STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R-C 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on 04/14/26 - 04/15/26.	D 000		
D 079	10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the facility was free from hazards including shower floors that were cracked in the special care unit (SCU) and in the assisted living (AL). The findings are: Observation of resident room #304 in the SCU on 04/14/26 at 8:29am revealed: -The shower floor was made of fiberglass material. -There were two patched areas on the floor of the shower in the bathroom.	D 079		

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	HAL017054	A. BUILDING: _____ B. WING _____	R-C 04/15/2026

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D 079	Continued From page 1 -Both patches were eight inches wide and had a rough finish and were not sanded smooth. -The patch on the left had three cracks that started from the center of the patch and went to the edge. -The patch on the right had a two-inch and a one-inch circular depression within the patch. Interview with a personal care aide (PCA) on 04/14/26 at 2:12pm revealed: -She noticed the cracks on the shower floor in resident room #304 about two weeks ago when she was assisting the resident with a shower. -She told the Maintenance Director, and he said he would work on it. Based on observations and interviews it was determined the resident who resided in resident room #304 was not interviewable. Observation of resident room #605 on the AL on 04/14/26 at 9:12am revealed: -The shower floor was made of fiberglass material. -There was a large crack that had smaller cracks branching off. -The area at the largest crack had separated, exposing a jagged edge. -The damage was approximately a ten-inch by twelve-inch area. Interview with the resident who resided in resident room #605 on 04/14/26 at 9:14am revealed: -The shower floor had cracks in it for a long time; he could not recall how long. -He used the shower yesterday. -He made sure he did not step on the area that was broken. -The Maintenance Director knew about the broken shower.	D 079		

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	HAL017054	A. BUILDING: _____ B. WING _____	R-C 04/15/2026

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D 079	Continued From page 2	D 079		

-The Maintenance Director looked at the shower floor about a month ago but did not make any repairs.

Interview with the Maintenance Director on 04/15/26 at 11:07am revealed:
-He made rounds in the facility three times a week to check for needed repairs.
-He was aware the shower floors in resident room #304 in the SCU and resident room #605 in the AL were to be repaired by 03/26/26.
-He was the only one in the facility making repairs for the facility and did not have time to repair the floors.
-He used puddy to patch the floors yesterday, 4/14/26.
-No one told him to use the puddy but that was all he had to repair the floors.

Telephone interview with the facility's Regional Maintenance Director on 04/14/26 at 4:42pm revealed:
-He was made aware today, 04/14/26 about the shower floors in resident room #304 in the SCU and resident room #605 in the AL.
-There had been a turnover in staff for Regional Maintenance Directors and they were not able to get to the facility to complete the needed repairs.
-He would have to submit a request to the Divisional Regional Director to repair the shower floors.
-He was not aware when the repairs would be completed.

Interview with the Administrator on 04/14/26 at 4:27pm revealed:
-She submitted a request on 02/09/26, to the Regional Maintenance Director to make the repairs to the shower floors for resident room #304 in the SCU and resident room #605 in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R-C 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

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D 079	Continued From page 3 AL. -She had not followed up on the request and had not checked the rooms to ensure the repairs had been completed. -She was not aware the shower floors had not been repaired in resident room #304 in the SCU and resident room #605 in the AL. -She did not do inspections of resident rooms because the Maintenance Director did inspections. -She expected the Maintenance Director to let her know what needed to be repaired and to do repairs as needed. Second interview with the Administrator on 04/15/26 at 9:15am revealed: -The Maintenance Director made repairs to the shower floors in resident room #304 in the SCU and resident room #605 in the AL yesterday, 04/14/26. -The Regional Maintenance Director was coming to the facility to assess the repairs, but she did not know when.	D 079		
D 105	10A NCAC 13F .0311 (a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition.	D 105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R-C 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

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D 105	Continued From page 4 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the smoke detectors were maintained in a safe and operating condition, as evidenced by a beeping smoke detector in the special care unit (SCU). The findings are: Observation of resident room #210 in the SCU on 04/14/26 at 8:24am revealed: -There was a battery-operated smoke detector in the room. -The smoke detector was beeping, indicating the battery needed to be changed. Observation of resident room #110 in the SCU on 04/14/26 at 8:26am revealed: -There was a battery-operated smoke detector in the room. -The smoke detector was beeping, indicating the battery needed to be changed. Observation of the 200 hallway on 04/14/26 at 8:41am revealed there was a medication aide (MA) in the hallway with her medication cart; the beeping from the smoke detector could be heard while standing at the medication cart. Observation of the 100-hallway and the 200-hallway on 04/14/26 between 8:12am-4:12pm revealed: -Staff were standing in the hallway near resident room #110 and resident room #210 and beeping could be heard from the hallway. -At 4:12pm, the smoke detector in resident room #110 and resident room #210 could still be heard beeping in hallway.	D 105		

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	HAL017054	A. BUILDING: _____ B. WING _____	R-C 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

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D 105	Continued From page 5	D 105		

Telephone interview with a resident's family member on 04/14/26 at 2:51pm revealed:
-She heard a smoke detector beeping about three weeks ago.
-She spoke to several staff about the smoke detectors every week she visited the facility.
-Staff told her they reported it to the Maintenance Director.
-She purchased batteries and attempted to change the battery to the smoke detector but could not reach the smoke detector.

