STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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TERRABELLA SHELBY	1550 CHARLES ROAD SHELBY, NC 28152

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D 000	Initial Comments The Adult Care Licensure Section and the Cleveland County Department of Social Services conducted an annual survey, a follow-up, and complaint investigations from May 5, 2026 to May 7, 2026.	D 000		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that 1 of 3 sampled (Staff B) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) completed upon hire. The findings are: Review of Staff B's medication aide (MA) personnel record revealed: -Staff B was hired on 09/30/25 as a MA. -There was no documentation a HCPR check was completed prior to hire. Review of staff schedules revealed Staff B worked as a MA on the Special Care Unit (SCU) from 05/05/26 to 05/07/26 (6:00am to 6:00pm). Interview with Staff B on 05/06/26 at 4:40pm revealed she worked on the assisted living unit and the SCU as a MA for the past nine months.	D 137		

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D 137	Continued From page 1 Interview with the Business Office Manager (BOM) on 05/07/26 at 5:15pm revealed: -She was responsible for ensuring personnel files were complete with the required qualifications. -She did not know Staff B's HCPR was missing from her personnel record. -She remembered running Staff B's HCPR upon hire but could not locate it at time of the survey. -She produced another HCPR that had no findings listed and placed it on Staff B's personnel record. -She expected all personnel files to be accurate and complete. Interview with the Administrator on 05/07/26 at 5:40pm revealed: -The BOM was responsible for completing HCPR for staff on their hire date. -She and the BOM were responsible for auditing staff files to ensure certifications and trainings were up to date and she did not know why Staff B's file was not identified as needing a HCPR. -She expected all personnel files to be completed with documents such as the HCPR. Review of a HCPR check for Staff B revealed it was dated 05/07/26 and there were no substantiated findings.	D 137		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified	D 234		

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D 234	Continued From page 2 in 10A NCAC 41A .0205 including subsequent amendments and editions. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure 2 of 5 sampled residents (#2 and #4) were tested for tuberculosis (TB) disease in compliance with the guidelines from the Commission for Public Health. The findings are: 1.Review of Resident #2's current FL2 dated 04/7/25 revealed: -Diagnoses included dementia, hypertension, heart valve disease and insomnia. -Resident #2's level of care was Special Care Unit (SCU). Review of Resident #2's Resident Register revealed an admission date of 04/09/25. Review of Resident #2's record on 05/05/26 revealed: -There was documentation a TB test was completed for Resident #2 on 04/05/25. -There was no documentation a second TB test was completed for Resident #2. Refer to interview with the Resident Care Coordinator (RCC) on 05/07/26 at 10:04am. Refer to interview with the Administrator on 05/07/26 at 5:40pm.	D 234		

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D 234	Continued From page 3 2. Review of Resident #4's current FL2 dated 04/27/26 revealed diagnoses included protein calorie malnutrition, Parkinson's disease, macular degeneration, acid reflux, and idiopathic neuropathy. Review of Resident #4's Resident Register revealed an admission date of 06/19/25. Review of Resident #4's record on 05/05/26 revealed: -There was documentation a TB test was completed for Resident #4 on 06/18/25. -There was no documentation a second TB test was completed for Resident #4. Refer to interview with the RCC on 05/07/26 at 10:04am. Refer to interview with the Administrator on 05/07/26 at 5:40pm. _____ Interview with the RCC on 05/07/26 at 10:04am revealed: -Resident #2's first TB test was completed before her admission date of 04/09/25. -There was no documentation Resident #2 completed a second TB test after she was admitted. -The former Health & Wellness Director (HWD) was responsible for ensuring TB tests were completed and the results were placed in resident records. -She could not locate Resident #2 and #4's second TB test results. Interview with the Administrator on 05/07/26 at 5:40pm revealed the former HWD was	D 234		

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D 234	Continued From page 4 responsible for ensuring the residents who needed a second TB test received one within 14 days after their admission assessment was completed.	D 234		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow-up for 2 of 5 sampled residents (#2 and #3) related to reporting a toe injury, missed doses of a medication to treat an infection in her toe and arm and dressing changes that were not completed (#2), and reporting an injury to right upper arm (#3) to Primary Care Provider (PCP) for treatment recommendations. 1. Review of Resident #2's current FL2 dated 05/05/26 revealed: -Diagnoses included dementia and hypertension. -She was constantly disoriented. -Her level of care was Special Care Unit (SCU). a. Review of Resident #2's signed physician's order dated 11/14/26 revealed an order for cephalexin (a medication used to treat infection) 500mg, three times a day for ten days. Review of Resident #2's signed physician's order dated 11/19/26 revealed an order to stop the	D 273		

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cephalexin once the minocycline (a medication used to treat infection) arrived and administer minocycline 100mg, two times a day for ten days.

Review of Resident #2's November 2025 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for cephalexin 500mg, three times a day for ten days at 8:00am, 2:00pm and 8:00pm, with no start or completion date.
-On 11/14/25 cephalexin was documented as administered at 2:00pm and refused at 8:00pm.
-On 11/15/25 to 11/19/25 cephalexin was documented as administered at 8:00am, 2:00pm and 8:00pm.
-On 11/20/25 cephalexin was documented as administered at 8:00am and 2:00pm when it should have been discontinued and minocycline 100mg two times daily started.
-On 11/21/25 to 11/22/25 cephalexin was documented as administered at 8:00am, 2:00pm and 8:00pm and should not have been.
-On 11/23/25 cephalexin was documented as administered at 8:00am and 8:00pm and should not have been.
-Cephalexin 500mg was documented administered on 10 of 30 opportunities that it should not have been.
-There was no entry or documentation the minocycline was administered after the 11/19/25 order was received.

Review of Resident #2's staff progress notes revealed:
-On 11/11/25 at 5:45am, the resident's right big toenail was green in color and resident yelled out in pain when touched.
-On 11/13/25 at 5:00pm, the resident's family member took her to a doctor's appointment to check on her toe and an x-ray was done at the

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office, awaiting results.
-On 11/14/25 at 4:15pm, the resident received a new order for an antibiotic for her toe.
-On 11/18/25 at 5:30pm, the resident's foot was swollen and was on an antibiotic.
-On 11/19/25 at 4:45pm, the resident was on an antibiotic, there were no issues or concerns and the foot was still swollen and red.

