2026, for this violation.<br><br>THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 15, 2026. | D 338 | | |
| D 344 | 10A NCAC 13F .1002(a) Medication Orders<br><br>10A NCAC 13F .1002 Medication Orders<br>(a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments:<br>(1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility;<br>(2) if orders are not clear or complete; or<br>(3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.<br>The facility shall ensure that this verification or clarification is documented in the resident's record. | D 344 | 1. Physician order for resident 5 was immediately clarified and verified by attending physician on 2/12/2026. Physician order for resident 5 was clarified and verified on 2/13/2026<br><br>2. Wellness Director and FED audited all resident signed physician orders on 3/7/2026 and 3/8/2026 to confirm that orders are implemented appropriately on the MAR.<br><br>3. Wellness Director or designee will in-service all medication aides on proper medication administration<br><br>4. Wellness Director and designee conduct weekly review of five resident medication orders for verification that medication orders match medications listed on the MAR. | 1. 2/12/2026 & 2/13/2026<br><br>2. 3/7/2026 and 3/8/2026<br><br>3. Ongoing<br><br>4. 3/4/2026 |

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| D 344 | Continued From page 62<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record reviews, the facility falled to ensure physician orders were clarified for 2 of 5 sampled residents who had orders for a heel protectors (#5) and a medication used as a mineral supplement that had no dosage (#4).<br><br>The findings are:<br><br>1. Review of Resident #1's FL2 dated 03/05/25 revealed diagnosis included Parkinson's disease, pre-diabetes, hyperlipidemia, scoliosis and atrial fibrillation.<br><br>Review of Resident #1's Resident Register revealed an admission date of 03/31/25.<br>Review of Resident #1's physician order dated 06/18/25 revealed:<br>-An order to use padded heal booties (heel protectors).<br>-The order was initialed by the facility nurse with a note faxed to pharmacy on 06/18/25 and noted on electronic Medication Administration Record (eMAR).<br><br>Review of Resident #1 physician orders dated 09/25/25 revealed:<br>-An order to use heel protectors as directed.<br>-To the right of the order was the time documented as needed (PRN).<br>-The order was initialed by the facility nurse with a note faxed to pharmacy on 09/24/25.<br><br>Review of Resident #1's December electronic medication administration record (eMAR) revealed:<br>-There was an entry for heel protectors wear at bedtime (8:00pm) and remove in morning for heel protection. | D 344 | | |

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| D 344 | Continued From page 63<br><br>-Heel protectors were documented as applied from 12/01/25 through 12/31/25.<br><br>Review of Resident #1's January electronic medication administration record (MAR) revealed:<br>-There was an entry for heel protectors, use heel protectors as directed with the documented time as needed (PRN).<br>-Heel protectors were not documented as not applied from 01/01/26 through 01/31/26.<br><br>Review of Resident #1's February medication administration record (MAR) revealed:<br>-There was an entry for heel protectors, use heel protectors as directed with the documented time as needed (PRN).<br>-Heel protectors were documented as not applied from 02/01/26 through 02/11/26.<br><br>Interview with an MA on 02/13/26 at 3:04pm revealed:<br>-She worked second shift and had worked with Resident #1.<br>-She had not asked anyone about the heel protectors being PRN as just followed the eMAR and the directions.<br><br>Interview with a facility nurse on 02/13/26 at 01:58pm revealed:<br>-The order should have been clarified when it was on the eMAR to put the heel protectors on every night in December 2025 to apply heel protectors PRN in January 2026 and February 2026.<br>-The MA should have notified the previous Health and Wellness Director (HWD) or could have contacted pharmacy if to clarify the order for when to apply the heel protectors.<br>-She was not aware the heel protectors were not being put on Resident #1.<br>-The previous HWD would have been responsible | D 344 | | |

