Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL004003	A. BUILDING: _____ B. WING _____	R 10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW TERRACE OF WADESBORO	123 ANSON HIGH SCHOOL ROAD WADESBORO, NC 28170

(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 000	Initial Comments The Adult Care Licensure Section and Anson County Department of Social Services conducted an annual, follow-up, and complaint investigation on October 21-23, 2025.	D 000	"Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truthy of the facts alleged or conclusion set forth in the Statement of Deficiencies Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State".	
D 068	10A NCAC 13F .0305 (i) Physical Environment 10A NCAC 13F .0305 Physical Environment (i) The requirements for floors are: (1) all floors shall be of smooth, non skid material and so constructed as to be easily cleanable; (2) scatter or throw rugs shall not be used; and (3) all floors shall be kept in good repair. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the floors were kept in good repair related to buckled and bowing flooring in residents rooms and the activity room. The findings are: Observation of the activity room on 10/21/25 at 8:45am revealed there was a section of flooring near the door that was being held down by tape. Observation of the floor in room number 103 on 10/21/25 at 9:15am revealed there was a buckled section of the sheet vinyl floor approximately 12 inches long in front of her bathroom door. Observation of the floor in room 109 on 10/22/25 at 12:15pm revealed: -There was a buckled section of the sheet vinyl floor approximately 8 inches long in front of the	D 068	Room numbers 103, 109, 115, and 111 the old flooring was removed and replaced with a new flooring containing a moisture barrier. Flooring materials for the activity room are in the facility and ready for placement. Scheduling is being made with the flooring company at an appropriate time.	11-1-25 1-4-26

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Betty Kester — Executive Director — 12-18-25

Jamaal Willis Reviewed and Acknowledged 12/19/25

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D 068	Continued From page 1 bathroom door. -There was a buckled section of the sheet vinyl floor approximately 6 inches long in front of her window. Observation of the floor in room 115 on 10/22/25 at 12:00pm revealed there were two sections of flooring in front of the resident bed that was being held down by blue tape. Observation of the floor in room 111 on 10/22/25 at 12:15pm revealed there were ten sections of flooring in front of the resident bed and in front of bathroom that was being held down by black tape. Observation of the activity room in on 10/21/25 at 8:45am revealed there was a section of flooring near the door that was being held down by tape. Interview with the resident in room 103 on 10/21/25 at 9:15am revealed the floor in front of her bathroom had been bowing since she could remember. Interview with the resident in room 109 on 10/22/25 at 12:15am revealed: -There was moisture that built up on her floors in front of her bathroom after showers. -There were times when she could feel the water on her feet when she walked near her bathroom. -The floors in front of her window and in front of her bathroom had been bowing since she could remember. Interview with the resident in room 115 on 10/22/25 at 12:00pm revealed there had been blue tape on her floor to hold her floorboards in place for about two weeks.	D 068	Facility Executive Director and Maintenance technician will monitor all floors for any further damage or buckling. A flooring inspection checklist has been added to the maintenance preventative care schedule. Findings will be documented and reviewed by Executive Director for scheduling of repairs.	1-4-26

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D 068	Continued From page 2 Interview with the resident in room 111 on 10/22/25 at 12:15pm revealed he had recently moved into the room and there was black tape on the floor since he had been there. Interview with the Maintenance Director on 10/23/25 at 9:00am revealed: -He was aware of the damaged floors in the resident rooms and the activity room. -He believed that when the facility got new floors they used the wrong material and that was why the floors were buckling. -The laminate floors were retaining moisture and were causing the problems. -The floors had been buckling and bowing throughout the facility for the two months he had been employed. Interview with the Resident Care Coordinator (RCC) on 10/23/25 at 9:20am revealed: -There had been a issues with the flooring throughout the facility since she had been employed for four months. -She believed it was moisture in the floors that was causing the issues. -The Maintenance Director was responsible for reporting any issues with flooring to the Administrator to get it fixed. Interview with the Administrator on 10/23/25 at 2:35pm revealed: -She was aware of the damaged floors throughout the facility. -The facility got new flooring in January 2023. -The flooring throughout the facility had slowly starting to buckle and bowe. -She believed they had the wrong types of flooring installed in the facility. -The flooring was bowing due to moisture in the floors.	D 068		