Telephone interview with Resident #2's power of attorney (POA) on 05/05/26 at 10:38am revealed:
-A medication aide (MA) asked her if she was told about an injury to Resident #2's toe on an unknown date.
-The MA did not know what had happened to Resident #2's toe, just that it was purplish, black in color and was painful to the touch.
-She took the resident to her doctor's office where the resident received an x-ray and an order for an antibiotic.

Telephone interview with Resident #2's PCP on 05/06/26 at 12:11pm revealed:
-On 11/13/25, according to the office records, Resident #2 was seen by another Nurse Practitioner (NP) at her office for possible trauma injury to her right toe.
-The other NP ordered a foot x-ray because there was slight swelling to the right foot.
-She should have been notified when the injury was first noticed because resident #2 was not seen in her office until a few days later which resulted in a delay of treatment.
-Resident #2 was seen at the PCP's office on 11/19/25 due to redness, swelling and cellulitis (a serious bacterial skin infection) to Resident #2's right foot.
-An order was written for the facility to check Resident #2's temperature twice daily for seven days, stop cephalexin once minocycline arrived

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and start minocycline 100 mg twice daily for 10 days, force fluids, and elevate legs.
-She expected the facility to give medications as ordered to help prevent worsening of symptoms and infection and/or buildup of resistance of cephalexin.
-The facility did not notify her that Resident #2 never received minocycline.

Telephone interview with a MA on 05/06/26 at 5:15pm revealed:
-She documented on 11/11/25 Resident #2's right big toenail was green in color and that the resident yelled out when touched.
-She did not notify the former SCC or former Health and Wellness Director (HWD).
-She documented Resident #2's right toenail on the 24-hour shift report sheet and reported it to the day shift MA before she left.
-The former SCC and former HWD were responsible to review the 24-hour shift report every day and call the PCP when needed.

Telephone Interview with the former SCC on 05/07/26 at 8:54am revealed:
-On 11/11/25, a MA told her that Resident #2's right toe was green.
-She looked at it and did not know if it was a fungal infection or from an injury, so she did not notify the PCP, Resident #2's POA or send Resident out for an evaluation.
-On 11/13/26, after a MA informed Resident #2's POA about the toe, Resident #2's POA made an appointment and took Resident #2 to the PCP to have the toe looked at.
-She did not notify Resident #2's PCP because Resident #2 had an outside PCP Resident #2's POA handled all appointments.
-Resident #2's POA brought back orders for cephalexin 500mg, three times a day for ten

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days.
-On 11/19/25, Resident #2 was seen by PCP because the toe was getting worse.
-She did not call Resident #2's PCP again, Resident #2's POA did.
-She did not remember what happed with the minocycline orders, only that the minocycline was not administered.
-She was responsible to notify the PCP when there was an issue with a resident and when medications were not administered as ordered but she did not with Resident #2.

Interview with the RCC on 05/07/26 at 10:04am revealed:
-The former HWD was responsible to notify Resident #2's PCP when her toe was green in color on 11/11/25.
-The former HWD was responsible to notify Resident #2's PCP when the cephalexin was not stopped and the minocycline was not started on 11/19/25.

Interview with the Administrator on 05/06/26 at 3:45pm revealed:
-The former HWD would have been responsible for notifying the PCP of Resident #2's toenail.
-The former SCC notified her in a standup meeting that Resident #2 may have an ingrown toenail that became infected.
-She did not remember the date of the stand up meeting.
-Resident #2's family member made her aware of infected right toe on 11/14/25.
-The MAs should have notified the former SCC or former HWD that Resident #2's foot was swollen.
-To her knowledge no one followed up with Resident #2's PCP about Resident #2's cephalexin not being stopped and the minocycline was not started.

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D 273	Continued From page 9 b. Review of Resident #2's Accident/Incident Report dated 01/04/26 revealed: -The Accident/Incident report was completed by the Administrator. -On 01/03/26 at 5:20am, Resident #2 was observed on the floor in front of her bed with a skin tear to her left elbow. -Resident #2 was transported to the local Emergency Department (ED) by family. Review of Resident #2's ED After Visit Summary dated 01/03/26 revealed: -Resident #2 was seen in the ED for a fall with a left elbow laceration. -Resident #2 received staples to the left elbow. -Resident #2 was to start taking cephalexin (used to treat an infection) 500mg by mouth, four times daily for five days. Review of Resident #2's staff progress note dated 01/03/26 at 5:45pm revealed: -Resident #2 returned from the ED with new medication orders. -Resident #2 had three staples in her left arm and bandage that needed to be changed daily. Telephone interview with a MA on 05/07/26 at 12:25pm revealed: -She only worked weekends. -On 01/03/26, when Resident #2 returned to the facility from the ED, there was an order for dressing changed to be completed daily. -Because it was a Saturday and because Resident #2's PCP was an outside physician, she was to slide all new orders under the former SCC office door for processing and Resident #2's POA brought in the cephalexin from the out pharmacy. -The former SCC was responsible to put the daily dressing change order on the eMAR for the MAs	D 273		

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to complete.
-On 01/04/26, she worked and did not see the dressing change on the eMAR to be completed.

Review of Resident #2's January 2026 eMAR revealed:
-There was an entry for cephalexin 500mg, four times a day at 9:00am, 1:00pm, 5:00pm and 9:00pm with no start or completion date.
-The cephalexin was documented as administered on 01/03/26 at 9:00pm and 01/04/26 through 01/07/26 at 9:00am, 1:00pm, 5:00pm and 9:00pm.
-There was no documentation the cephalexin was administered on 01/08/26 at 9:00am, 1:00pm and 5:00pm.
-There was no entry or documentation the dressing change was completed on Resident #2's elbow.

Telephone interview with a Pharmacist from Resident #2's pharmacy on 05/06/26 at 10:22am revealed:
-There was an order from the ED dated 01/03/26 for cephalexin 500mg four times a day for five days.
-On 01/03/26, there were 20, cephalexin 500mg capsules dispensed.
-If the cephalexin was not completed as ordered, Resident #2 could experience a recurrent infection or worsening of the infection due to the laceration.

Telephone interview with Resident #2's PCP on 05/06/26 at 12:11pm revealed:
-The facility did not notify her of Resident #2 not completing her ordered dose of cephalexin.
-She did not know daily dressing changes with vaseline for five days and apply telfa that was ordered by the ED Provider were not completed.

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-Not receiving medications as ordered and not completing daily dressing changes could increase risk of infection and delay healing.

