	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL-096056			R 12/23/2024	
NAME OF PR	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
LATTER D	AYS LTC		SMITH CHAPE			
			OLIVE, NC 283			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLET	
{C 000}	Initial Comments		{C 000}			
	The Adult Care Licens follow-up survey on 1	sure Section conducted a 2/23/24.				
{C 007}	10A NCAC 13G .0206	6 Capacity	{C 007}	10 NCAC 13G .0206 Capacity	1/7/24	
	homes have a capaci (b) The total number exceed the number si (c) A request for an inadding rooms, remode modifications shall be department of social sthe Division of Health accompanied by two plans. One plan show with the current use of plan indicating the ad in use of spaces show	131D-2(a)(5), family care ty of two to six residents. of residents shall not hown on the license. ncrease in capacity by eling or without any building a made to the county services and submitted to		2 of 5 residents were none ambulatory, u evacuate the facility independently. Rule Correction: The 2 non-ambulatory residents were give discharge notices on 10/13/24. One resident of discharged on 1/3/24 and the second resident of discharged on 1/7/24 to a higher level of Systematic Changes: All staff have had an Inservice on the defambulatory." The Administrator and/or Direview residents and care plans once an when there is a significant change in statt residents. If then the resident is no longer ambulatory, both the family and DSS will notified, and a 30-day d/c notice will be is	en dent was ident was care. inition of " ON will nonth or us for the er be	
	addition will be tied in all proposed changes (d) When licensed he designed capacity by remodeling of the exis	to the existing building and in the structure. Tomes increase their the addition to or string physical plant, the		higher level of care. Monitoring: Using a facility created audit tool the Adn and/or DON will complete monthly audits ensure all residents that remain in the face.	to	
Division of Hea	regulations. (e) The licensee or the notify the Division of I the overall evacuation changes from the evathe homes license or non-resident that will This information shall county department of forwarded to the Consideration of Health Sei	be residing within the home. be submitted through the		ensure all residents that remain in the fact ambulatory. The Administrator or Director Nursing will report findings to the Quality Assurance Performance Improvement Comonthly and make changes to the plan a necessary to maintain continued compliant	or of ommittee s	
ABORATORY I		SUPPLIER REPRESENTATIVE'S SIGNATUR	E 6899	Administrator	(X6) DATE 1/13/2025 If continuation sheet 1	

Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			, DOILDING.		R	
		FCL-096056	B. WING		12/23/20)24
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ITE, ZIP CODE		
LATTER D	AYS LTC		SMITH CHAPEL			
(V.A) ID	SLIMMADV ST.	ATEMENT OF DEFICIENCIES	LIVE, NC 2836	PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE CO	(X5) DMPLETE DATE
{C 007}	Continued From page	e 1	{C 007}	C007 answered on page 1		
	the building.					
	This Rule is not met	as evidenced by:				
		ns, interviews, and record				
		illed to notify the Division of				
		ation (DHSR) when the 2 of 5 residents differed				
	from the evacuation of	capability listed on the				
		by residents requiring hands all prompting to ambulate				
	and to evacuate the f	· · · · · ·				
	The findings are:					
	-	s current license effective				
		31/24 revealed the facility				
		nbulatory residents. (The ng Code defines ambulatory				
	residents in Family C	are Homes as residents able				
	to respond and evacu physical or verbal ass	uate the facility without				
	physical of verbal ass	siotariooj.				
		acility on 12/23/24 at 8:00am				
	revealed: -The facility had a cer	nsus of 5 residents.				
	-There were three exi	it doors, one located on the				
		e located on the side of the				
	-	ed on the back of the facility rch area with an attached				
	ramp.					
	Observation of a resid	dent on 12/23/24 at 8:36am				