Interview with a personal care aide (PCA) on 04/14/26 at 1:57pm revealed:
-She heard the smoke detectors beeping in resident room #110 for about a month.
-She told the Maintenance Director, and he said he would change the batteries.
-She thought the battery to the smoke detector in resident room #110 was replaced last week.
-She was not aware it was still beeping.
-She was not aware the smoke detector was beeping in resident room #210.

Interview with another PCA on 04/14/26 at 2:12pm revealed:
-She was aware the smoke detector was beeping in resident room #210, but could not recall for how long.
-A resident's family member asked her about the smoke detector beeping in resident room #210 about two weeks ago.
-She reported it to the Maintenance Director, and he said he would work on it.
-She was not aware the smoke detector was beeping in resident room #110.

Interview with the MA on 04/14/26 at 2:22pm revealed:
-She was not aware that the smoke detectors

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R-C 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

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D 105	Continued From page 6	D 105		

were beeping in resident room #110 and resident room #210.
-She did not pay attention to the smoke detectors beeping.
-She would have made the Maintenance Director aware of the beeping smoke detectors.

Interview with the Maintenance Director on 04/15/26 at 11:07am revealed:
-He made rounds in the facility three times a week to check for needed repairs.
-He was responsible for changing the batteries to the smoke detectors.
-The facility purchased batteries for the smoke detectors that would only last for two months, he did not report it to the Administrator.
-Staff notified him a couple of weeks ago about the smoke detectors beeping.
-He had not had a chance to change the batteries.
-He changed the batteries yesterday, 04/14/26.

Interview with the Administrator on 04/14/26 at 4:27pm revealed:
-The Maintenance Director was responsible for changing the batteries in the smoke detectors.
-She expected staff to let the Maintenance Director know when they heard a smoke detector beeping so the battery could be changed.
-She was concerned no one had notified the Maintenance Director, so the battery could have been changed sooner.

Based on observations and interviews it was determined the residents who resided in resident room #110 and resident room #210 were not interviewable.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R-C 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

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D 358	Continued From page 7	D 358		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW UP TO THE UNABATED TYPE B VIOLATION. Based on these findings, the previous Unabated Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 3 residents (#6 and #7) observed during the morning medication pass including errors with a nasal spray (#6) and a medication for acid reflux and a medication for stomach discomfort (#7); and for 1 of 5 sampled residents for record review (#1) who had an order for a supplement. The findings are: 1. The medication error rate was 10% as evidenced by the observation of 3 errors out of 29 opportunities during the 8:00am medication pass on 04/15/26. a. Review of Resident #6's current FL-2 dated 08/17/25 revealed diagnoses included dementia,	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R-C 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

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D 358	Continued From page 8	D 358		

hypertension, and neuropathy.

Review of Resident #6's signed physician orders dated 01/06/26 revealed there was an order for fluticasone nasal spray 50mcg (used to treat sneezing, itchy and runny nose, and itchy and watery eyes) instill 1 spray in each nostril twice daily for seasonal allergies.

Observation of the morning medication pass on 04/15/26 at 7:50am revealed:
-The medication aide (MA) removed Resident #6's multi-dose pack from the medication cart and a box that contained one medication.
-The MA prepared 7 pills from the multi-dose pack and one pill from the box of medications.
-The MA removed an inhaler from the top drawer of the medication cart.
-The MA entered Resident #6's room and administered 8 pills and the inhaler.
-The MA returned to the medication cart, returned the inhaler to the top drawer of the medication cart, and signed off on the electronic medication administration record (eMAR).
-The MA did not remove the bottle of fluticasone nasal spray from the medication cart, and the MA did not administer the fluticasone nasal spray.

Review of Resident #6's April 2026 eMAR for 04/15/26 revealed:
-There was an entry for fluticasone nasal spray 50mcg instill one spray in each nostril daily for seasonal allergies with a scheduled administration time of 9:00am.
-There was documentation that the fluticasone nasal spray was administered on 04/15/26 at 9:00am.

Observation of Resident #6's medication on hand on 04/15/26 at 9:26am revealed there was a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R-C 04/15/2026

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CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

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D 358	Continued From page 9	D 358		

bottle of fluticasone nasal spray for Resident #6 that was dispensed on 03/31/26 and opened on 04/01/26 which was ½ full.