Telephone interview with Resident #2's power of attorney (POA) on 05/05/26 at 10:38am revealed:
-On 01/03/26, Resident #2 went to the ED for a fall and a laceration to her left elbow.
-The ED physician ordered cephalexin 500mg, four times a day for five days.
-Resident #2 was to finish the cephalexin on 01/08/26 by 9:00pm.
-On 01/10/26, she visited Resident #2 and due to issues with the cephalexin not being administered correctly in the past, she asked the medication aide (MA) about the cephalexin.
-The MA showed her the bottle of cephalexin dated 01/03/26 and there were 3 red capsules remaining in the bottle that had not been administered.
-The MA at that time administered one and there were then 2 red capsules left in the bottle.

Review of two photos dated 01/10/26 revealed:
-On one photo, there was a medication bottle with Resident #2's name on it and labeled cephalexin 500mg, four times daily for 5 days, with a dispense date of 01/03/26.
-On the second photo there were two red capsules in the bottle.

Telephone interview with the former SCC on 05/07/26 at 8:54am revealed:
-On 01/03/26, she was aware Resident #2 went to the ED for a fall with a laceration to the elbow.
-There were orders for daily dressing changes to Resident #2's left elbow.
-She and the former HWD were responsible to put orders in the eMAR/electronic Treatment Administration Record (eTAR) system and

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because she was not sure about the dressing changes, she gave the ED orders for the daily dressing changes to the HWD because the former HWD was the nurse.
-She did not remember if the wound care and dressing changes were completed.

Interview with the RCC on 05/07/26 at 10:04am revealed:
-The former HWD was responsible to enter Resident #2's wound care and dressing changes into the eMAR/eTAR system for the MAs to complete.
-The former HWD was responsible to notify Resident #2's PCP when the wound care and dressing changes were not complete.
-The former HWD was responsible to notify Resident #2's PCP when the cephalexin was not administered as ordered.

Interview with the Administrator on 05/06/26 at 11:00am and at 3:45pm revealed:
-On 01/03/26, Resident #2 fell and was taken to the ED by Resident #2's POA.
-Resident #2 was given an order for cephalexin 500mg four times a day for five days.
-Resident #2's POA filled the cephalexin at an outside pharmacy and brought the cephalexin back to the facility on 01/03/26 according to the January 2026 eMAR.
-The MA working that shift when Resident #2 returned to the facility was responsible to fax the order for cephalexin to their contracted pharmacy.
-Their contracted pharmacy was responsible to enter the cephalexin order as "profile only" which then showed up on the January 2026 eMAR for administration by the MAs.
-The previous SCC and previous HWD were responsible to change the start date for the cephalexin based on when the cephalexin arrived

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TERRABELLA SHELBY	1550 CHARLES ROAD SHELBY, NC 28152

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at the facility and change the stop date so that Resident #2 received a full five days of the cephalexin.
-According to Resident #2's January 2026 eMAR, Resident #2 did not receive a full five days of the cephalexin.
-The former SCC and formed HWD was responsible to notify Resident #2's PCP that the cephalexin was not administered as ordered and not completed.
-The former HWD was responsible for ensuring a referral for home health dressing changes had been completed because she thought it was a dressing that was to be completed by a Registered Nurse.
-There was no documentation of a home health referral being made and "it did not look like it was done" and no one notified the PCP about the dressing changes not being completed.

2. Review of Resident #3's current FL2 dated 07/01/25 revealed:
-Diagnoses included dementia and lower extremity edema.
-He was constantly disoriented.
-His level of care was Special Care Unit (SCU).

Review of Resident #3's Resident Register revealed he was admitted to the facility on 03/03/25.

Telephone interview with Resident #3's family member on 03/11/26 at 3:00pm revealed:
-She visited the resident and noticed that he was lethargic and not himself.
-She asked the medication aide (MA) how he was doing, and the MA stated he was sleeping more than normal and not eating.
-The Primary Care Provider (PCP) was there at the time she visited the facility and she requested

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D 273	Continued From page 14 a visit. -The PCP visited Resident #3 and during the assessment the family member and the PCP observed a bandage on his upper right arm. -The family member was not aware of his right upper arm injury. -It took the PCP 15 minutes to remove the bandage and once removed, the resident's skin under the bandage was observed to be red and inflamed. -The family member immediately asked the Administrator and the former Health and Wellness Director (HWD) what happened, and they stated the wound occurred during the fall on 02/11/26. -The family member was only made aware the resident was pushed by another resident, fell, and sustained a wound to his left middle finger. -The family member immediately took Resident #3 to the emergency department (ED) for a wound assessment and ensure no sepsis was present. Review of Resident #3's Accident and Incident Report that was viewed on the Administrator's computer dated 02/11/26 revealed: -Resident #3 cut his left middle finger and right upper arm. -Resident #3's family member was notified on 02/12/26 at 8:15pm. -Resident #3's PCP was notified on 02/12/26 at 5:51pm. Review of Resident #3's ED after visit summary dated 02/18/26 revealed: -Reason for visit was documented for right upper arm cellulitis. -Keflex (used to treat an infection) 500mg, three times a day for 10 days was to be started.	D 273		

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D 273	Continued From page 15 Review of Resident #3's progress note dated 02/18/26 revealed: -Staff reported he was very sleepy. -While helping him to the bathroom, he complained that his right upper arm was hurting and there was bandage over a skin tear. -The wound had an odor and was red around the skin tear. -Keflex was ordered stat. -A family member took him to the local ED for an evaluation. -Under section titled treatment, cellulitis of the right upper extremity was documented. Interview with Resident #3's PCP on 05/06/26 at 3:57pm revealed: -She and a family member were in Resident #3's room on 02/18/26 when both discovered he had a large bandage on his right upper arm. -She did not know Resident #3 had sustained a skin tear to his right upper arm. -The facility reported the resident had been involved in an altercation on 02/11/26. -The facility did not report the skin tear or Resident #3's upper right arm or that the facility had applied a bandage. -If the facility had made her aware on the skin tear of Resident #3's upper right arm, she could have given orders for dressing changes. -She did not know how long the bandage was on Resident #3's upper right arm but after taking the bandage off, the area was red and inflamed. -She ordered daily dressing changes, however the facility stated they could not complete daily dressing changes. -Resident #3 needed daily dressing changes for about three days and she visited daily to change herself. -Resident #3 could have become septic without dressing changes or antibiotic treatment.	D 273		