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D 068	Continued From page 3 -The facility was having the floors in the facility removed and replaced. -She was responsible for ensuring floors throughout the facility remained in good working order.	D 068		
D 079	10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide a safe and clean environment related to the presence of live and dead cockroaches throughout the facility. The findings are: Review of the facility's census on 10/21/25 revealed there were 53 residents in the facility. Review of the facility's October 2025 pest control inspection report dated 10/09/25 revealed:	D 079		

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D 079	Continued From page 4 -The type of service performed was regular commercial monthly service. -The kitchen, public and spa areas, common areas, living, dining, sitting areas, nurse stations, hallways, lobby, entry/exit points, exterior and up to 5 resident rooms were treated for prevention of crawling insects. Observation of the kitchen on 10/21/25 at 10:00am revealed: -There was a roach trap in the area with the dry goods with multiple dead cockroaches observed. -There were three roach traps throughout the kitchen, each containing multiple dead cockroaches. Interview with the Kitchen Manager on 10/21/25 at 10:05am revealed: -The kitchen had issues with roaches. -Pest control came out and sprayed the kitchen every 6 months. -The pest control company began putting roach traps out throughout the kitchen about 2 weeks ago. Observation of room 110 on 10/22/25 at 8:44am revealed there were 2 roach traps in the bedroom which contained multiple dead cockroaches. Interview with the resident in room 110 on 10/22/25 at 8:44am revealed she was not concerned with bugs in her room. Observation of room 220 on 10/22/25 at 9:00am revealed: -There were 3 roach traps in her bedroom which contained multiple dead cockroaches. -There were live cockroaches throughout the bedroom.	D 079	Upon notification of 10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings, all roach traps were immediately removed and discarded from kitchen and resident rooms 110 and 220. Entire Dietary kitchen including dry storage, refrigeration and freezer were deep cleaned and sanitized for safety of residents. All identified resident rooms and common areas were cleaned and sanitized as well. Pest control provided treatment to all affected areas Staff communicated with residents regarding steps to ensure safety and cleanliness.	12-7-25 2-7-25 11-6-25 12-7-25

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D 079	Continued From page 5 Interview with the resident in room 220 on 10/22/25 at 8:44am revealed pest control came out and sprayed his room and he had seen less roaches recently. Interview with the resident in room 220 on 10/22/25 at 8:44am revealed he was not concerned with bugs in his room. Interview with a housekeeper on 10/22/25 at 9:00am revealed: -Room 220 always had an issue with roaches. -There were live roaches in room 220 when she cleaned it. -There were dead roaches observed throughout the facility when she cleaned. Interview with the Resident Care Coordinator (RCC) on 10/22/25 at 10:25am revealed: -The resident in room 220 kept a lot of food in his room and had issues with roaches. -Pest control came out at least monthly to spray the facility. -Housekeeping was responsible for cleaning the facility, personal care aides (PCAs) and medication aides (MAs) also helped with the cleaning. -The Maintenance Director was responsible for monitoring for pests and contacting pest control. Interview with the Maintenance Director on 10/22/25 at 9:40am revealed: -He was aware that there were cockroaches throughout the facility. -The facility was scheduled for monthly pest control services. -If there were concerns the pest control technician follows up bi-weekly. -The pest control technician reported there was roach activity in room 220.	D 079	To protect all residents a full facility-wide inspection of housekeeping conditions and pest activity was conducted. No issues were identified. The facility implemented a revised housekeeping schedule ensuring daily cleaning of all resident rooms and weekly deep cleaning. Implemented in-service training on environmental sanitation and reporting procedures for maintenance concerns. Established immediate reporting protocol requiring staff to log any pest sightings and notify management the same shift.	12-7-25 10-24-25