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| D 344 | Continued From page 64<br>for ensuring orders are clarified if she was aware of an order needing to be clarified.<br><br>Telephone interview with a representative with the facility's contracted pharmacy on 02/12/26 at 2:40pm revealed:<br>-There was an order dated 06/18/25 for heel protectors use as directed.<br>-The heel protectors were delivered to the facility on 06/23/25.<br>-The pharmacy was responsible for adding the order to the MAR and they added administration time as PRN as that was what the order said.<br><br>Interview with the Administrator on 02/13/26 at 2:45pm revealed:<br>-The previous HWD was responsible for completing physician and medication order audits.<br>-The physician order for heel protectors should have been clarified with Resident #1's PCP.<br><br>2. Review of Resident #4's current FL2 dated 07/08/25 revealed:<br>-Diagnoses included hypertension, hypothyroidism, acid reflux, and osteoporosis.<br>-Resident #4's level of care was Special Care Unit.<br><br>Review of Resident #4's Resident Record revealed an admission date of 08/30/25.<br><br>Review of a physician order summary dated 11/13/25 revealed:<br>-Resident #4 had an order for magnesium (a mineral supplement used to enhance cognitive function, boost focus, and improve sleep) give one capsule by mouth two times a day for supplement.<br>-The order for magnesium oral capsule, give one | D 344 | | |

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| D 344 | Continued From page 65 | D 344 | | |

capsule by mouth two times a day for supplement did not list a dosage.

Review of Resident #4's December 2025 Medication Administration Record (MAR) revealed:
-There was an entry for magnesium oral capsule, give one capsule by mouth two times a day for supplement.
-There was no dosage for the magnesium.

Review of Resident #4's January 2026 MAR revealed there was an entry for magnesium 3-1 L-threonate advanced, take one capsule by mouth every day for supplement.

Review of Resident #4's record revealed there was no documentation of a physician's order for magnesium 3-1 L-threonate advanced, take one capsule by mouth every day for supplement.

Review of Resident #4's February 2026 revealed from 02/01/26 to 02/13/26 revealed there was an entry for magnesium L-threonate advanced, take one capsule by mouth every day for supplement.

Observation of Resident #4's medications available for administration on 02/13/26 at 12:48pm revealed there were two medication cards (quantity of 36 capsules) magnesium 3-1 L-threonate advanced, take one capsule by mouth every day for supplement.

Interview with a pharmacist from the facility's contracted pharmacy on 02/12/26 revealed:
-There was not an active order for magnesium one capsule by mouth two times a day.
-The pharmacy received an order change on 11/13/25 for magnesium one capsule by mouth two times a day and was not filled because there

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| D 344 | Continued From page 66<br><br>was no strength indicated on the order.<br>-The pharmacy contacted the facility to clarify the change in magnesium order and did not receive a response.<br>-The pharmacy continued to use the current order for magnesium 3-1 L-Threonate advanced (dated 11/03/25), take one capsule by mouth every day for supplement.<br>-The pharmacy dispensed magnesium 3-1 L-Threonate advanced 30 capsules (30 day supply) on 11/03/26, 12/01/25, 01/02/26 and 02/02/26.<br>-The pharmacy did not dispense enough magnesium 3-1 L-threonate in December 2025 for Resident #4 to receive 2 capsules daily in December 2025, since the pharmacy followed the order for magnesium 3-1 L-Threonate advanced once daily and dispensed 30 capsules accordingly.<br><br>Interview with the medication aide (MA) on 02/13/26 at 12:47pm revealed:<br>-She administered Resident #4's magnesium once daily, according to the order.<br>-She was not aware of an order for magnesium twice daily or need for clarification.<br>-If a medication needed to be clarified, she would contact the pharmacy or the SCD.<br><br>Interview with the Special Care Unit Director (SCD) on 02/13/26 at revealed:<br>-She and/or the previous Wellness Director were responsible for auditing medication orders, medication carts and following up with the pharmacy if a medication needed clarification by the physician.<br>-MAs were responsible for ensuring the medication administration record matched the orders.<br>-She was not aware there was an order that | D 344 | | |

