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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey with a complaint investigation from 04/28/26 to 04/30/26.	D 000		
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. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the automatic sprinkler system was maintained in a safe and operating condition, and the fire doors remained closed in the Assisted Living (AL) when the automatic sprinkler system was not in service. The findings are: Review of the facility's undated policy for Fire Watch Procedures revealed: -Short term, emergency measures should be implemented to provide an acceptable level of life safety in the facility when a fire safety system was inoperable. -This allowed for continued occupancy of the	D 105		

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facility until appropriate repairs or changes to the fire safety system could be completed.
-Staff were to ensure all facility fire doors remained closed.

Review of the facility's census on 04/28/26 revealed the census was 71 with 35 residents residing in the AL.

Observation of the 100-hallway and 200-hallway on 04/28/26 from 8:23am to 8:55am revealed:
-The fire doors were tied to the handrail on the wall with a plastic trash bag to keep the fire doors open.
-The magnetic locks on the fire doors were not secured to the magnet on the wall.

Review of a fire inspection report dated 11/24/25 revealed:
-There was one dry system and one backflow inspected and tested on 11/24/25.
-The dry system and backflow failed the inspection and testing.

Review of the Fire Department call log for the facility from 05/09/25 to 04/25/26 revealed:
-The fire department was called 15 times during this timeframe.
-Seven of the fifteen calls were related to the water valve.

Interview with the Fire Marshal on 04/29/26 at 10:10am revealed:
-The sprinkler system had been out of service and the facility placed on fire watch multiple times this year.
-The facility was responsible for maintaining a sprinkler system that worked.
-The fire department was called to the facility multiple times over the past year.

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-The fire department was called to the facility most recently in the early morning on 04/26/26.
-The facility was placed on a fire watch at that time.
-He was visiting the facility today with the fire inspector, because he thought they were still on a fire watch.
-He had not been notified by the facility that the sprinkler system had been reset.
-He could not reset the sprinkler system.
-He asked the Administrator to notify him with the sprinkler system had been reset.
-He was ready to evacuate the building of all residents because of what appeared to be the lack of concern related to a working sprinkler system and the multiple times the Fire Department had been called related to the sprinkler system alarming.

Interview with the Fire Inspector on 04/29/26 at 10:10am revealed:
-The fire doors should not be tied open for any reason.
-The fire doors should be latched when they were closed.
-The magnetic locks on the fire doors did not work when the sprinkler system was not in service.
-When the sprinkler system was not in service the fire doors should remain closed to prevent the spread of fire if a fire occurred.
-If a fire occurred when the fire doors were tied to the handrails, the fire doors would not close, allowing the fire to spread.
-The fire doors should only be opened if they were secured with the magnetic lock.
-The issue with the sprinkler system was an easy fix.

Interview with the facility's environmental services

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technician on 04/28/26 at 1:45pm revealed:
-He knew the fire doors were tied to the handrails when the sprinkler system was not in service.
-He did not know who tied the fire doors to the handrails.
-He did not know if the fire doors could be tied to the handrails when the sprinkler system was not in service.
-He did not instruct the staff to tie the fire doors to the handrails when the sprinkler system was not in service.
-The facility had a problem with the sprinkler system that month, April 2026.
-The sprinkler system was out of service three times that month, April 2026.
-The sprinkler system would automatically alarm and be out of service.
-It was like a fire drill; the firemen responded, the fire doors would automatically close, and the staff would account for the residents.
-The facility staff were on fire watch when the sprinkler system was not in service until the automatic sprinkler system was reset.
-A representative from the sprinkler system company would come within 1 to 2 days of the system being out of service to reset it.
-The firemen instructed the staff on fire watch to walk the affected areas every 30 minutes, in this case it was the AL, and look for water damage, smoke, and fire.
-The staff were given monitoring sheets by the firemen to complete during the time they were on fire watch.

Interview with a medication aide (MA) on 04/28/26 at 2:35pm revealed:
-She did not notice the fire doors being tied to the handrail that morning, 04/28/26, when she came to work.
-She did not know who tied the fire doors to the