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D 079	Continued From page 6 Interview with the Administrator on 10/23/25 at 2:35pm revealed: -She was aware that the facility had issues with roaches throughout the facility. -The pest control technician made her aware that there were roaches in the kitchen walls. -Pest control did a deep cleaning of the kitchen and put bait out. -Pest control sprayed the kitchen and a minimum of five rooms during each visit. -The pest control technician treated the facility for cockroaches at least monthly. -The housekeepers cleaned residents' rooms daily. Telephone interview with the facility's pest control company on 10/22/25 at 3:27pm revealed they would not give information about facility pest concerns over the phone.	D 079	Maintenance will conduct weekly pest-control inspections and document findings. ED or designee will perform daily room inspections for cleanliness and sanitation for 30 days, then weekly. Pest Control supports Community at least one time per month spraying kitchen, common areas, offices, exterior of building and 5 bedrooms.	12-7-25 11-6-25
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 B VIOLATION Based on record reviews and interviews, the facility failed to ensure referrals were completed for 1 of 5 sampled residents (#5) related to scheduling a physician ordered endocrinologist appointment and following up with the primary care provider (PCP) regarding a speech pathologist recommendation for a neurology	D 273		

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D 273	Continued From page 7 referral. The findings are: Review of Resident #5's current FL-2 dated 04/25/25 revealed diagnoses included arteriosclerotic cardiovascular disease, hyperlipidemia, essential hypertension, chronic obstructive pulmonary disease, gastro-esophageal reflux disease, anxiety disorder, depression, overactive bladder, partial bilateral paralysis, ambulatory dysfunction, and traumatic brain injury. Review of the Resident Register dated 04/22/25 for Resident #5 revealed the resident was admitted to the facility from home on 04/22/25. a. Review of a primary care provider (PCP) progress note for Resident #5 revealed on 04/25/25, the PCP conducted an initial visit and ordered an initial laboratory workup, including a thyroid stimulating hormone (TSH) value. Review of Resident #5's laboratory values dated 05/05/25 revealed the TSH value was 0.29 units/milliliter of blood (TSH blood levels measure the function of a gland in the brain and the normal range for a TSH value is 0.35 - 4.94). Review of a PCP progress note for Resident #5 dated 05/23/25 revealed the PCP noted that Resident #5 had low TSH in recent laboratory values and ordered T3 and T4 laboratory blood levels for further investigation which resulted in normal blood levels on 06/02/25. Review of a PCP progress note for Resident #5 dated 07/02/25 revealed: -Resident #5's TSH laboratory values dated	D 273		

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D 273	Continued From page 8 06/30/25 was 0.08 units/milliliter of blood. -There was a physician's order for an endocrine referral secondary to the low TSH (0.08). Review of a PCP progress note for Resident #5 dated 07/17/25 revealed: -The TSH blood level was lower than previous and indicated "potential hyperthyroidism". -Resident #5 denied experiencing any symptoms typically associated with hyperthyroidism, such as palpitations or tachycardia. -Resident #5 reported mild exophthalmos (a disorder of the eyes associated with thyroid disease). Review of a physician's order for Resident #5 dated 07/17/25 revealed: -There was a physician's order for Methimazole (used to treat hyperthyroidism, a condition where the thyroid gland produces too much thyroid hormone) 5mg tablet daily. -There was a physician's order for an endocrinologist referral for hyperthyroidism. Review of a PCP progress notes for Resident #5 dated 08/07/25 revealed the resident agreed to continue to follow up with referrals that had been made, such as endocrinology. Review of a PCP progress notes for Resident #5 dated 10/03/25 revealed: -Subclinical hyperthyroidism was "chronic, ongoing". -Resident #5 had chronic fatigue and mild exophthalmos. Review of Resident #5's record revealed: -There was no documentation for contact with an endocrinologist. -There was no documentation for an	D 273		

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D 273	Continued From page 9 endocrinologist appointment scheduled or conducted for Resident #5. Interview with Resident #5 on 10/22/25 at 3:14pm revealed: -She was supposed to go see an endocrinologist. -The only doctor she saw was the doctor that came to the facility. -She remembered going to one appointment away from the facility since she was admitted which was for "a scope on my throat at the hospital". Telephone interview with Resident #5's current PCP on 10/23/25 at 1:00pm revealed: -She was not sure why the endocrinology referral was not done. -There was a delay in care. -A three-month delay was excessive for an appointment. -Resident #5's TSH blood level was "quite low in June - 0.08." -Resident #5 could have symptoms such as fatigue. Telephone interview with Resident #5's previous PCP on 10/23/25 at 2:16pm revealed: -She was the PCP for the facility from June 2025 through September 2025. -She was not aware the referral for Resident #5 to the endocrinologist was not made. -She was concerned the resident had hyperthyroidism. -She wanted to make sure the correct medication was being prescribed to treat Resident #5. -She had not been informed that the endocrinology appointment was not made. -She saw Resident #5 in early September 2025, and the facility did not provide any information on the endocrinology appointment.	D 273		