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D 273	Continued From page 16 Interview with a personal care aide (PCA) on 05/07/26 at 3:04pm revealed: -She knew Resident #3 had a bandage on his right upper arm. -She was told by the MA to not let the bandage get wet. -She does not know if Resident #3's bandage had ever been changed. -The MAs normally initial and date any resident bandages. Interview with a MA on 05/07/26 at 2:55pm revealed: -She knew that Resident #3 had a bandage to his right upper arm. -She was never instructed to change the bandage because MAs could not complete dressing changes. -She did not know if Resident #3's bandage had been changed since 02/11/26 when the resident sustained the right upper arm injury. Interview with the former Special Care Coordinator (SCC) on 05/07/26 at 9:05am revealed: -She did not know Resident #3 sustained a skin tear to his right upper arm on 02/11/26. -The former HWD had placed a 4" by 4" bandage on Resident #3's right upper arm but did not report this to her. -The former HWD should have notified Resident #3's PCP. -She observed Resident #3's right upper arm after the PCP removed the 4" by 4" bandage. -Resident #3's upper right arm was really red. -She did not know if Resident #3 had received a new bandage since the former HWD had placed it on 02/11/26.	D 273		

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D 273	Continued From page 17 Interview with the Administrator on 05/07/26 at 11:18am revealed: -She was notified by the former HWD that Resident #3 was assaulted by another resident however after she investigated the incident, she determined the resident had fallen. -She notified Resident #3's family member the same afternoon the incident occurred but did not know about the resident having a bandage placed on his right upper arm. -There was no documentation of the facility placing a bandage on Resident #3's upper right arm. -There was no documentation the facility ever changed the resident's bandage. -There was no documentation of Resident #3 having a skin assessment. -The HWD and/or MA were responsible for documenting and notifying the PCP of any type of bandage placed on the resident and were responsible for completing a skin assessment. Attempted telephone interview with the former HWD on 05/07/26 at 9:43am was unsuccessful. _____ The facility failed to ensure referral and follow-up for Resident #2 related to an infected toenail that was not reported to the PCP when first noticed along with not starting the new antibiotic as ordered resulting in cellulitis of the foot, and not completing the antibiotic and daily dressing changes for an elbow wound (#2). The facility also failed to report that Resident #3 sustained a skin tear to his upper right arm where a bandage was placed and was not changed for seven days, causing a visit to the ED with antibiotic treatment for cellulitis (#3). This failure resulted in serious physical harm and neglect to the residents and constitutes a Type A1 Violation.	D 273		

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D 273	Continued From page 18 The facility provided a plan of protection in accordance with G.S. 131D-34 on May 7, 2026, for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 6, 2026	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the implementation of physician orders for 1 of 5 sampled residents related to orders for an antibiotic and daily dressing changes (#2). The findings are: Review of Resident #2's current FL2 dated 05/05/26 revealed: -Diagnoses included dementia and hypertension. -She was constantly disoriented. -Her level of care was Special Care Unit (SCU).	D 276		

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D 276	Continued From page 19 a. Review of Resident #2's signed physician's order dated 11/14/26 revealed an order for cephalexin (a medication used to treat infection) 500mg, three times a day for ten days. Review of Resident #2's signed physician's order dated 11/19/26 revealed an order to stop the cephalexin once the minocycline (a medication used to treat infection) arrives and administer minocycline 100mg, two times a day for ten days. Review of Resident #2's November 2025 electronic Medication Administration Record (eMAR) revealed: -There was an entry for cephalexin 500mg, three times a day for ten days at 8:00am, 2:00pm and 8:00pm with no start or completion date. -There was an entry for cephalexin 500mg, three times a day for ten days at 8:00am, 2:00pm and 8:00pm, with no start or completion date. -On 11/14/25 cephalexin was documented as administered at 2:00pm and refused at 8:00pm. -On 11/15/25 to 11/19/25 cephalexin was documented as administered at 8:00am, 2:00pm and 8:00pm. -On 11/20/25 cephalexin was documented as administered at 8:00am and 2:00pm when it should have been discontinued and minocycline 100mg two times daily started. -On 11/21/25 to 11/22/25 cephalexin was documented as administered at 8:00am, 2:00pm and 8:00pm and should not have been. -On 11/23/25 cephalexin was documented as administered at 8:00am and 8:00pm and should not have been. -Cephalexin 500mg was documented administered on 10 of 30 opportunities that it should not have been. -There was no entry or documentation the minocycline was administered after the 11/19/25	D 276		

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D 276	Continued From page 20 order was received. Review of Resident #2's staff progress notes revealed: -On 11/11/25 at 5:45am, the resident's right big toenail was green in color and resident yelled out in pain when touched. -On 11/13/25 at 5:00pm, the resident's family member took her to a doctor's appointment to check on her toe and an x-ray was done at the office, awaiting results. -On 11/14/25 at 4:15pm, there was a new order for an antibiotic for her toe. -On 11/18/25 at 5:30pm, the resident's foot was swollen and was on an antibiotic. -On 11/19/25 at 4:45pm, the resident was on an antibiotic, there were no issues or concerns and the foot was still swollen and red. Telephone interview with Resident #2's PCP on 05/06/26 at 12:11pm revealed: -On 11/13/25, according to the office records, Resident #2 was seen by another Nurse Practitioner (NP) at her office for possible trauma to her right toe. -Resident #2 was seen at the PCP's office on 11/19/25 due to redness, swelling and cellulitis to Resident #2's right foot. -An order was written for the facility to check Resident #2's temperature twice daily for seven days, stop cephalexin once minocycline arrived and start minocycline 100 mg twice daily for 10 days, force fluids, and elevate legs. -She expected the facility to give medications as ordered to help prevent worsening of symptoms and infection and/or buildup of resistance of cephalexin. Telephone Interview with the former SCC on 05/07/26 at 8:54am revealed:	D 276		

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-On 11/19/25, Resident #2 was seen by PCP because the toe was getting worse.
-Resident #2's POA was responsible to make sure the order for minocycline was sent to the pharmacy and brought to the facility because Resident #2 used an outside PCP.
-She and the former HWD were responsible to make sure the orders were on the eMAR as written.
-She did not remember what happened with the minocycline orders, only that the minocycline was not administered.