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| D 344 | Continued From page 67<br>indicated an increase in Resident #4's magnesium.<br>-Resident #4's family member may have brought in an over-the-counter magnesium in December 2025.<br>-Resident #4 may have been administered magnesium supplement twice daily in December 2025 from the pharmacy dispensed capsules and the over-the-counter magnesium supplement brought in by Resident #4's family.<br>-She did not know the pharmacy sent a clarification request to the facility to verify the strength of the magnesium order from 11/13/25.<br>-She did not know Resident #4's magnesium order was not clarified and the pharmacy continued with the current order for magnesium once daily.<br>-She expected better communication between the facility and the contracted pharmacy.<br><br>Interview with the Administrator on 02/13/26 at 1:45pm revealed:<br>-The previous Wellness Director was responsible for auditing medication orders and medication administration records.<br>-He was not sure what the Wellness Director's process was and did not know why Resident #4's magnesium order was not clarified in November 2025.<br>-He expected the facility and pharmacy to communicate in a timely manner to get orders clarified by contacting the primary care provider (PCP). | D 344 | | |
| D 358 | 10A NCAC 13F .1004 (a) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(a) An adult care home shall assure that the | D 358 | | |

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| D 358 | Continued From page 68<br><br>preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interviews, the facility failed to ensure medications were administered as ordered for 2 of 5 sampled residents related to a medication to control blood sugar levels (#3) and a medication used as a dietary supplement (#4).<br><br>The findings are:<br><br>1. Review of Resident #3's current FL2 dated 06/17/25 revealed:<br>-Diagnoses included diabetes type 2 and hypertension.<br>-There was an order for Rybelsus (a medication to control blood sugar levels) 3mg, one tablet daily.<br><br>Review of Resident #3's December 2025 electronic medication administration record (MAR) revealed:<br>-There was an entry for Rybelsus 3mg, one tablet daily scheduled at 6:00am.<br>-There was documentation Rybelsus 3mg, one tablet was administered to Resident #3 from 12/01/25 to 12/10/25.<br>-There was documentation Rybelsus 3mg, one tablet daily was not administered to Resident #3 from 12/11/25 through 12/15/25 because the resident refused the medication.<br>-Documentation on the December 2025 eMAR ended on 12/15/25. | D 358 | 1. Medications have been reviewed daily using med exception reports to identified any missed late or refused medication. Any discrepancies are reviewed, corrected, and documented.<br><br>2. Physician order for resident 4 was immediately clarified and verified by attending physician on 2/13/2026<br><br>3. Wellness Director and FED audited all resident signed physician orders on 3/7/2026 and 3/8/2026 to confirm that orders are implemented appropriately on the MAR<br><br>4. Wellness Director or designee will in-service all medication aides on proper medication administration.<br><br>5. Wellness Director and designee reviewed that medications in the med cart matched the medications that are listed on the MAR. | 1. Ongoing<br><br>2. 2/13/2026<br><br>3. 03/7/26 – 3/8/26<br><br>4. 3/4/2026<br><br>5. 3/8/2026 |

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| | HAL060152 | A. BUILDING: _____ B. WING _____ | R-C 02/13/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LEGACY HEIGHTS SENIOR LIVING COMMUNITY | 11230 BALLANTYNE TRACE COURT CHARLOTTE, NC 28277 |

| (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 |
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| D 358 | Continued From page 69<br><br>Review of Resident #3's December 2025 paper MAR revealed:<br>-The paper MAR was a printout of the eMAR with electronic documentation ending on 12/15/25.<br>-There was documentation Rybelsus 3mg, one tablet was administered on 12/16/25 and 12/17/25 at 6:00am.<br>-The Rybelsus 3mg, one tablet daily entry had an "X" documented on Resident #3's MAR from 12/18/25 to 12/29/25.<br>-The Rybelsus 3mg, one tablet daily entry had no documentation on 12/30/25 and 12/31/25.<br>-There was no documentation Rybelsus 3mg, one tablet daily was administered from 12/18/25 through 12/31/25 and no documentation why it was not administered to Resident #3.<br><br>Review of Resident #3's January 2026 paper MAR revealed:<br>-There was an entry for Rybelsus 3mg, one tablet daily scheduled at 6:00am.<br>-There was no documentation Rybelsus 3mg, one tablet was administered to Resident #3 from 01/01/26 to 01/02/26, from 01/04/26 to 01/07/26, on 01/10/26, from 01/13/26 to 01/16/26, from 01/18/26 to 01/24/26, on 01/26/26 and on 01/30/26.<br>-There was no documentation Rybelsus 3mg, one tablet daily was administered 20 of 31 opportunities and no documentation why it was not administered to Resident #3.<br><br>Review of Resident #3's February 2026 paper MAR revealed:<br>-There was an entry for Rybelsus 3mg, one tablet daily scheduled at 6:00am.<br>-Rybelsus 3mg, one tablet was documented as administered to Resident #3 from 02/01/26 to 02/04/26. | D 358 | | |