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D 273	Continued From page 10 -She did not think any other laboratory levels had been drawn to evaluate Resident #5's thyroid levels and response to the medication prescribed. -She did not think there was any harm to Resident #5 by not seeing the endocrinologist but would like Resident #5 to see the endocrinologist to ensure the right medication was prescribed. -If the facility had not received a call from an endocrinologist office to schedule an appointment for Resident #5, she would expect the facility to contact the PCP to follow up on the referral. Refer to the interview with the Resident Care Coordinator (RCC) on 10/23/25 at 3:00pm. Refer to the interview with the Administrator on 10/23/25 at 10:19am. b. Review of a speech-language pathology evaluation for Resident #5 dated 07/28/25 revealed: -Resident #5 was seen for a modified barium swallow . -There was a recommendation for a neurology consult given the severity and unknown etiology of dysphagia (difficulty in swallowing). Review of a primary care provider (PCP) progress note for Resident #5 dated 08/07/25 revealed: -The PCP noted that Resident #5 had failed the modified barium swallow study. -There was a diagnosis documented of dysphagia, unspecified. -There were no new orders provided. Review of Resident #5's record revealed: -There was no documentation for contact with a neurologist. -There was no documentation for a neurology	D 273		

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D 273	Continued From page 11 appointment scheduled or conducted for Resident #5. -There was no documentation the facility contacted the PCP regarding the recommendation for a neurology referral. Interview with Resident #5 on 10/22/25 at 3:16pm revealed: -She had not been to see a neurologist. -She used to go to a neurologist when she was younger. -She did not remember who told her an appointment with neurology was scheduled and did not know why she did not go to the appointment. -The only doctor she saw was the doctor that came to the facility. -She remembered going to one appointment away from the facility since she was admitted which was for "a scope on my throat at the hospital". Telephone interview with Resident #5's current PCP on 10/23/25 at 1:00pm revealed: -She knew about the barium swallow study but never saw the notes regarding barium swallow. -She had recently returned to the facility as the PCP. -She had recently seen Resident #5 and the dysphagia was not such that she could not understand the resident. -She thought it was a problem if appointments were not being made but neurology was "hard to get into". -Three months was excessive for an appointment. Telephone interview with Resident #5's previous PCP on 10/23/25 at 2:16pm revealed: -She was the PCP for the facility from June 2025	D 273		

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D 273	Continued From page 12 through September 2025. -She did not order the modified barium swallow study for Resident #5 but followed up on it. -She saw the resident on 08/07/25 and discussed the barium swallow study. -She thought the decision was made to go toward palliative care and was not going to do anything further. -Staff should have made the neurology appointment because the recommendation came from the hospital. -The facility was responsible for making referral appointments. -She did not have any records of which doctor the neurology referral was sent to. -If the facility had not received a call from a neurology office to schedule an appointment for Resident #5, she would expect the facility to contact the PCP to follow up on the referral. Refer to the interview with the Resident Care Coordinator (RCC) on 10/23/25 at 3:00pm. Refer to the interview with the Administrator on 10/23/25 at 10:19am. _____ Interview with the Resident Care Coordinator (RCC) on 10/23/25 at 3:00pm revealed: -She was responsible for reviewing physician/primary care provider (PCP) progress notes. -If there were PCP orders in the PCP progress notes, the RCC was responsible for following up on the orders, including making appointments. -If she made an appointment for a referral ordered by the PCP, she contacted the PCP office first to determine if there was a particular provider the appointment needed to be scheduled with.	D 273	Referral and follow-up for Health care needs. A physician-ordered resident 5 and endocrinologist appointment. It is scheduled for December 22, 2025, 9am in Monroe at Atrium.	12-22-25

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MEADOWVIEW TERRACE OF WADESBORO	123 ANSON HIGH SCHOOL ROAD WADESBORO, NC 28170