Division of Health Service Regulation

STATE FORM 6899 EN4Z12 If continuation sheet 2 of 15

Division o	of Health Service Regul	lation			FORM	APPROVED
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL-096056	B. WING		1	3/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
LATTER DAYS LTC		SMITH CHAPEL				
		MOUNT C	LIVE, NC 2836	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
{C 007}	Continued From page	2	{C 007}	C007 answered on page 1		
	revealed:					
	-She was lying in a ho	ospital bed.				
		nair in the corner across the				
	room.					
		dent on 12/23/24 at 8:36am				
	revealed:					
		nd watched TV during the				
	dayShe did not get out o	f bed because her hip was				
	broken.	r bod booddoo nor mp wao				
		could stand to transfer into				
	a wheelchair if she ne	eded to.				
	Observation of the me	edication aide (MA) on				
		second resident to stand				
	from the dining room					
	•	follow the instructions to				
	-The MA took her righ	t hand in his hand, grasped				
	•	is left and assisted the				
	resident to stand and	guided her down the hall.				
	Interview with the MA revealed:	on 12/23/24 at 8:57am				
		ed fell and broke her hip				
		ice services required total				
		was also on hospice and				
		stance and guidance with				
	ambulation and follow	ring directions.				

at 3:02pm revealed:

Telephone interview with the Registered Nurse (RN) for the hospice agency service on 12/23/24

-The first resident fell on 11/23/24 and sustained a fracture to her hip and not was bedbound.
-This resident was unable to exit the facility on her own in the event of an emergency.

STATE FORM 6899 EN4Z12 If continuation sheet 3 of 15

Division of Health Service Regulation					FORIVI APPROVE	ט
STATEMENT OF AND PLAN OF C	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL-096056	B. WING		R 12/23/2024	
NAME OF PROV	IDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	NTE, ZIP CODE		
LATTER DAYS	פודר	928 OLD S	MITH CHAPEL	ROAD		
LATTER DATA		MOUNT OF	LIVE, NC 2836	5		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
-T by me	the arm, even for n ental capacity to exi	e 3 required staff to guide her neals, and did not have the t the facility in the event of	{C 007}	C007 answered on page 1		
Inf 9: -S co of -S an reg -S ap -S po the fire -T inc dis du sta so	terview with the Adn 19am and 11:07am the was aware ambu- ould get out of facility an emergency. The had not notified the ervices Regulation (Inbulatory status but garding capacity chat the received but she oplication. The did not think chat ossible until construc- e facility that include e system with pull state the two residents that dependently had pre- scharge notice but so the state of the was so aff for each resident	ninistrator on 12/23/24 at revealed: ulatory meant that a resident by by themselves in the event the Division of Health DHSR) of residents' had requested information ange. In had not completed the enging the capacity was cation changes were made to ed a sprinkler system and a stations. In the thought having 2 staff on sufficient since there was 1 that required assistance, marged.				
10 (a)	OA NCAC 13G .0214 Either the Secreta otify the domiciliary h	Suspension of Admissions Suspension of Admissions Sury or his designee shall Shome by certified mail of the Sidmissions. Such notice will	C 015	10A NCAC 13G .0214 Suspension of Adr 1 resident was admitted after suspension missions was issued. Rule Correction:		

include:

(1) the period of the suspension,

(2) factual allegations,

STATE FORM 6899 EN4Z12 If continuation sheet 4 of 15

No residents moving forward will be admitted until

suspension is lifted.

Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	
		FCL-096056	B. WING		1	3/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
LATTER D	AYS LTC		MITH CHAPEL			
			_IVE, NC 2836 ⊤			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
C 015	Continued From page	2 4	C 015	Continued from Page 4		
	• •	and rules alleged to be		10A NCAC 13G .0214 Suspension of Adr	missions	
	violated, (4) notice of the facilit	y's right to contested case		Systematic Changes		
	hearing or the susper (b) The suspension we notice is served or on notice of suspension, suspension will remain specified in the notice demonstrates to the Sthat conditions are not health and safety of the (c) The home shall not during the effective day (d) Any action taken to Services to revoke a street the license to a provise accompanied by a respective to the services to revoke a secretary or his designation.	Ision. It be effective when the the date specified in the whichever is later. The meffective for the period or until the facility. Gecretary or his designee longer detrimental to the me residents. It admit new residents are of the suspension. In the difference or to reduce sional license shall be commendation to the gnee to suspend new major may be ordered.		Admissions will be stopped even when ar is filed. Admissions will only resume when sion is lifted as the result of a successful POC is fulfilled. Monitoring: Administrator will ensure no admissions a completed until suspension is lifted.	n suspen appeal or	
	reviews, the facility fa	ns, interviews and record iled to adhere to rules and admitting a resident (#5) to ce of Suspension of				
	The findings are:					
	01/01/24 through 12/3 was licensed for 6 am North Carolina Buildir residents in Family Ca	s current license effective 31/24 revealed the facility abulatory residents. (The ang Code defines ambulatory are Homes as residents able tate the facility without				