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| D 358 | Continued From page 70<br>-Rybelsus 3mg, one tablet was documented not administered to Resident #3 on 02/05/26 because the resident was not available.<br><br>Telephone interview with a Pharmacist with the facility's contracted pharmacy on 02/13/26 at 1:14pm revealed:<br>-Resident #3 had an active order date 05/23/25 for Rybelsus 3mg, one tablet daily.<br>-Rybelsus 3mg, 30 tablets were dispensed for Resident #3 on 10/29/25, 12/01/25 and 12/23/25.<br>-Resident #3 could experience increased blood sugar levels if she did not receive Rybelsus 3mg, one tablet daily as ordered.<br><br>Interview with a medication aide (MA) on 02/13/26 at 1:59pm revealed:<br>-The MAs were responsible to administer resident medications according to the eMAR.<br>-If a medications was not administered, the MAs were responsible to document the medication was not administered to the resident and the reason why.<br>-There should not be blank areas on the eMARs.<br><br>Interview with the Administrator on 02/13/26 at 10:58am revealed:<br>-The MAs were responsible to document if a medication was administered or if a medication was not administered.<br>-If a medication was not administered, the MA was to provide a reason why the medication was not administered.<br>-The previous Health and Wellness Director (HWD) was responsible for weekly MAR audits.<br>-The previous HWD did not voice any concerns to him related to the weekly MAR audits and resident medications not being administered.<br><br>2. Review of Resident #4's current FL2 dated | D 358 | | |

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| D 358 | Continued From page 71<br><br>07/08/25 revealed:<br>-Diagnoses included hypertension, hypothyroidism, acid reflux, and osteoporosis.<br>-Resident #4's level of care was Special Care Unit.<br><br>Review of Resident #4's Resident Record revealed an admission date of 08/30/25.<br><br>Review of Resident #4's physician order summary dated 11/13/25 revealed:<br>-Resident #4 had an order for magnesium oral capsule (a mineral supplement used to enhance cognitive function, boost focus, and improve sleep), give one capsule by mouth two times a day for supplement.<br>-The order for magnesium oral capsule, give one capsule by mouth two times a day for supplement did not list a dosage.<br><br>Review of Resident #4's December 2025 Medication Administration Record (MAR) revealed:<br>-There was an entry for magnesium oral capsule, give one capsule by mouth two times a day for supplement.<br>-There was no entry for the dosage of magnesium to be administered.<br>-There was documentation magnesium oral capsule, give one capsule by mouth two times a day for supplement was administered daily.<br><br>Review of Resident #4's January MAR revealed:<br>-There was no entry for magnesium oral capsule, give one capsule by mouth two times a day for supplement.<br>-There was an entry for magnesium 3-1 L-threonate advanced, take one capsule by mouth every day for supplement.<br>-There was documentation magnesium 3-1 | D 358 | | |

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| D 358 | Continued From page 72<br>L-threonate advanced capsule by mouth every day for supplement was administered daily.<br><br>Review of Resident #4's February MAR revealed:<br>-There was no entry for magnesium oral capsule, give one capsule by mouth two times a day for supplement from/01/26 to 02/13/26.<br>-There was an entry for magnesium 3-1 L-threonate advanced, take one capsule by mouth every day for supplement from 02/01/26 to 02/13/26.<br>-There was documentation magnesium 3-1 L-threonate advanced capsule by mouth every day for supplement was administered from 02/01/26 to 02/13/26.<br><br>Observation of Resident #4's medications available for administration on 02/13/26 at 12:48pm revealed there were two medication cards (36 capsules) magnesium 3-1 L-threonate advanced, take one capsule by mouth every day for supplement.<br><br>Review of Resident #4's record revealed there was no physician's order for magnesium 3-1 L-threonate advanced, take one capsule by mouth every day for supplement.<br><br>Interview with a pharmacist from the facility's contracted pharmacy on 02/12/26 revealed:<br>-There was not an active order for magnesium one capsule by mouth two times a day.<br>-The pharmacy received an order change on 11/13/25 for magnesium one capsule by mouth two times a day and was not filled because there was no strength indicated on the order.<br>-The pharmacy contacted the facility to clarify the change in magnesium order and did not receive a response. | D 358 | | |