Interview with the Administrator on 05/06/26 at 3:45pm revealed the former SCC and former HWD were responsible to make sure Resident #2's order for the minocycline to start and the cephalexin stopped were implemented.

b. Review of Resident #2's Emergency Department (ED) After Visit Summary dated 01/03/26 revealed:
-Resident #2 was seen in the ED for a fall with a left elbow laceration.
-Resident #2 received staples to the left elbow.

Review of Resident #2's staff progress note dated 01/03/26 at 5:45pm revealed:
-Resident #2 returned from the ED with new medication orders.
-Resident #2 had three staples in her left arm and bandage that needed to be changed daily.

Telephone interview with a MA on 05/07/26 at 12:25pm revealed:
-She only worked weekends.
-On 01/03/26, when Resident #2 returned to the facility from the ED, there was an order for dressing changed to be completed daily.
-Because it was a Saturday, she was to slide all

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new orders under the former SCC office door for processing.
-On 01/04/26, she worked and did not see the dressing change on the eMAR to be completed.

Review of Resident #2's January 2026 eMAR revealed there was no entry or documentation the dressing change was completed on Resident #2's elbow.

Telephone interview with Resident #2's PCP on 05/06/26 at 12:11pm revealed:
-According to Resident #2's office notes, the ED ordered daily dressing changes with vaseline and apply telfa for five days.
-She did not know daily dressing changes with vaseline for five days and apply telfa that was ordered by the ED Provider were not completed.
-Not completing daily dressing changes could increase risk of infection and delay healing.

Telephone Interview with the former SCC on 05/07/26 at 8:54am revealed:
-On 01/03/26, she was aware Resident #2 went to the ED for a fall with a laceration to the elbow.
-There were orders for daily dressing changes to Resident #2's left elbow.
-She and the former HWD were responsible to put orders in the eMAR/eTAR system and because she was not sure about the dressing changes, she gave the ED orders for the daily dressing changes to the HWD because the former HWD was the nurse.
-She did not remember if the wound care and dressing changes were completed.

Interview with the RCC on 05/07/26 at 10:04am revealed the former HWD was responsible to enter Resident #2's wound care and dressing changes into the eMAR system for the MAs to

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D 276	Continued From page 23 complete. Interview with the Administrator on 05/06/26 at 3:45pm revealed the former HWD was responsible for ensuring a referral for home health dressing changes had been completed because she thought it was a dressing that was to be completed by a Registered Nurse.	D 276		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights 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. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to ensure residents possessions were secured in a lockable place when 1 of 5 sampled residents (#2) who had a diagnosis of dementia and staff failed to secure her dentures and they were lost. The findings are: Review of Resident #2's current FL2 dated 04/07/25 revealed: -Diagnoses included dementia, hypertension, heart valve disease and insomnia. -Resident #2 was constantly disoriented. -Resident #2's level of care was special care unit (SCU). Review of Resident #2's Resident Register	D 338		

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D 338	Continued From page 24 revealed an admission date of 04/09/25. Interview with the Administrator on 05/06/26 at 3:45pm revealed: -The policy was for the staff to remove all Special Care Unit (SCU) resident's dentures, place them in a container with a denture cleaning agent and place the container on the medication cart every night. -There was not a written policy but it was the policy and staff were trained to do that before starting work in the SCU. Interview with Resident #2's power of attorney (POA) on 05/05/26 at 10:38am revealed: -Resident #2's dentures went missing on 04/16/26 after a staff person wrapped them in tissue instead of placing them on the medication cart. -She was told the facility protocol was for staff to remove Resident #2's dentures from her mouth at night, place them on the medication cart for safekeeping, then place the dentures in Resident #2's mouth in the morning. -She took Resident #2 to the dentist to see about getting a new set of dentures and was told by the dental provider that Resident #2 could not be assessed for replacement dentures due to her disease progression that included her inability to follow commands and withstand the discomfort of fitting new dentures. -She was told by the Administrator that the facility was not responsible for replacing Resident #2's dentures due to facility policy related to lost property. Interview with a personal care aide (PCA) on 05/06/26 at 5:15pm revealed: -She was trained to remove Resident #2's dentures at night, place them in a container with	D 338		

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water on the medication cart until the morning.
-She did not know what happened to Resident #2's dentures the night they went missing on 04/16/26.

Interview with a second PCA on 05/07/26 at 3:08pm revealed:
-Resident #2 had upper dentures and no bottom teeth.
-Resident #2 could be combative and always had an issue when staff tried to remove the dentures at night and place the dentures in her mouth in the morning.
-She did not know what happened to Resident #2's dentures the night they went missing on 04/16/26.

Telephone interview with a third PCA on 05/07/26 at 3:45pm revelaed:
-She and another PCA were working with Resident #2 on 04/16/26.
-The other PCA wrapped Resident #2's denture in toilet paper and laid them on the TV stand in Resident #2's room while the two of them were toileting Resident #2.
-Resident #2 was combative.
-She told the other PCA to give the dentures to the MA once the MA came back on the hall.
-The PCAs were responsible to take all SCU resident's denture out and place them in a denture cup with a denture cleaning agent and give the dentures to the MA for the night.
-She did not check with the MA to see if that happened and she did not know what happened to the dentures.

Telephone interview with a fourth PCA on 05/07/26 at 4:01pm revealed:
-On 04/16/26, she found Resident #2's dentures on her bedroom floor, wrapped them in a napkin

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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
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and placed them on the television stand.
-She did not know what to do with them because she did not routinely work in the SCU and was helping that night when Resident #2's dentures went missing on 04/16/26.
-She was told by another PCA that Resident #2's dentures were supposed to be stored on the medication cart according to the facility's policy.
-She forgot about giving the dentures to the MA to place on the medication cart for safekeeping.

Interview with the previous Special Care Coordinator (SCC) on 05/07/26 at 8:54am revealed medication aides (MA) were responsible for placing Resident #2's dentures in a cup on the medication cart at night.

Interview with Resident #2's Primary Care Provider (PCP) on 05/06/26 12:11pm revealed lack of dentures in Resident #2's mouth could lead to malnutrition due to eating difficulties, long-term jawbone deformities and choking risks.

Interview with the Administrator on 05/06/26 at 3:45pm revealed:
-She made Resident #2's POA aware that the dentures were lost/ missing on 04/16/26.
-Staff reported Resident #2 took her dentures out and a PCA placed them on a dresser.
-Another PCA saw Resident #2's dentures in a cup on her bathroom sink.
-The entire staff searched through the dumpster, trash and laundry for the dentures to no avail.
-The facility had an "unwritten policy" for safe-keeping Resident #2's dentures by removing them at nights, placing them in a container of water on the medication cart and replacing the dentures in Resident #2's mouth each morning and staff were made aware of this "unwritten policy".