Division of Health Service Regulation

STATE FORM 6899 EN4Z12 If continuation sheet 5 of 15

Division	Division of Health Service Regulation					
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R	
		FCL-096056	B. WING		12/2	3/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREETADL	DRESS, CITY, STA	II E, ZIP CODE		
LATTER D	AVELTO	928 OLD S	MITH CHAPEL	. ROAD		
LATTER D	ATSLIC	MOUNT O	LIVE, NC 2836	5		
0(0)15	STIMMADV ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION		0/5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	•	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE		DATE
				DEFICIENCY)		
				0045 Assessed as a second 5		
C 015	Continued From page	e 5	C 015	C015 Answered on pages 4 and 5.		
	Davious of a letter from	m the the Division of Health				
		OHSR), Adult Care Licensure				
	Section dated 10/11/2					
		I survey conducted at the				
	facility on 10/10/24 at	which time a violation was				
	identified in 10A NCA	.C 13G .0302 Design and				
	Construction.					
	-The conditions of the	home were found to be				
	detrimental to the hea	alth, safety and welfare of				
	the residents.	,				
		ome were to be suspended				
	immediately.	me were to be easpened				
	iiiiiiodiatory.					
	Observations of the fo	acility on 12/23/24 at 8:00am				
	revealed the facility in	ad a census of 5 residents.				
	Observation of a fine	duill a sun durate di sun 40/00/04				
	-	drill conducted on 12/23/24				
	from 10:00am to 10:0					
		o evacuate independently				
	with one resident that	required 1-2 people to				
	verbally direct and ph	ysically assist her to				
	evacuate and a secon	nd resident that remained in				
	bed and was unable t	to evacuate.				
	Review of Resident #	5's current FL-2 dated				
	10/04/24 revealed:					
		Alzheimer's disease with				
	behavioral disturbance					
		, constantly disoriented and				
	had wandering behav					
	nad wandering beliav	1010.				
	Paview of Posidont #	5's Resident Posistor on				
		5's Resident Register on				
		e was admitted to the facility				
	from her own residen	ce on 11/18/24.				
		ministrator on 12/23/24 at				
	12:28pm revealed:					
	-She admitted a resid	ent to the facility after				

Division of Health Service Regulation

receiving the notice for the Suspension of

Admissions in October 2024.

STATE FORM 6899 EN4Z12 If continuation sheet 6 of 15

Division of Fleath Service Regu	Division of fleatin Service Regulation							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED					
	FCL-096056	B. WING	R 12/23/2024					
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STATE, ZIP CODE						

LATTER DAYS LTC

928 OLD SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365

_ATTER D	MOUNT	OLIVE, NC 283	65	
(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
C 015	Continued From page 6	C 015	C015 Answered on pages 4 and 5.	
	-She thought she could continue to admit residents to the facility while an appeal was in place.			
	[Refer to Tag C 022 10A NCAC 13G .0302 (b) Design And Construction].			
{C 022}	10A NCAC 13G .0302 (b) Design And Construction	{C 022}	10A NCAC .0302 (b) Design and Construction Residents #1 and #3 were none ambulatory,	1/7/24
	10A NCAC 13G .0302 Design And Construction		unable to evacuate the facility independently. Rule Correction:	
	(b) Each home shall be planned, constructed, equipped and maintained to provide the services offered in the home.		The 2 non-ambulatory residents were given discharge notices on 10/13/24. One resident was discharged on 1/3/24 and the second resident was discharged on 1/7/24 to a higher level of care. Discharge of these tw0 residents corrects the need of a sprinkler system currently.	
	This Rule is not met as evidenced by:		Systematic Changes: All staff have had an Inservice on the definition of "	
	FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated.		ambulatory." The Administrator and/or DON will review residents and care plans once a month or when there is a significant change in status for the residents. Until a sprinkler system and change of licensure is completed in the future; if a resident is no longer ambulatory, both the family and DSS	
	Based on observations, interviews, and record reviews, the facility failed to ensure the building was equipped and maintained for 2 of 5 residents (#1, #3), one who was bed bound due to a		will be notified, and a 30-day d/c notice will be issued for higher level of care. Monitoring:	
	broken hip (#1) and one who required verbal direction and hands-on guidance for ambulation (#3).		Using a facility created audit tool the Administrator and/or DON will complete monthly audits to ensure all residents that remain in the facility are ambulatory. The Administrator or Director of Nursing will report findings to the Quality	
	The findings are:		Assurance Performance Improvement Committee monthly and make changes to the plan as necessary to maintain continued compliance.	
	Observation of the facility's current license on 12/23/24 revealed:		,	