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| D 358 | Continued From page 73<br><br>-The pharmacy continued to use the current order for magnesium 3-1 L-Threonate advanced (dated 11/03/25), take one capsule by mouth every day for supplement.<br>-The pharmacy dispensed magnesium 3-1 L-Threonate advanced 30 capsules/ 30 day supply on 11/03/26, 12/01/25, 01/02/26 and 02/02/26.<br>-The pharmacy could not have dispensed enough magnesium in December 2025 for Resident #4 to receive 2 capsules daily in December 2025, since the pharmacy followed the order for magnesium 3-1 L-Threonate advanced once daily and dispensed 30 capsules accordingly.<br><br>Interview with the medication aide (MA) on 02/13/26 at 12:47pm revealed:<br>-She administered Resident #4's magnesium once daily, according to the order.<br>-She was not aware of an order for magnesium twice daily or need for clarification.<br><br>Interview with the Special Care Unit Director (SCD) on 02/13/26 at revealed:<br>-She and/or the previous Wellness Director were responsible for auditing medication orders, medication carts and following up with the pharmacy if a medication needed clarification by the physician.<br>-The MAs were responsible for ensuring the medication administration record matched the orders.<br>-She was not aware there was an order that indicated an increase in Resident #4's magnesium.<br>-Resident #4's family member may have brought in an over-the-counter magnesium in December 2025.<br>-Resident #4 may have been administered magnesium supplement twice daily in December | D 358 | | |

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| D 358 | Continued From page 74<br><br>2025 from the pharmacy dispensed capsules and the over-the-counter magnesium supplement brought in by Resident #4's family.<br>-She did not know the pharmacy sent a clarification request to the facility to verify the strength of the magnesium order from 11/13/25.<br>-She did not know the Resident #4's magnesium order was not clarified and the pharmacy continued with the current order for magnesium once daily.<br><br>Interview with the Administrator on 02/13/26 at 1:45pm revealed:<br>-The previous Wellness Director was responsible for auditing medication orders and medication administration records.<br>-He was not sure what the Wellness Director's process was and did not know why Resident #4's magnesium order was not clarified in November 2025. | D 358 | | |
| D 367 | 10A NCAC 13F .1004 (j) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(j) The resident's medication administration record (MAR) shall be accurate and include the following:<br>(1) resident's name;<br>(2) name of the medication or treatment order;<br>(3) strength and dosage or quantity of medication administered;<br>(4) instructions for administering the medication or treatment;<br>(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;<br>(6) date and time of administration;<br>(7) documentation of any omission of | D 367 | | |

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| D 367 | Continued From page 78<br>-She was not aware of an order for magnesium twice daily or need for clarification.<br><br>Interview with the SCD on 02/13/26 at revealed:<br>-She and/or the previous Wellness Director were responsible for auditing medication orders, medication carts and following up with the pharmacy if a medication needed clarification by the physician.<br>-MAs were responsible for ensuring the MARs matched the orders.<br>-She was not aware there was an order that indicated an increase in Resident #4's magnesium.<br>-She did not know Resident #4's December 2025 MAR showed entries magnesium was given twice daily without a strength then January 2026 and February 2026 MARs showed magnesium once daily.<br>-Resident #4's family member may have brought in an over-the-counter magnesium in December 2025.<br>-Resident #4 may have been administered magnesium supplement twice daily in December 2025 from the pharmacy dispensed capsules and the over-the-counter magnesium supplement brought in by Resident #4's family.<br>-She did not know the pharmacy sent a clarification request to the facility to verify the strength of the magnesium order from 11/13/25.<br>-She did not know the Resident #4's magnesium order was not clarified and the pharmacy continued with the current order for magnesium once daily.<br>-The facility transitioned from electronic MARs to paper MARs on 12/18/25 due to a vendor change.<br>-She expected MARs to be accurate according to active medication orders.<br>-She expected better communication between the | D 367 | | |