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D 105	Continued From page 4 handrails. Telephone interview with a second MA on 04/29/26 at 8:31am revealed: -She worked the night when the sprinkler system alarmed and was out of service; she thought it was early Friday morning, 04/24/26. -The fire doors would not stay open when the sprinkler system out of service. -The residents who used walkers and wheelchairs were having problems getting through the doorway with the fire doors closed. -She tied the fire doors to the handrails so the fire doors would stay open to keep the residents safe from falling while they moved about the facility. -She did not know when the sprinkler system was reset or when the fire doors were untied. -The staff was on fire watch when the sprinkler system was not in service. -The fire department told the staff to check the halls every 30 minutes and make sure there were no fires. -The staff completed fire watch logs until the sprinkler system was reset. Interview with a third MA on 04/29/26 at 1:15pm revealed: -The fire doors were tied to the handrails in the AL the weekend of 04/25/26 and 04/26/26. -She did not know who tied the fire doors to the handrails. -The doors stayed tied to the handrails all weekend. -It was reported that the sprinkler system alarmed in the early morning hours of Saturday, 04/25/26. -The staff were on fire watch throughout the weekend of 04/25/26 and 04/26/26. Interview with the Dietary Manager (DM) on 04/29/26 at 1:30pm revealed:	D 105		

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-He was the manager on call the weekend of 04/25/26 and 04/26/26.
-He was in the facility for 4 to 6 hours each day over the weekend.
-He was available to the staff if any issues arose that they needed assistance with.
-He did not walk down the 100 and 200-hallways in the AL.
-He walked to the workstation and spoke to the staff; he did not notice the fire doors in the hallways tied to the handrails.
-The facility was not on fire watch during the weekend of 04/25/26 and 04/26/26.
-He did not know why the fire doors would be tied to the handrails and he did not know who tied the fire doors to the handrails.

Interview with the Resident Care Coordinator (RCC) on 04/29/26 at 9:19am revealed:
-She did not see the fire doors tied to the handrails the morning of 04/28/26, when she came to work.
-She had never seen the fire doors tied to the handrails.
-The fire doors should never be tied to stay open; they stayed open with the magnetic lock.
-The fire doors should stay closed until the sprinkler system was reset.
-She had not noticed the fire doors closed at any time.
-When the sprinkler system alarmed, it was like having a fire drill.
-Staff had called her during the night when the sprinkler system was not in service and the alarms sounded.
-She instructed the staff to call the Administrator for guidance.
-She thought the Fire Marshal would reset the sprinkler system.
-The staff were responsible for resetting the fire

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doors and securing them to the magnetic locks after the sprinkler system was reset.
-If the sprinkler system was reset and the fire doors were tied to the handrails, the fire doors would not have closed had there been a fire.
-The staff were instructed to do a fire watch by the Fire Marshal until the sprinkler system was reset.
-The facility's environmental services technician would tell the MAs when the fire watch was to be done, what to do, and when to stop.
-She knew the sprinkler system was out of service twice in the last two weeks; she was not sure about any other time.

Telephone interview with a representative from the facility's contracted sprinkler system company on 04/29/26 at 9:53am revealed:
-The sprinkler system company received a telephone call on 04/24/26 and 04/27/26 that the sprinkler system alarmed in the early morning hours and the system needed to be reset.
-A representative from the company went to the facility to reset the sprinkler system on 04/24/26 and 04/27/26.
-It was determined that a valve was malfunctioning and needed to be replaced.
-He thought the company was working on a quote to send to the facility regarding the cost of the valve and work to replace the valve.

Telephone interview with a second representative from the facility's contracted sprinkler system company on 04/29/26 at 12:13pm revealed:
-He was notified on 04/13/26 that the sprinkler system needed to be reset.
-The sprinkler system was reset on 04/16/26.
-He did not find the cause on 04/16/26 as to why the sprinkler system was out of service.
-There was no leak in the system that would have

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caused the problem.
-He was notified again on 04/24/26 that the sprinkle system was not in service.
-He provided service the same day and found a problem with a valve.
-Before he could get a quote together for the facility, the sprinkler system was out of service again in the early morning of 04/27/26; he reset the sprinkler system the same day.
-He was scheduled to be at the facility on Thursday, 04/30/26, to initiate the sprinkler repair and it should be completed on Friday 05/01/26.

Review of the work acknowledgement from the sprinkler system company dated 04/27/26 revealed:
-There was a service call to reset both dry systems.
-System 1 tripped due to an open air connection to the already tripped system 2.
-System 2 might have had a problem with the dry pipe valve.
-The accelerator was isolated to determine which component was failing.
-A quote to replace the dry pipe valve had been issued and approved.

Review of an email dated 04/29/26 revealed:
-The licensed contractor would be onsite Thursday, 04/30/26, with materials to start the automatic sprinkler system repair.
-The date of completion was planned for 05/01/26 and to return the system back to normal.

Interview with the Administrator on 04/28/26 at 3:30pm revealed:
-She did not know the fire doors were tied to the handrail on Tuesday morning, 04/28/26.
-The sprinkler system was reset on Monday afternoon, 04/27/26, before 5:00pm.