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D 273	Continued From page 13 Interview with the Administrator on 10/23/25 at 10:19am revealed: -She did not remember knowing about any appointments for Resident #5 until 10/22/25. -Resident #5's family transported her to most of her appointments, but she had not contacted the family about a neurology or endocrinology appointment. -If the PCP office sent the referral to a consulting physician, the consulting physician office was supposed to call the facility to schedule the appointment. -Generally, the RCC received the information for appointments and provided the appointment information to the facility transporter. -She expected the RCC to review PCP progress notes to make sure appointments were not missed. The facility failed to follow up with scheduling an endocrinology appointment for Resident #5 as ordered by the primary care provider to evaluate the appropriateness of a medication prescribed for hyperthyroidism, and a neurology appointment recommended by a licensed Speech Pathologist following a failed modified barium swallow. The delay in care was detrimental to the health and welfare of Resident #5 and constitutes a Type B Violation. The facility provided a plan of correction in accordance with G. S. 131D-34 on 10/21/25 for the violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED December 7, 2025.	D 273	Follow-up paperwork was completed for resident 5 for a neurology referral. Resident provider DC'd per resident request. Resident 5 requiring endocinology follow-up was immediately scheduled on December 22, 2025. Appointment details were communicated to resident 5. Resident 5 requested neurology appointment dc'd. Resident care coordinator was re-educated regarding timely referral completion and documentation expectations. An audit of all resident referrals, specialist orders, therapy recommendations, and appointments was completed. No additional residents were found to have missed referrals. All staff were in-serviced regarding referral management, timelines and documentation.	12-10-25 12-10-25 12-10-25 12-7-25 12-7-25 11-7-25

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D 317	Continued From page 14	D 317		
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be at least 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge, and learning of new skills. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide 14 hours of planned group activities per week for active involvement of residents. The findings are: Observation of the facility on 10/23/25 from 8:00am to 3:30pm revealed: -There was an October 2025 calendar posted in the hallway. -The listed activities for 10/23/25 were ball toss from 10:00am to 11:00am, bingo from 1:00pm to 3:00pm, and trunk or treat from 4:30pm to 8:00pm located off site. -The listed ball toss and bingo activities did not occur at the facility on 10/23/25. Interview with a resident on 10/23/25 at 10:15am revealed: -Activities rarely occurred as scheduled. -The only activity she had known of that occurred this whole week was a trip for some residents to a retail store on 10/22/25. -The activity that most often occurred at the facility was bingo and that was because the residents called and organized the game; no staff members routinely assisted with bingo.	D 317	All residents will be offered meaningful activities. Activity Director and Management Staff met with residents to identify interests and activities they prefer to participate in. Monthly Calendar revised to reflect residents' recommendations. Activity Director re-educated on role of Activity Director Care staff were re-educated on their role in encouraging resident participation and assisting with activities as needed. Activity program performance will be reviewed during the monthly QA meeting.	12-7-25 12-7-25 12-7-25 12-7-25 12-7-25 11-16-25

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D 317	Continued From page 15 -If the resident who planned to lead bingo did not want to do it, bingo would be cancelled. Interview with the Resident Care Coordinator (RCC) on 10/23/25 at 2:10pm revealed: -Planned and scheduled activities usually occurred as scheduled. -Since the activity director was also responsible for transportation of residents, all the administrative staff would help with scheduled activities or transportation of residents. Interview with the Activity Director (AD) on 10/23/25 at 2:40pm revealed: -The ball toss scheduled at 10:00am this morning was not completed because she was transporting a resident to a doctor's appointment. -Bingo scheduled for 1:00pm to 3:00pm this afternoon was not completed because the resident that was supposed to lead the activity did not feel like doing it. -She did not lead bingo scheduled for 1:00pm because she was busy with other duties. -The activity calendar was often not followed as scheduled because of her dual roles as AD and transporter. -Residents often led activities instead of a staff member. -Activities did not occur as scheduled at least 3 times a week due to scheduling conflicts. Interview with the facility Administrator on 10/23/25 at 2:20pm revealed: -The facility had a lot of help with activities from volunteers, including a nearby school group. -About 3 listed activities per week were not done as scheduled because of conflicts between the AD's dual role of also transporting residents. -Activities had not been completed as planned from 10/21/25 to 10/23/25 because of the survey	D 317		