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| D 367 | Continued From page 75<br>medications or treatments and the reason for the omission, including refusals; and,<br>(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).<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews and interviews, the facility failed to ensure the medication administration records (MARs) were accurate for 1 of 5 sampled residents (#4) related to documentation of a medication used as a mineral supplement.<br><br>The findings are:<br><br>Review of Resident #4's current FL2 dated 07/08/25 revealed:<br>-Diagnoses included hypertension, hypothyroidism, acid reflux, and osteoporosis.<br>-Resident #4's level of care was Special Care Unit.<br><br>Review of Resident #4's Resident Record revealed an admission date of 08/30/25.<br><br>Review of Resident #4's physician order summary dated 11/13/25 revealed:<br>-Resident #4 had an order for magnesium oral capsule (a mineral supplement used to enhance cognitive function, boost focus, and improve sleep), give one capsule by mouth two times a day for supplement.<br>-The order for magnesium oral capsule, give one capsule by mouth two times a day for supplement | D 367 | 1. Medications have been reviewed daily using med exception reports to identified any missed late or refused medication. Any discrepancies are reviewed, corrected, and documented<br><br>2. Physician order for resident 4 was immediately clarified and verified by attending physician on 2/13/2026<br><br>3. Wellness Director and FED audited all resident signed physician orders on 3/7 and 3/8 to confirm that orders are implemented appropriately on the MAR<br><br>4. Wellness Director or designee in-serviced all medication aides on proper medication administration on 3/4/2026<br><br>5. Wellness Director and FED will conduct ongoing review of resident MARs and review that medications are administered to residents based on the MAR. | 1. Ongoing<br>2. 2/13/2026<br>3. 3/7/26 and 3/8/2026<br>4. 3/4/2026 |

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| D 367 | Continued From page 76<br>did not list a dosage.<br><br>Review of Resident #4's December 2025 Medication Administration Record (MAR) revealed:<br>-There was an entry for magnesium oral capsule, give one capsule by mouth two times a day for supplement.<br>-There was no entry for the dosage of magnesium to be administered.<br>-There was documentation magnesium oral capsule, give one capsule by mouth two times a day for supplement was administered daily.<br><br>Review of Resident #4's January MAR revealed:<br>-There was no entry for magnesium oral capsule, give one capsule by mouth two times a day for supplement.<br>-There was an entry for magnesium 3-1 L-threonate advanced, take one capsule by mouth every day for supplement.<br>-There was documentation magnesium 3-1 L-threonate advanced capsule by mouth every day for supplement was administered daily.<br><br>Revlew of Resident #4's February MAR revealed:<br>-There was no entry for magnesium oral capsule, give one capsule by mouth two times a day for supplement from/01/26 to 02/13/26.<br>-There was an entry for magnesium 3-1 L-threonate advanced, take one capsule by mouth every day for supplement from 02/01/26 to 02/13/26.<br>-There was documentation magnesium 3-1 L-threonate advanced capsule by mouth every day for supplement was administered from 02/01/26 to 02/13/26.<br><br>Observation of Resident #4's medications available for administration on 02/13/26 at | D 367 | | |