Interview with Resident #6 on 04/15/26 at 9:39am revealed:
-She did not receive her fluticasone nasal spray this morning.
-She was administered the fluticasone nasal spray because she had allergies.
-She was not having any problems with allergy symptoms such as itchy and watery eyes or nose.

Interview with the MA on 04/15/26 at 9:27am revealed:
-She thought she administered the fluticasone nasal spray to Resident #6.
-She administered two sprays to Resident #6.
-She administered Resident #6 her inhaler.
-She forgot to administer the fluticasone nasal spray.
-It was an oversight, and she was nervous because she was being observed by the surveyor.

Telephone interview with a representative from the facility's contracted pharmacy on 04/15/26 at 12:36pm revealed:
-Resident #6 had an order for fluticasone nasal spray one spray in each nostril daily for seasonal allergies.
-The fluticasone nasal spray was used to treat seasonal allergies such as itchy and watery eyes and nose, and sneezing.
-If fluticasone nasal spray was not administered as ordered, it could cause an increase of symptoms of seasonal allergies.

Interview with the Administrator on 04/15/26 at 10:36am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R-C 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

(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 358	Continued From page 10	D 358		

-Resident #6 could experience symptoms of watery and itchy eyes and a runny nose if she was not administered fluticasone nasal spray as ordered.
-The MA did not verify all medications administered if she signed a medication that she did not administer.

Attempted telephone interview with Resident #6's Primary Care Provider (PCP) on 04/15/26 at 10:27am was unsuccessful.

b. Review of Resident #7's current FL-2 revealed diagnoses included gastro-esophageal reflux disease (GERD) and dyskinesia of esophagus.

1. Review of Resident #7's signed physician orders dated 01/06/26 revealed there was an order for omeprazole 20mg (used to reduce the amount of acid in the stomach) take one capsule twice daily 30 minutes before breakfast and dinner.

Observation of the morning medication pass on 04/15/26 at 8:08am revealed:
-Resident #7 was sitting in the dining room eating breakfast.
-The medication aide (MA) removed Resident #7's multi-dose pack from the medication cart that contained 6 pills and prepared the 6 pills for administration.
-The MA entered the dining room and administered the pills to Resident #7.
-One of the 6 pills was omeprazole 20mg capsule.
-Resident #7 had consumed ½ of her breakfast when the omeprazole was administered.

Review of Resident #6's April 2026 eMAR for 04/15/26 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R-C 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

(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 358	Continued From page 11	D 358		

-There was an entry for omeprazole 20mg take on capsule twice daily 30 minutes before breakfast and dinner with a scheduled administration time of 7:30am and 5:30pm.
-There was documentation that omeprazole was administered at 7:30am.

Interview with the MA on 04/15/26 at 9:30am revealed:
-She was aware that omeprazole was to be administered before breakfast.
-The omeprazole was scheduled with the morning medication pass.
-The time the omeprazole was administered should be changed so that third shift could administer the omeprazole.
-She had not spoken to anyone in management about changing the time of administration for omeprazole to third shift.

Telephone interview with a representative from the facility's contracted pharmacy on 04/15/26 at 12:36pm revealed:
-Resident #7 had an order for omeprazole 20mg take on capsule twice daily 30 minutes before breakfast and dinner.
-Omeprazole was used to reduce the acid in the stomach.
-If omeprazole was administered with food it would reduce the effectiveness of the medication.

2. Review of Resident #7's signed physician orders dated 01/06/26 revealed there was an order for sucralfate 1 gram take ½ tablet before meals and at bedtime.
Observation of the morning medication pass on 04/15/26 at 8:08am revealed:
-Resident #7 was sitting in the dining room eating breakfast.
-The MA removed Resident #7's multi-dose pack

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R-C 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

(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 358	Continued From page 12	D 358		

from the medication cart that contained 6 pills and prepared the 6 medications for administration.
-The MA removed a second multi-dose pack for Resident #7 from the medication cart that contained ½ tablet of sucralfate and prepared the medication for administration.
-The MA entered the dining room and administered the pills to Resident #7.
-Resident #7 had consumed ½ of her breakfast when the sucralfate was administered.

Review of Resident #6's April 2026 eMAR for 04/15/26 revealed:
-There was an entry for sucralfate 1mg take ½ tablet before meals and at bedtime with a schedule administration time of 7:00am, 11:00am, 4:00pm, and 9:00pm.
-There was documentation sucralfate was administered at 7:00am.

Interview with the MA on 04/15/26 at 9:30am revealed:
-She was aware that sucralfate was to be administered before breakfast.
-The sucralfate was scheduled to be administered at 7:00am.
-Sometimes the third shift MA administered the medication and sometimes 1st shift administered the medication.
-If the third shift MA did not administer the sucralfate, she administered the medication.
-She had not spoken to anyone in management about the medication being administered on first shift at times.