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D 317	Continued From page 16 and the amount of staff callouts.	D 317		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record review, the facility failed to ensure medications were administered as ordered for 1 of 5 residents sampled (#4) related to medications used to treat infections. The findings are: Review of the facility's undated Medication Services policy revealed: -The Executive Director (Administrator), Resident Care Coordinator (RCC) or designee would ensure that medication services required for each resident are provided. -Each resident is given the option to have the Community order medications through the preferred pharmacy or the pharmacy of their choice. -All pharmacies must have the ability to provide 24-hour emergency service, including delivery of medications seven days per week.	D 358		

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D 358	Continued From page 17 -If the pharmacy chosen by the resident does not meet minimum quality standards, the Community preferred backup pharmacy would be used in the event that medications were needed on an emergency basis. -All medications that staff members administer, handle, store, would be documented on the medication administration record (MAR) and in accordance with State regulations and the Community's preferred pharmacy standard and procedure manual. Review of Resident #4's current FL-2 dated 09/04/25 revealed diagnoses included cerebral infarction, essential hypertension, muscle weakness, and type 2 diabetes mellitus without complications. Review of an incident report for Resident #4 dated 10/19/25 revealed Resident #4 was transported to a local hospital emergency room by emergency medical service (EMS) with stomach pain. Review of a hospital After Visit Summary (AVS) for Resident #4 dated 10/19/25 revealed: -Resident #4's diagnoses included unspecified constipation and acute cystitis with hematuria (inflammation of the bladder accompanied with blood in the urine). -Resident #4 was prescribed Ciprofloxacin (a medication used to treat infection) with pharmacy address and telephone number for picking up the medication. Review of Resident #4's October 2025 electronic medication administration record (eMARs) revealed: -There was an entry for Ciprofloxacin 500mg tablet twice daily for five days with a start date of	D 358		

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D 358	Continued From page 18 10/22/25. -Ciprofloxacin 500mg tablet was documented as administered at 8:00pm on October 22, 2025 only. Interview with Resident #4 on 10/21/25 at 12:21pm revealed: -He was administered medications at the facility in the morning and at night. -He went to a local hospital on 10/19/25. -He was constipated and had a urinary tract infection. -He was started on and administered Cipro (brand name for Ciprofloxacin) while at the hospital. -Resident #4 was concerned that he had not been administered anymore Cipro since 10/19/25. Interview with Resident #4 on 10/22/25 at 10:23am revealed: -When he returned from the hospital on 10/19/25, he gave the facility medication aide (MA) the paperwork from the hospital emergency visit. -The MA made a copy of the hospital emergency room visit paperwork and returned the paperwork to him. -His medications were kept on the medication cart. -The only medication he had in his room was the Cipro he was prescribed at the hospital for the urinary tract infection. -The RCC knew he had the Cipro in his room, and he told the RCC he was going to keep the Cipro in his room. -The prescription was filled at the pharmacy on Monday (10/20/25). -He went to the pharmacy on 10/21/25 and picked up the Cipro. -He was already behind two days from taking the	D 358		

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D 358	Continued From page 19 Cipro. -He was supposed to be administered the Cipro two times a day. -He talked to the RCC on the morning of 10/21/25 and was told by the RCC that she (RCC) would call the pharmacy and have the Administrator pick up the Cipro from the pharmacy, but the Administrator did not pick up the Cipro from the pharmacy. -He called a family member on 10/21/25 to take him to the pharmacy and went to the pharmacy about 4:00pm and picked up the Cipro. -He asked the pharmacy (no name provided) if the facility had contacted them about delivering the Cipro and was told that nobody from the facility had called. -He was concerned about his health, he had a urinary tract infection in the past that turned septic and he did not want to get septic (Sepsis is a life-threatening condition that occurs when the body's immune system overacts to an infection that can be caused by any type of infection, including a urinary tract infection). -Resident #4 stated he was having pain in the right side on 10/20/25 and 10/21/25 and did not sleep good on the night of 10/21/25. -He took one of the Cipro on the evening of 10/21/25 and one tablet on the morning of 10/22/25. Observations of a pharmacy labeled medication container in Resident #4's room on 10/22/25 at 10:23am revealed: -A local pharmacy dispensed Ciprofloxacin HCL 500mg tablet twice daily, quantity of 10 tablets, on 10/20/25. -Resident #4 poured the medication from the medication container and there were 8 tablets in the medication container.	D 358		