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D 105	Continued From page 8 -She made rounds before she left the facility on Monday evening, 04/27/26, and the fire doors were opened and secured with the magnetic locks. -She did not know who disengaged the fire doors from the magnetic locks or who tied the fire doors to the handrails with trash bags. -Fire doors should never be tied open for any reason. -She expected the staff to call her if the fire doors would not stay open with the magnetic locks. -The sprinkler system was out of service three times that month, 04/12/26, 04/23/26, and 04/26/26. -A representative from the sprinkler system company came to the facility to reset the system. -She knew the representative from the sprinkler system company came on Friday, 04/24/26, and again on 04/27/26 to reset the system. -She thought the environmental services technician instructed the staff on a fire watch. -She did not know what the staff were told to do during a fire watch, but she knew the staff did a fire watch until the sprinkler system was reset; the staff completed fire watch logs. Attempted telephone interview with a previous fire protection company related to an inspection dated 11/24/25 on 04/30/26 at 2:23pm was unsuccessful. _____ The facility failed to ensure the fire doors remained closed when the sprinkler system was not in service, placing the residents at risk for harm in the event of a fire. Tying open the fire doors would allow a fire to spread throughout the facility beyond the fire doors, instead of containing the fire behind the fire doors. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B	D 105		

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D 105	Continued From page 9 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/29/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 14, 2026.	D 105		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: FOLLOW-UP TO UNABATED TYPE B VIOLATION Based on these findings, the previous Unabated Type B violation was not abated. Based on record reviews and interviews, the facility failed to ensure the minimum number of staff were present at all times to meet the needs of residents residing in the Special Care Unit (SCU) for 7 of 18 shifts sampled from 03/27/26 to 04/05/26. The findings are:	D 465		

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D 465	Continued From page 10 Review of the facility's 2026 license from the Division of Health Service Regulation revealed the facility was licensed for a SCU with a capacity of 48 beds. Review of the SCU census dated 04/03/26-04/05/26 revealed a census of 39 residents, requiring 39 aide hours on first and second shift and 31.2 aide hours on third shift. Review of the Employee time cards dated 04/03/26 revealed there were 31.5 aide hours provided on the first shift, leaving the shift short 7.5 aide hours. Review of the Employee time cards dated 04/04/26 revealed: -There were 23.75 aide hours provided on the first shift, leaving the shift short 15.25 aide hours. -There were 24.5 aide hours provided on the second shift, leaving the shift short 14.5 aide hours. -There were 16 aide hours provided on the third shift, leaving the shift short 15.2 aide hours. Review of the Employee time cards dated 04/05/26 revealed: -There were 27.5 aide hours provided on the first shift, leaving the shift short 11.5 aide hours. -There were 24.75 aide hours provided on the second shift, leaving the shift short 14.25 aide hours. -There were 18 aide hours provided on the third shift, leaving the shift short 13.2 aide hours. Interview with a personal care aide (PCA) on 04/29/26 at 10:02am revealed: -There were 3 PCAs and a medication aide (MA) on first and second shift, and 2 PCAs and a MA	D 465		

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on third shift.
-The SCU was short staffed on the weekends because of "call-outs."
-Staff complained to the Special Care Unit Coordinator (SCC) about the unit being short staffed.

Interview with another PCA on 04/29/26 at 10:12am revealed:
-There were 4 PCAs and a MA on first and second shift, and 2 PCAs and a MA on third shift.
-The SCU was sometimes short staffed during the weekends because staff would "call out."
-It took her longer to provide personal care to the residents when the SCU was short staffed.

Interview with a MA on 04/29/26 at 10:19am revealed:
-There were 4 PCAs and a MA on first and second shift, and 3 PCAs and a MA on third shift.
-The SCU was not always fully staffed on the weekends due to a lot of "call outs."
-There would be 2 PCAs on each shift.
-She would work on the floor after passing medications to provide care to residents when they were short staffed.

Interview with the SCC on 04/29/26 at 10:34am revealed:
-She was responsible for scheduling staff to work in the SCU.
-The Resident Care Coordinator (RCC) was responsible for scheduling staff from 04/03/26 to 04/05/26 because she was not working.
-She scheduled 4 PCAs and a MA on first and second shift, and 3 PCAs and a MA on third shift.
-The SCU schedule was fully staffed but staff would "call out" causing the unit to be short staffed.
-She would ask staff to come in to work or ask

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staff to work overtime.
-Staff complained in the past about being short staff but not currently.

Interview with the RCC on 04/29/26 at 10:50am revealed:
-She was responsible for scheduling staff in the SCU from 04/03/26 to 04/05/26.
-She scheduled 4 PCAs and a MA on first and second shift, and 3 PCAs and a MA on third shift.
-The SCU was short staffed because there were a lot of "call outs."
-When the SCU was short staffed, she would send a PCA from the Assisted Living (AL) to work the full shift in the SCU.