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D 338	Continued From page 27 -She did not know that Resident #2 had no upper or bottom teeth and that the lost upper dentures were the only teeth Resident had. -She did not know that Resident #2's dentist reported she was no longer a candidate for dentures due to the Resident #2's disease process and inability to participate in the process. _____ The facility failed to ensure Resident #2's dentures were kept from being lost or misplacement when staff found the dentures on the floor in Resident #2's room and did not take them to the MA to store in the medication cart, resulting in the dentures going missing. Resident #2 was assessed by her dentist, who determined she was not eligible for a new set of dentures due to a decline in cognitive disease progression, putting Resident #2 at risk for difficulty eating and choking. This failure was detrimental to the safety, health and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on May 7, 2026, for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 6, 2026	D 338		
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:	D 358		

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D 358	Continued From page 28 (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: Based on record reviews and interviews, the facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents related to a medication to treat infection (#2). The findings are: Review of Resident #2's FL2 dated 04/07/25 revealed diagnoses included dementia and hypertension. Review of Resident #2's Emergency Department (ED) After Visit Summary dated 01/03/26 revealed: -Resident #2 was seen in the ED for a fall with a left elbow laceration. -Resident #2 received stapes to the left elbow. -Resident #2 was to start taking cephalexin (used to treat an infection) 500mg by mouth, four times daily for five days. Review of Resident #2's January 2026 eMAR revealed: -There was an entry for cephalexin 500mg, four times a day at 9:00am, 1:00pm, 5:00pm and 9:00pm. -The cephalexin was documented as administered on 01/03/26 at 9:00pm and 01/04/26 to 01/07/26 at 9:00am, 1:00pm, 5:00pm and 9:00pm. -There was no documentation the cephalexin was administered on 01/08/26 at 9:00am, 1:00pm and 5:00pm.	D 358		

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D 358	Continued From page 29 Telephone interview with a Pharmacist from Resident #2's pharmacy on 05/06/26 at 10:22am revealed: -There was an order from the ED dated 01/03/26 for cephalexin 500mg four times a day for five days. -On 01/03/26, there were 20, cephalexin 500mg capsule dispensed and picked up by a family member. -Because the cephalexin was not completed as ordered, Resident #2's could experience a recurrent infection or worsening of the infection due to the laceration. Telephone interview with the facility's contracted pharmacy on 05/06/26 at 10:36am revealed: -On 01/03/26, there was an order for cephalexin 500mg four times a day for five days that was entered as profile only. -The facility was responsible to change the start and stop date for the cephalexin because there was no way to know when the cephalexin arrived since their pharmacy did not dispense the cephalexin. Telephone interview with Resident #2's PCP on 05/06/26 at 12:11pm revealed: -She did not know Resident #2 did not complete the five day course of cephalexin. -Not receiving medications as ordered could increase risk of infection and delay healing. Telephone interview with Resident #2's power of attorney (POA) on 05/05/26 at 10:38am revealed: -On 01/03/26, Resident #2 went to the ED for a fall and a laceration to her left elbow. -The ED physician ordered cephalexin 500mg, for times a day for five days. -Resident #2 was to finish the cephalexin on	D 358		

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01/08/26 by 9:00pm.
-On 01/10/26, she visited Resident #2 and due to issues with the cephalexin not being administered correctly before, she asked the medication aide (MA) about the cephalexin.
-The MA showed her the bottle of cephalexin dated 01/03/26 and it contained 3 red capsules in it that had not been administered.
-The MA at that time administered one and there were then 2 red capsules left in the bottle.

Review of two photos dated 01/10/26 revealed:
-On one photo, there was a medication bottle with Resident #2's name on it and labeled cephalexin 500mg, four times daily for 5 days, with a dispense date of 01/03/26.
-On the second photo there were two red capsules in the bottle.

Telephone interview with a MA on 05/06/26 at 9:03pm revealed:
-On 01/08/26, he worked night shift 6:00pm to 6:00am.
-On 01/08/26, he was passing medications at 9:00pm and found a bottle of cephalexin 500mg with Resident #2's name on it.
-There were 3 red capsules remaining in the bottle.
-Because it did not prompt him to administer the cephalexin and there were 3 capsules left in the bottle, he put the bottle in the top drawer of the medication cart.
-The cephalexin had not been documented as administered the full five days, but he could not administer it because the eMAR was "grayed out".
-He documented on the 24-hour report sheet, and reported it to the day shift MA.
-He reported it to the former Special Care Coordinator (SCC) on 01/09/26.

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D 358	Continued From page 31 -He saw on the 24-hour report sheet that a MA had administered one of the three cephalexin's that were left in the bottle, but he could not remember what day he saw that on. Telephone Interview with the former SCC on 05/07/26 at 8:54am revealed: -On 01/03/26, she was aware Resident #2 went to the ED for a fall with a laceration to the elbow. -The MAs were responsible to fax the order for Resident #2's cephalexin to the facility's contracted pharmacy for profile only since Resident #2 received medications from an outside pharmacy. -She was responsible to complete monthly audits to make sure medications were administered as ordered but she did not remember if the cephalexin was administered correctly for Resident #2 in January 2026. -The MAs were responsible to administer medications as ordered. Interview with the RCC on 05/07/26 at 10:04am revealed: -The MAs were responsible to fax all new orders to the facility's contracted pharmacy to be entered into the eMAR system. -Because Resident #2 used an outside pharmacy and PCP, the MAs were responsible to fax the orders to their contracted pharmacy for profile only and Resident #2's POA delivered all new medications filled by the outside pharmacy. -Once Resident #2's cephalexin order was entered into the eMAR system, the former HWD was responsible for changing the start and stop time for the cephalexin ordered on 01/03/26 once Resident #2's POA delivered the cephalexin. -Both the former SCC and former HWD were able to change start and stop days for the cephalexin.	D 358		