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D 358	Continued From page 20 Interview with the RCC on 10/21/25 at 12:18pm revealed: -She called the local pharmacy on 10/21/25. -The local pharmacy was supposed to have delivered the Cipro for Resident #4 on 10/21/25. -Resident #4 went to pick up the medication "because he didn't want to wait". -She was made aware by Resident #4 that he had the Cipro and was not going to give it to the facility. Telephone interview with a Pharmacy Technician at the local pharmacy on 10/22/25 at 12:52pm revealed: -The pharmacy received a prescription for Resident #4 for the Cipro on 10/19/25. -The Cipro was ready for pick up on 10/20/25. -The local pharmacy delivered medication to the facility, but she did not see any request in the pharmacy record for a request for the Cipro to be delivered to the facility. Telephone interview with a pharmacist at the local pharmacy on 10/22/25 at 1:00pm revealed: -An antibiotic should be started as soon as possible. -It should not make a big difference if the next dose was received on 10/20/25 because the resident received a dose of the Cipro in the emergency room. -It would be important for the resident to complete the antibiotic therapy and would need follow up if still having symptoms. Interview with the Administrator on 10/23/25 at 10:50am revealed: -She was aware Resident #4 went to the hospital for stomachache and was prescribed an antibiotic. -She became aware on 10/20/25 of the antibiotic	D 358		

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D 358	Continued From page 21 prescribed for Resident #4. -She expected the Cipro antibiotic to be delivered to the facility by the contracted provider pharmacy on the afternoon of 10/20/25. -The RCC informed her on 10/20/25 "early in the day or sometime that day" the Cipro for Resident #4 was at another local pharmacy that delivered to the facility. -She knew Resident #4 went to the local pharmacy to pick up the Cipro but did not know when the resident picked up the Cipro from the pharmacy. -She was not aware of Resident #4 having any complaints after the hospital emergency room visit. -Antibiotics needed to be started as soon as the facility received it. -She expected antibiotics to be started in the afternoon of the date the pharmacy received the order if the pharmacy was local. Telephone interview with Resident #4's primary care provider (PCP) on 10/23/25 at 1:11pm revealed: -Depending on when the resident was discharged from the hospital, the antibiotic should start on the next day. -She did not know why there was a delay. -Typically, the medication was available at the facility on the next day following the hospital visit. -If the resident was symptomatic, she would be more concerned. The facility failed to obtain an antibiotic for Resident #4 for administration until two days post an emergency room visit with complaints of stomach ache which resulted in a diagnosis of urinary tract infection. The resident continued to have right-sided pain following the hospital emergency room visit. Resident #4 presented to	D 358	On 10-21 Resident 4 independently picked his own medication up from local pharmacy refusing to give to staff. Once the delay was discovered the med aides assessed the resident immediately for signs of infection or decline. Resident 4 was encouraged to allow staff to manage the medication. Provider was notified. Medication was administered by facility until finished. A review of residents receiving medications such as antibiotics was completed on 10-25-2025. No other residents had medication delays.	10-21-25 10-25-25

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D 358	Continued From page 22 the pharmacy to obtain the prescribed antibiotic for administration. This failure and delay in care was detrimental to the health and welfare of Resident #4 and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/21/25 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED December 7, 2025.	D 358	Clinical Nurse will in-service Resident Care coordinator and Med Aides on safe and accurate med passes, six rights medication administration, and order process system	11-26-25
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews the facility failed to ensure the staff observation of the resident actually taking their medication for 2 of 6 sampled residents (#1, #7). The findings are:	D 366	Facility Clinical Nurse will In-service the Resident Care Coordinator on the rule area found to be non-compliant:10A NCAC 13 F .1004 Facility Clinical Nurse will In-service Medication Aides on the following: 1.Med Administration 2. Accurate Documentation of Mar 3.Cart Audits 4. Order Processing	11-26-25 11-17-25 11-26-25