Interview with the Administrator on 04/29/26 at 11:02am revealed:
-The SCC was responsible for scheduling staff to work in the SCU.
-The SCC scheduled 4 PCAs and a MA on first and second shift, and 3 PCAs and a MA on third shift.
-There were a lot of "call outs" from 04/03/26 to 04/05/26.
-The SCC made her aware when there were "call outs."
-The SCC would try to find another staff member to come in.
-There was always a Manager on Duty scheduled to work weekends.
-Some of the Managers on Duty were not able to provide personal care to the residents because they had not been trained.

Attempted telephone interview with a resident's responsible party on 04/29/26 at 9:56am was unsuccessful.

Attempted telephone interview with another

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 465	Continued From page 13 resident's responsible party on 04/29/26 at 11:42am was unsuccessful. _____ The facility failed to ensure the minimum number of staff were present at all times on all three shifts to meet the needs of residents residing in the SCU for 7 of 18 shifts sampled over 6 days from 03/27/26 to 04/05/26. The facility's failure to provide sufficient staffing in the SCU was detrimental to the health, safety, and welfare of the residents and constitutes a Continuing Unabated Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/29/26 for this violation.	D 465		
D 510	10A NCAC 13F .0309 (q) Fire Safety and Emergency Preparedness Plans 10A NCAC 13F .0309 Fire Safety and Emergency Preparedness Plans (q) Where a fire alarm or automatic sprinkler system is out of service, the facility shall immediately notify the fire department, the fire marshal, and the Division of Health Service Regulation Construction Section and, where required by the fire marshal, a fire watch shall be conducted until the impaired system has been returned to service as approved by the fire marshal. The facility will adhere to the instructions provided by the fire marshal related to the duties of staff performing the fire watch. The facility will maintain documentation of fire watch activities which shall be made available upon request to the DHSR Construction Section and fire marshal. The facility shall notify the DHSR Construction Section when the facility is no longer conducting	D 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R-C 04/30/2026

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D 510	Continued From page 14 a fire watch as directed by the fire marshal. 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 interviews, observations, and record reviews, the facility failed to immediately notify the Division of Health Service Regulation (DHSR) Construction Section and the Fire Marshal regarding the facility's automatic sprinkler system being out of service in the Assisted Living (AL). The findings are: Review of the facility's current license effective 01/01/26 revealed the capacity was 46 residents in the AL. Review of the facility's undated policy for Fire Watch Procedures revealed: -The facility would contact DHSR to notify them of the situation (the automatic sprinkler system being out of service) and what actions were being taken to correct the situation. -Once the sprinkler system had been reset and was functioning properly, notify the local fire department and the district Fire Marshal. Observation of the 100-hallway and 200-hallway on 04/28/26 from 8:23am to 8:55am revealed: -The fire doors were tied to the handrail on the wall with a plastic trash bag to keep the fire doors open. -The magnetic locks on the fire doors were not secured to the magnet on the wall. Telephone interview with a representative from	D 510		

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D 510	Continued From page 15	D 510		

the facilty's contracted sprinkler system company on 04/29/26 at 12:13pm revealed:
-He was notified on 04/13/26 that the sprinkler system needed to be reset.
-The system was reset on 04/16/26.
-He did not find the cause of why the sprinkler system was out of service on 04/16/26.
-There were no leaks in the sprinkler system that would have caused the system to be out of service on 04/13/26.
-He was notified on 04/24/26 that the sprinkler system was not in service again.
-He preset the sprinkler system the same day and found a problem with a valve.
-Before he could get a quote together for the facility, the sprinkler system went out of service again in the early morning of 04/27/26; he reset the system the same day.
-He was scheduled to be at the facility on Thursday, 04/30/26, to initiate the sprinkler system repair and complete the repair on Friday, 05/01/26.

Interview with the Fire Marshal on 04/29/26 at 10:10am revealed:
-The sprinkler system had been out of service and the facility placed on fire watch multiple times in the past 12 months.
-The facility was responsible for maintaining an sprinkler system that worked.
-The fire department was called to the faciliy most recently in the early morning on 04/26/26.
-The facility was placed on a fire watch at that time.
-He was visiting the facility today because he thought the facility was still on fire watch.

Interview with the Administrator on 04/28/26 at 3:30pm revealed:
-The sprinkler system was out of service three

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D 510	Continued From page 16 times that month, 04/13/26, 04/23/26, and 04/26/26. -She did not notify the construction section at DHSR about the sprinkler system being out of service. -She did not know that the construction section at DHSR needed to be notified. -She did not call the Fire Marshal when the sprinkler system was reset on Monday, 04/27/26. -She knew she should call the Fire Marshal, but she forgot.	D 510		