Telephone interview with a representative from the facility's contracted pharmacy on 04/15/26 at 12:36pm revealed:
-Resident #7 had an order for sucralfate 1 gram

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R-C 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

(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 358	Continued From page 13	D 358		

take ½ tablet before meals and at bedtime.
-Sucralfate was used to coat the stomach to decrease discomfort of the stomach lining.
-If sucralfate was given with food it would reduce the effectiveness of the medication.

Interview with the Administrator on 04/15/26 at 10:36am revealed:
-Resident #7's medications should be administered on an empty stomach as ordered.
-The MAs had not spoken to her about the administration time of the medications and that the times of administration needed to be changed so the Resident #7 would receive the medications before breakfast.

Attempted telephone interview with Resident #'s Primary Care Provider (PCP) on 04/15/26 at 10:27am was unsuccessful.

Based on observations, interviews, and record reviews it was determined Resident #7 was not interviewable.
2. Review Resident #1's FL2 dated 03/18/25 revealed diagnoses included dementia, major depressive disorder, pulmonary embolism and low back pain.

Review of Resident #1's signed physician's orders dated 03/18/25 revealed an order for cholecalciferol (Vitamin D3) 1,250mcg (50,000 unit) twice monthly.

Review of Resident #1's laboratory results revealed there was no Vitamin D levels available for review.

Review of Resident #1's March 2026 electronic medication administration record (eMAR) revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL017054	A. BUILDING: _____ B. WING _____	R-C 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

(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 358	Continued From page 14	D 358		

-There was an entry for cholecalciferol (Vitamin D3) 250mcg (50,000 unit) take 1 capsule every 15 days.
-There was documentation cholecalciferol was administered on 03/01/26 and 03/15/26.

Review of Resident #1's April 2026 eMAR revealed:
-There was an entry for cholecalciferol (Vitamin D) 1,250mcg (50,000 unit) take 1 capsule every 15 days.
-There was documentation cholecalciferol was administered on 04/01/26 and 04/15/26.

Observation of Resident #1's medications on hand on 4/15/26 at 2:46pm revealed there was no cholecalciferol available for administration.

Telephone interview with the pharmacist from the facility's contracted pharmacy on 04/14/26 at 3:27pm revealed:
-Resident #1's order for cholecalciferol (Vitamin D) 1,250mcg was ordered to be given the 1st and 15th of each month.
-Cholecalciferol was last dispensed 01/14/26.
-The cholecalciferol order was entered on the eMAR to be reordered 3 days prior to the medication running out because the medication was not on cycle-fill.

Interview with a medication aide (MA) on 04/15/26 at 8:45am revealed:
-She documented cholecalciferol as administered on 04/01/26.
-She did not remember if cholecalciferol was a stock medication or if it came pre-packaged from the pharmacy.
-She usually administered the 8:00am medications.
-The process for ordering medications was the

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D 358	Continued From page 15	D 358		

responsibility of all the MAs.
-Medication cart audits were done on Tuesdays, Wednesdays and Thursdays.
-The MAs were given a random list of residents to check the carts for the medications.
-To document a medication as administered, she had to individually select each medication and click her initials that the medication was given
-The Resident Care Coordinator (RCC), looked at the eMARs weekly to make sure they were correct.

Interview with Resident #1 on 04/15/26 at 10:55am revealed he did not know the name of any of the medications he received.

Interview with another MA on 04/15/26 at 11:03am revealed:
-She documented on the eMAR that she administered cholecalciferol to Resident #1 on 03/01/26 and 03/15/26.
-Her initials on the eMAR documenting cholecalciferol as administered to Resident #1 on 04/15/26 was a mistake; she did not give the medication because it was not in the medication bubble pack.
-The medication carts were audited Tuesday, Wednesday and Thursday from a random list given to the MAs on all shifts.
-The expectation was for the MA to call the pharmacy if the medication was missing, then to let the doctor know the medication was missing and inform the RCC and the Administrator.

Interview with the RCC on 04/15/26 at 11:10am revealed:
-The cholecalciferol for Resident #1 should come in the daily pre-packaged bubbled medication pack with the other medications from the pharmacy.

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D 358	Continued From page 16 -The medications came from the pharmacy weekly, one week ahead of the delivery date. -She audited the eMAR weekly. -She double checked the physician orders against the medications. -If the medication was not on the cart, she would call the pharmacy to inquire. -The MA did not tell her the cholecalciferol was not on the cart. -The expectation was the MA would call the pharmacy first if the medication was missing. Interview with the Administrator on 04/15/26 at 10:00am revealed: -Resident #1's cholecalciferol was discontinued on 04/15/26 at 8:50am by the primary care provider (PCP) due to an issue with Resident #1's insurance. -The Administrator stated she informed the MA not to document the medication as given for 4/15/26.	D 358		