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| D 367 | Continued From page 77<br>12:48pm revealed there were two medication cards (36 capsules) magnesium 3-1 L-threonate advanced, take one capsule by mouth every day for supplement.<br><br>Review of Resident #4's record revealed there was no physician's order for magnesium 3-1 L-threonate advanced, take one capsule by mouth every day for supplement.<br><br>Interview with a pharmacist from the facility's contracted pharmacy on 02/12/26 revealed:<br>-There was not an active order for magnesium one capsule by mouth two times a day.<br>-The pharmacy received an order change on 11/13/25 for magnesium one capsule by mouth two times a day and was not filled because there was no strength indicated on the order.<br>-The pharmacy contacted the facility to clarify the change in magnesium order and did not receive a response.<br>-The pharmacy continued to use the current order for magnesium 3-1 L-threonate advanced (dated 11/03/25), take one capsule by mouth every day for supplement.<br>-The pharmacy dispensed magnesium 3-1 L-threonate advanced 30 capsules/ 30 day supply on 11/03/26, 12/01/25, 01/02/26 and 02/02/26.<br>-The pharmacy could not have dispensed enough magnesium in December 2025 for Resident #4 to receive 2 capsules daily in December 2025, since the pharmacy followed the order for magnesium 3-1 L-threonate advanced once daily and dispensed 30 capsules accordingly.<br><br>Interview with the medication aide (MA) on 02/13/26 at 12:47pm revealed:<br>-She administered Resident #4's magnesium once daily, according to the order and documented on the MAR. | D 367 | | |

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| D 367 | Continued From page 79<br>pharmacy and the facility.<br><br>Interview with the Administrator on 02/13/26 at 1:45pm revealed:<br>-The previous Wellness Director was responsible for auditing medication orders and medication administration records.<br>-He was not sure what the Wellness Director's process was and did not know why Resident 4's magnesium order was not clarified in November 2025.<br>-The facility transitioned from electronic MARs to paper MARs on 12/18/25 due to a vendor change.<br>-He expected the facility and pharmacy to communicate in a timely manner to get orders clarified and the MARs to be accurately documented. | D 367 | | |
| D 451 | 10A NCAC 13F .1212(a) Reporting of Accidents and Incidents<br><br>10A NCAC 13F .1212 Reporting of Accidents and Incidents<br>(a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and staff interviews, the facility failed to notify the local county Department of Social Services (DSS) of an incident for 1 of 5 | D 451 | 1. Community trained team members on reporting accidents and incidents to DSS within 48 hours of a reportable | 1. 2/14/2026 |

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| D 451 | Continued From page 80<br>sampled residents (#5) who had a fall which required medical intervention at a local emergency department.<br><br>The findings are:<br><br>1. Review of Resident #1's FL2 dated 03/05/25 revealed diagnosis included Parkinson's disease, pre-diabetes, hyperlipidemia, scoliosis and atrial fibrillation.<br><br>Review of Resident #1's Resident Register revealed an admission date of 03/31/25.<br><br>Review of Resident #1's emergency department (ED) after visit summary dated 12/30/25 revealed resident #1 was seen for fall initial encounter, effusion of right knee and head injury due to fall.<br><br>Review of an accident incident report for Resident #1 dated 12/30/25 revealed:<br>-Resident slipped in shower with staff present.<br>-She had no lacerations or complaints of pain but hit her head during fall.<br>-Medication aide (MA) on duty called emergency medical services (EMS), Primary Care Provider (PCP) and power of attorney (POA).<br>-She was sent to the emergency department (ED) for evaluation and treatment if necessary.<br>-There was no documentation DSS was notified of the incident.<br><br>Review of Resident #1's record revealed:<br>-A progress note dated 12/30/25 documenting Resident #1 returned on 12/30/26 with her family member and a brace on her right knee.<br>-She had a follow up with orthopedics on 01/05/26.<br><br>Review of Resident #1's record revealed a | D 451 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL060152 | A. BUILDING: _____ B. WING _____ | R-C 02/13/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LEGACY HEIGHTS SENIOR LIVING COMMUNITY | 11230 BALLANTYNE TRACE COURT CHARLOTTE, NC 28277 |

| (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 451 | Continued From page 81<br>progress note dated 01/05/26 that resident returned from her orthopedic appointment and had no fracture.<br><br>Interview with the Corporate Clinical Director on 02/11/26 at 3:23 revealed she was not aware if a resident was sent out to the hospital due to a fall without injury it required a report to the Department of Social Services (DSS).<br><br>Interview with a representative from DSS on 02/11/26 at 4:18pm revealed DSS had not received an incident report for Resident #1 regarding a fall on 12/30/25.<br><br>Interview with the Administrator on 02/13/26 at 2:45pm revealed he expected any fall that required treatment beyond first aid should be sent to DSS. | D 451 | | |