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D 358	Continued From page 32 -According to Resident #2's January 2026 eMAR, the cephalexin was started on 01/03/26 at 9:00pm so the stop date should have been five days later on 01/08/26 at 5:00pm. Interview with the Administrator on 05/06/26 at 11:00am revealed: -On 01/03/26, Resident #2 fell and taken to the ED by Resident #2's POA. -Resident #2 was given an order for cephalexin 500mg four times a day for five days. -Resident #2's POA filled the cephalexin at their pharmacy and brought the cephalexin back to the facility on 01/03/26 according to the January 2026 eMAR. -The MA working that shift when Resident #2 returned to the facility was responsible to fax the order for cephalexin to their contracted pharmacy. -Their contracted pharmacy was responsible to enter the cephalexin order as "profile only" which then showed up on the January 2026 eMAR for administration by the MAs. -The previous SCC and previous HWD were responsible to change the start date for the cephalexin based on when the cephalexin arrived at the facility and also change the stop date so that Resident #2 received a full five days of the cephalexin. -According to Resident #2's January 2026 eMAR, Resident #2 did not receive a full five days of the cephalexin. -She expected the staff to administer he cephalexin as ordered.	D 358		
D 364	10A NCAC 13F .1004 (g) Medication Administration 10A NCAC 13F .1004 Medication Administration (g) The facility shall ensure that medications are	D 364		

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administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered within one hour before or after the scheduled times for 1 of 5 residents sampled (#2), resulting in medications ordered multiple times a day being administered too close to the next scheduled administration time and medications not being administered at consistent time intervals to ensure therapeutic effectiveness.

The findings are:

Review of Resident #2's current FL2 dated 05/05/26 revealed diagnoses included dementia and hypertension.

Review of Resident #2's signed physician's order dated 11/14/26 revealed for cephalexin (a medication used to treat infection) 500mg, three times a day for ten days.

Review of Resident #2's November 2025 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for cephalexin 500mg, three times a day for ten days at 8:00am, 2:00pm and 8:00pm.
-On 11/15/25, the cephalexin was administered at 3:21pm instead of within one hour before or after the scheduled 2:00pm administration time.
-On 11/18/25, the cephalexin was administered at 11:02am instead of within one hour before or after the scheduled 8:00am administration time.
-On 11/18/25, the cephalexin was administered at 4:31pm instead of within one hour before or after

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the scheduled 2:00pm administration time.
-On 11/21/25, the cephalexin was administered at 9:40am instead of within one hour before or after the scheduled 8:00am administration time.
-On 11/22/25, the cephalexin was administered at 9:22am instead of within one hour before or after the scheduled 8:00am administration time.

Telephone interview with Resident #2's PCP on 05/06/26 at 12:11pm revealed:
-On 11/13/25, according to the office records, Resident #2 was seen by another Nurse Practitioner (NP) at her office for possible trauma to her right toe.
-She expected the staff to administer medications within one hour before or after the scheduled administration time for antibiotics to help prevent worsening of symptoms and infection and/or buildup of resistance of cephalexin.

Telephone interview with a medication aide (MA) on 05/07/26 at 12:30pm revealed:
-The MAs were responsible to administer resident medications within one hour before to one hour after the scheduled time.
-According to the eMAR, on 11/22/25, she documented that she administered Resident #2's cephalexin at 9:22am which was twenty-two minutes outside of the one hour before to one hour after the scheduled time.
-She was probably running late with medication administration that day.

Telephone interview with the former Special Care Coordinator (SCC) on 05/07/26 at 8:54am revealed:
-The MAs were responsible to administer resident medications within one hour before to one hour after the scheduled time.
-If a MA was running behind passing medications

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D 364	Continued From page 35 the MA could ask for help from another MA or ask her for help. -She did not review the Medication Administration Audit Report regularly unless residents complained of late administration of medications. -There were no complaints from Resident #2. Interview with the Administrator on 05//26 at 2:53pm revealed: -She expected the MAs to administer resident medications within the 2-hour range, from an hour before to an hour after the scheduled administration time. -If a MA administered medications late she expected them to notify former SCC and to document why the medications were late. -She did not know Resident #2's cephalexin was not administered within the one hour before to one hour after the scheduled time. -She did not know there was a time variance report that could tell when a medication was outside the one hour before to one hour after the scheduled time.	D 364		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to complete Health Care Personnel Registry (HCPR) reporting and investigation requirements within 24 hour and 5 day	D 438		

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requirements for 1 of 1 sampled residents who had an injury of unknown origin to her right toe (#2).

The findings are:

Review of Resident #2's current FL2 dated 05/05/26 revealed:
-Diagnoses included dementia and hypertension.
-She was constantly disoriented.
-Her level of care was Special Care Unit (SCU).

Review of Resident #2's Care Plan dated 12/04/25 revealed:
-She was independent with eating, ambulation, and transfers.
-She required physical assistance with toileting, bathing, dressing and grooming.

Request for Accident/Incident reports for Resident #2 on 05/5/26 at 1:00pm were not provided by the survey exit date.

Review of Resident #2's staff progress notes revealed:
-On 11/11/25 at 5:45am, the resident's right big toenail was green in color and resident yelled out in pain when touched.
-On 11/13/25 at 5:00pm, the resident's family member took her to a doctor's appointment to check on her toe and an x-ray was done at the office, awaiting results.

Telephone interview with Resident #2's power of attorney (POA) on 05/05/26 at 10:38am revealed:
-A medication aide (MA) asked her if she was told about an injury to Resident #2's toe on an unknown date.
-The MA did not know what had happened to Resident #2's toe, just that it was purplish, black

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in color and was painful to the touch.
-She took the resident to her doctor's office where the resident received an x-ray and an order for an antibiotic.

Telephone interview with Resident #2's PCP on 05/06/26 at 12:11pm revealed:
-On 11/13/25, according to the office records, Resident #2 was seen by another Nurse Practitioner (NP) at her office for possible trauma injury to her right toe.
-The other NP ordered a foot x-ray because there was slight swelling to the right foot.
-Resident #2 was seen at the PCP's office on 11/19/25 due to redness, swelling and cellulitis (a serious bacterial skin infection) to Resident #2's right foot.

Telephone interview with a MA on 05/06/26 at 5:15pm revealed:
-She documented on 11/11/25 Resident #2's right big toenail was green in color and that the resident yelled out when touched.
-She thought Resident #2 injured her right toe.
-She documented Resident #2's right toenail on the 24-hour shift report sheet and reported it to the day shift MA before she left.

Telephone Interview with the former SCC on 05/07/26 at 8:54am revealed:
-On 11/11/25, a MA told her that Resident #2's right toe was green.
-She looked at it and did not know if it was a fungal infection or from an injury so she did not notify the PCP or send Resident out for an evaluation.
-On 11/13/26, after a MA informed Resident #2's POA about the toe, Resident #2's POA made an appointment and took Resident #2 to the PCP to have the toe looked at.