Division of Health Service Regulation

STATE FORM 6899 EN4Z12 If continuation sheet 7 of 15

DIVISION	n nealth Service Negu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
					-	
		ECI ADEAEC	B. WING		F	
		FCL-096056	1		1212	23/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ATE, ZIP CODE		
		928 OLD S	MITH CHAPEL	ROAD		
LATTER D	AYS LTC		LIVE, NC 2836			
	CLIMMA DV CT					
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	•	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE		DATE
				DEFICIENCY)		
{C 022}	Continued From page	. 7	{C 022}			
(0 022)	Continued From page	- 1	(0 022)	C022 Answered on Page 7		
		as 01/01/24 to 12/31/24.				
	-The facility was licen	sed for 6 ambulatory				
	residents (The North	Carolina Building Code				
	defines ambulatory re	esidents in Family Care				
	Homes as residents a	able to respond and				
	evacuate the facility v	vithout physical or verbal				
	assistance).					
	Observations of the fa	acility on 12/23/24 at 8:00am				
	revealed:					
	-There was no sprink	ler system installed in the				
	facility.					
	-There were three en	trance/exit doors, one				
	located on the front of	f the facility, one located on				
	the side of the facility	, and one located on the				
		at lead to a small porch area				
	with an attached ram	p				
	1. Review of Residen	t #1's current FL-2 dated				
	08/28/24 revealed dia	agnoses included				
		sease without heart failure,				
		D deficiency, rash and				
		n eruption, hypothyroidism,				
		of other diseases of the				
	respiratory system.					
	, , ,					
	Record review of Res	sident #1's hospice				
	comprehensive asses	ssment and plan of care				
	dated 12/18/24 revea	•				[
	-The hospice start of	care date was 11/16/23.				
	•	nced a fall resulting in a				
	-	the right hip that resulted in				
	her becoming bedbou	• .				
		pendent on staff for all				
	activities of daily living					
		5				
	Observation of Reside	ent #1 on 12/23/24 at				
	8:36am revealed:					
	-She was lying in a ho	ospital bed.				

Division of Health Service Regulation

-There was a wheelchair in the corner across the

STATE FORM 6899 EN4Z12 If continuation sheet 8 of 15

Division of	of Health Service Regu	lation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLI	
					R	≀
		FCL-096056	B. WING		12/2	3/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ITE, ZIP CODE		
LATTER D	AYS LTC		MITH CHAPEL			
		MOUNT OL	IVE, NC 2836	5		
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
{C 022}	Continued From page	÷ 8	{C 022}	C022 Answered on Page 7		
	room.					
	revealed: -She stayed in bed andayShe did not get out of brokenShe did not think she a wheelchair if she ned in the she a wheelchair if she ned in the she as wheelchair if she ned in the she as wheelchair if she ned in the she in the sh	dication aide (MA) on evealed: able to stand because she recently, was on hospice total care from staff. did not recommend surgery age.				
	remained in bed throuse remained in bed throuse remained in bed throuse (RN) for the hospice at 3:02pm revealed: -Resident #1 fell on 1 fracture to her hipResident #1 was ess-Resident #1 was una own in the event of an Attempted telephone Care Provider (PCP) at 1:06pm was unsuccessive.	with the Registered Nurse agency service on 12/23/24 1/23/24 and sustained a sentially bedbound. able to exit the facility on her in emergency. interview with the Primary for Resident #1 on 12/23/24				