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D 438	Continued From page 38 Interview with the Administrator on 05/06/26 at 3:45pm revealed: -The former SCC notified her in a standup meeting that Resident #2 may have an ingrown toenail that became infected. -She did not remember the date of the stand up meeting. -Resident #2's family member made her aware of infected right toe on 11/14/25. -She did not know there was a possible injury to Resident #2's right toe so she did not complete a 24-hour and 5-day report for an injury of an unknown origin.	D 438		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (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. This Rule is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to notify the local county Department of Social Services (DSS) of an incident for 2 of 2 sampled residents who received an x-ray and antibiotics for her right toe/foot (#2), and a resident who sustained a fall with injuries to his hand and arm (#3).	D 451		

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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 451	Continued From page 39 The finding are: 1. Review of Resident #2's current FL2 dated 05/05/26 revealed: -Diagnoses included dementia and hypertension. -She was constantly disoriented. -Her level of care was Special Care Unit (SCU). Review of Resident #2's Resident Register revealed an admission date of 04/09/25. Review of Resident #2's record revealed there was no Accident/Incident report dated 11/11/25 or 11/13/25 and there was none provided by the survey exit date. Review of Resident #2's staff progress notes revealed: -On 11/11/25 at 5:45am, the resident's right big toenail was green in color and resident yelled out in pain when touched. -On 11/13/25 at 5:00pm, the resident's family member took her to a doctor's appointment to check on her toe and an x-ray was done at the office, awaiting results. Telephone interview with Resident #2's PCP on 05/06/26 at 12:11pm revealed: -On 11/13/25, according to the office records, Resident #2 was seen by another Nurse Practitioner (NP) at her office for possible trauma injury to her right toe. -The other NP ordered a foot x-ray because there was slight swelling to the right foot. Telephone interview with a MA on 05/06/26 at 5:15pm revealed: -She documented on 11/11/25 Resident #2's right big toenail was green in color and that the	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023048	A. BUILDING: _____ B. WING _____	R 05/07/2026

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D 451	Continued From page 40	D 451		

resident yelled out when touched.
-She thought Resident #2 injured her right toe.
-She documented Resident #2's right toenail on the 24-hour shift report sheet and reported it to the day shift MA before she left.

Telephone Interview with the former SCC on 05/07/26 at 8:54am revealed on 11/13/26, after a MA informed Resident #2's POA about the toe, Resident #2's POA made an appointment and took Resident #2 to the PCP to have the toe looked at.

Interview with the Administrator on 05/06/26 at 3:45pm revealed:
-The former SCC notified her in a standup meeting that Resident #2 may have an ingrown toenail that became infected.
-She did not remember the date of the stand up meeting.
-Resident #2's family member made her aware of infected right toe on 11/14/25.
-She did complete an Accident/Incident report because Resident #2's POA took Resident #2 to see her PCP.

2. Review of Resident #3's current FL2 dated 07/01/25 revealed:
-Diagnoses included dementia and lower extremity edema.
-He was constantly disoriented.
-His recommended level of care was Special Care Unit (SCU).

Review or Resident #3's Resident Register revealed he was admitted to the facility on 03/03/25.

Review of Resident #3's hospital discharge summary dated 02/18/26 revealed:

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D 451	Continued From page 41 -He visited the emergency department (ED) with concerns of wound check. -His discharge diagnoses included cellulitis (a bacterial skin infection) of right upper extremity. Telephone interview with Resident #3's POA on 03/11/26 at 3:00pm revealed: -She visited the resident and noticed he was lethargic and not himself. -She asked the MA how he was doing and the MA stated he was sleeping more than normal and not eating. -The Primary Care Practitioner (PCP) was currently in the facility and she requested a visit. -The PCP visited Resident #3 and began an assessment when she and the PCP observed a bandage on right upper arm. -She did not know about and was not notified by the facility of the injury to the resident's right upper arm. -It took her and the PCP 15 minutes to remove the bandage and the area was red and inflamed. -She immediately asked Administrator and the HWD what happened and they stated the wound happened with the incident and fall on 02/11/26. -She was notified of a push, fall, and wound to resident's left middle finger. -She immediately took Resident #3 to the ED for a wound assessment and to ensure he was not septic (a serious life-threatening reaction to an infection). Interview with personal care aide (PCA) on 03/24/26 at 2:18pm revealed: -She did not know Resident #3 had fallen on 02/11/26. -The policy and procedure for an unwitnessed fall, was to notify the MA on shift and assist as directed.	D 451		

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D 451	Continued From page 42 Interview with a second PCA on 03/24/226 at 2:25pm revealed: -She did not know Resident #3 had an incident or fall. -If there is an unwitnessed fall, she was to alert and inform the MA immediately and help however needed. Interview with a third MA on 03/24/26 at 2:35pm revealed: -The MA declined to answer questions. -The MA was filling in on the SCU but typically did not work in the SCU. Interview with a forth MA on 03/24/26 2:37pm revealed: -She did not know details that occurred with incident and fall with Resident #3 on 02/11/26 due to being assigned to the other SCU hall. -If there was an unwitnessed fall, she would assess the resident, determine if he the resident needs to be sent out, and notify appropriate parties if needed. Telephone interview with a third shift MA on 03/24/26 at 4:00pm revealed: -Resident #3 did have an unwitnessed fall on 02/11/26. -Resident #3 wandered into another resident room where he was pushed into the wall. -She observed Resident #3 on the floor and notified the HWD. -The HWD completed assessment of Resident #3 and placed a bandage on a wound on the resident's finger and arm. -The HWD called and notified appropriate parties. -MAs were responsible for completing accident and incident reports. Interview with the Administrator and DHW on	D 451		

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D 451	Continued From page 43 03/10/25 at 1:47pm revealed: -They knew Resident #3 had an unwitnessed fall on 02/11/26. -Resident #3 wandered into another resident's room were he was pushed which resulted in him falling. -Resident #3 did receive an injury to his hand and arm. -The HWD who was still in the building completed an assessment and placed a bandage on his injuries. -The resident was fine and the HWD notified the resident's POA. -The Administrator and HWD did not complete a accident and incident report for the incident on 02/11/26. -They did not feel the accident/incident on 02/11/26 needed to be reported because the resident did not need to go to the ED.	D 451		