dated 04/27/24 revealed:

chronic hypotension

-Diagnoses included Alzheimer's disease and

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<u>Division</u> of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R	.
		FCL-096056	B. WING		1	3/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE		
LATTER D	AVS LTC	928 OLD	SMITH CHAPE	ROAD		
LATIER	MATS LIC	MOUNT	OLIVE, NC 2836	65		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETE DATE
{C 022}	Continued From page	9	{C 022}	C022 Answered on Page 7		
	ambulatory.	atory status was listed as				
	Interview with the me 12/23/24 at 8:57am re	dication aide (MA) on evealed Resident #3 was on physical assistance and				
	Based on observation determined that Resid	n and interviews, it was dent #3 on 12/23/24.				
	Observation of Residence 9:00am revealed:	ent #3 on 12/23/24 at				
	dining room table.	esident #3 to stand from the				
	-The resident did not stand.	follow the instructions to				
	unsteady gait while he	•				
	10:27am revealed Re	ministrator on 12/23/24 at esident #3 could walk but assistance with ambulation.				
	from 10:00am to 10:0 -Resident #3 was sea just inside the front en -The MA approached	ated in the television room				

-Resident #3 remained seated as the MA assisted

-The MA led Resident #3 to the front door, but Resident #3 planted her feet and refused to exit

the resident to a standing position while continuing to hold onto Resident #3.

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` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL-096056	B. WING		R 12/2	3/2024
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	1 12/2	07202-4
LATTER D	AYS LTC		MITH CHAPEL IVE, NC 2836			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
{C 022}	Resident #3 onto the stepsResident #3 required 1-2 persons to evacuate designated safe areaThe other resident concentrated and the resident #3 along with was cleared and the resident facility. Telephone interview with (RN) for the hospice at 3:02pm revealed Reguide her by the arm, have the mental capate event of an emergence Attempted telephone Care Provider (PCP) at 1:06pm was unsuce. The facility failed to every equipped and maintain safely provide services needed physical assist evacuate in the evental fire. This failure was safety, and welfare of a Type B violation.	isted the MA with getting porch and down the porch. I the physical assistance of ate the facility to the continued to hold onto the the MA until the fire drill resident returned inside the swith the Registered Nurse agency service on 12/23/24 resident #3 required staff to even for meals, and did not city to exit the facility in the city. Interview with the Primary for Resident #3 on 12/23/24 ressful. Insure the building was and in a manner that would the sto 2 of 5 residents who estance with ambulation to to fan emergency, such as a detrimental to the health, if the resident and constitutes	{C 022}	C022 Answered on Page 7		
C 232		1 (c) Resident Assessment	C 232	C232 Answered on Page 12		

Division of Health Service Regulation

STATE FORM 6899 EN4Z12 If continuation sheet 11 of 15

Division of Health Service Regulation

NAME OF PROVIDER OR SUPPLIER FCL-096056 STREET ADDRESS, CITY, STATE, ZIP CODE 928 OLD SMITH CHAPFEL ROAD MOUNT OLIVE, NC 28365 CA BUILDING: 10 PROVIDERS PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES 928 OLD SMITH CHAPFEL ROAD MOUNT OLIVE, NC 28365 CASS OLD SMITH CHAPFEL ROAD MOUNT OLIVE, NC 28365 CONSTRUCTION MUST BE PRECEDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION) CONTROLL CO 232 Continued From page 11 C 232 INDAMARY STATEMENT OF DEFICIENCIES resident is completed within 10 days following a significant change in the resident's condition using the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change is not or more of the following: (A) deterioration in two or more activities of daily living; (B) change in the ability to walk or transfer; (C) change in the ability to walk or transfer; (C) deterioration in behavior or mood to the point where daily problems arise or relationships have become problematic; (E) no response by the resident to the treatment for an identified problem; (F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period; (G) threat to life such as stroke, heart condition, or metastatic canned: (H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crafter, or higher;	DIVISION	or riealin Service Negu	ialion				
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		which is a superficial	ulcer presenting an				
		abrasion, blister or sh	allow crater, or higher;				
(I) a new diagnosis of a condition likely to affect		(I) a new diagnosis	of a condition likely to affect				
the resident's physical, mental, or psychosocial		the resident's physica	ıl, mental, or psychosocial				
well-being over a period of time such as initial							
diagnosis of Alzheimer's disease or diabetes;		diagnosis of Alzheime	er's disease or diabetes;				
(J) improved behavior, mood or functional health							
status to the extent that the established plan of							
care no longer matches what is needed;							
(K) new onset of impaired decision-making;		_					
(L) continence to incontinence or indwelling							
catheter; or		` '	9				

Division of Health Service Regulation

STATE FORM 6899 EN4Z12 If continuation sheet 12 of 15

Division of Health Service Regulation						
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		A. BUILDING:				
		FCL-096056	B. WING		R 12/23/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
LATTER D	AVELTO	928 OLD S	MITH CHAPEL	ROAD		
LATTER D	ATS LIC	MOUNT O	LIVE, NC 2836	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLE	
C 232	Continued From page	e 12	C 232	C232 was answered on Page 12		
	` '	ndition indicates there may straint and there is no r for the resident.		, and the second		
	facility failed to ensure completed for a reside	and record reviews, the e an assessment was ent within 10 days of a l) following a fall in which				
	The findings are:					
	08/28/24 revealed dia hypertensive heart dis osteoarthritis, vitamin other non-specific ski	1's current FL-2 dated agnoses included sease without heart failure, D deficiency, rash and n eruption, hypothyroidism, of other diseases of the				
	Care Plan dated 10/1 -She required the use she was non-ambulat -She required extensi eating and toiletingShe was totally depe	e of a wheelchair because ory. ve assistance from staff for				
	assessment and plan revealed: -The hospice start of -Resident #1 experier	1's hospice comprehensive of care dated 12/18/24 care date was 11/16/23. need a fall resulting in a the right hip that resulted in				

her becoming bedbound.

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Division of	of Health Service Regu	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	FIED
					F	₹
		FCL-096056	B. WING		12/2	23/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
LATTER D	MAYS LTC	928 OLD	SMITH CHAPEL	ROAD		
LATTER D	AISLIC	MOUNT (DLIVE, NC 2836	55		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
C 232	Continued From page	: 13	C 232	C232 was answered on Page 12		
	-Resident #1 was dep	endent on staff for all				
	Observation of Resident #1 on 12/23/24 at 8:36am revealed: -She was lying in a hospital bed.					
	, ,	nair in the corner across the				
	8:36am revealed: -She stayed in bed ar	sident #1 on 12/23/24 at				
	dayShe did not get out o broken.	f bed because her hip was				
	-She did not think she could stand to transfer into a wheelchair if she needed to.					
	12/23/24 at 2:44pm re able to stand and tran staff assistance befor	y member of Resident #1 on evealed Resident #1 was asfer to her wheelchair with e she fell an broke her hip e to bear her own weight.				
	fell and broke her hip services and required	evealed: able to stand because she recently, was on hospice				

at 3:02pm revealed:

fracture to her hip.

Telephone interview with the Registered Nurse (RN) for the hospice agency service on 12/23/24

-Resident #1 fell on 11/23/24 and sustained a

-Resident #1 could stand and assist with transfers prior to the fall but was now essentially bedbound.

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Division of Health Service Regulation

2. Troisin C. Frodian Co. Troganation					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED		
	FCL-096056	B. WING	R 12/23/2024		
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STATE, ZIP CODE			

ATTER D	AYS LTC	928 OLD SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365			
(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	
C 232	Continued From page 14	C 232	C232 was answered on Page 12		
	Attempted telephone interview with the Primary Care Provider (PCP) for Resident #1 on 12/23/24 at 1:06pm was unsuccessful.				
	Interview with the Administrator on 12/23/24 at 12:28pm and 2:41pm revealed: -Resident #1 used a wheelchair and could stand and pivot prior to her fallResident #1 broke her hip when she fell and was now bedboundThe facility had not updated the care plan for Resident #1 following her fallResident #1 was on hospice care, and updated their care plan and she thought that was sufficient.				

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