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D 366	Continued From page 23 Review of the facility's medication administration policy, undated, revealed all medications that staff members administer, handle, and store will be documented on the medication administration record (MAR) and in accordance with the state regulations. 1. Review of Resident #7's FL-2 dated 03/25/25 revealed: -Diagnoses included subarachnoid hemorrhage, gastroesophageal reflux disease, seizures, hypertension, and depression. -There was no information on orientation. Review of Resident #7's Resident Register revealed the resident was admitted 03/06/25. Review of Resident #7's physician orders dated 03/28/25 revealed: -There was an order for tamsulosin 0.4mg one capsule at 6:00pm (tamsulosin is used to treat the symptoms of an enlarged prostate). -There was an order for mirtazapine 15mg one tablet at 8:00pm (mirtazapine is used to treat major depressive disorder). Review of Resident #7's physician order dated 08/01/25 revealed there was an order for levetiracetam 1000mg one tablet twice daily (levetiracetam is used to treat seizures). Review of Resident #7's physician order dated 09/17/25 revealed there was an order for atorvastatin 20mg one tablet at 8:00pm (atorvastatin is used to lower cholesterol). Review of Resident #7's physician order dated 09/19/25 revealed there was an order for gabapentin 300mg one capsule at 8:00pm (gabapentin is used to treat seizures and pain).	D 366	ED, RCC will complete med pass observations with med aides to ensure proper documentation including six rights of medicatioin	12-7-25

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D 366	Continued From page 24 Review of Resident #7's physician order dated 10/02/25 revealed there was an order for buspirone 5mg one tablet three times daily (buspirone is used to treat anxiety disorders). Observation of Resident #7's room on 010/22/25 at 4:25pm revealed: -There were 6 multi dose pill packs of his medication in his nightstand drawer. -The multi dose pill packs each contained 6 pills and was labeled atorvastatin 20mg, buspirone 5mg, gabapentin 300mg, levetiracetam 1000mg, mirtazapine 15mg, and tamsulosin 0.4mg. -The pill blister packs were dated 10/01/25, 10/04/25, 10/06/25, 10/18/25, 10/19/25, and 10/20/25. Review of Resident #7's October electronic medication administration record (eMAR) revealed: -There was an entry for atorvastatin 20mg tablet documented as administered at 8:00pm on 10/01/25 through 10/21/25. -There was an entry for buspirone 5mg tablet documented as administered at 8:00pm on 10/01/25 through 10/21/25. -There was an entry for gabapentin 300mg capsule documented as administered at 8:00pm on 10/01/25 through 10/20/25. -There was an entry for levetiracetam 1000mg tablet documented as administered at 8:00pm on 10/01/25 through 10/21/25. -There was an entry for mirtazapine 15mg tablet documented as administered at 8:00pm on 10/01/25 through 10/21/25. -There was an entry for tamsulosin 0.4mg capsule documented as administered at 6:00pm on 10/01/25 through 10/21/25.	D 366		

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D 366	Continued From page 25 Interview with Resident #7 on 10/22/25 at 4:25pm revealed: -He began getting new medications without seeing his primary care provider (PCP) and did not know what the medications were for. -Some of medication aides (MAs) that passed medications came in and placed the pill blister pack on his dresser and left without watching to see if he took the medications. Interview with a medication aide (MA) on 10/23/25 at 9:45am revealed: -She passed medications to residents in the mornings. -She often saw unopened blister packs in Resident #7's room when she passed morning medications. -When she saw medications in resident rooms she would take them and give them to the Administrator. -The Administrator did not do anything to ensure medications were being administered to residents properly on the night shift. -Medication error reports should have been completed by the Resident Care Coordinator (RCC) or the Administrator. -Medication error reports were not completed for Resident #7. Interview with the RCC on 10/23/25 at 10:15am revealed: -She was not aware that the MAs were giving Resident #7 his night medications in the multi dose pill packs and not observing him taking them. -MAs were expected to observe residents actually take their medication before documenting the medication was administered on the eMAR. -MAs were expected to make 3 attempts to administer medications to residents, if they	D 366		

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D 366	Continued From page 26 refused 3 times a refusal was recorded on the eMAR. Interview with the Administrator on 10/23/25 at 2:35pm revealed: -The MAs that administered medications at night were not observing residents take their medications. -Staff members had reported to her that the night MAs were not observing residents take their medications. -The MA that was not observing residents take their medications was given a verbal warning, prior to the survey. -All of the MAs were given training on medication administration on 10/16/25. -MAs were expected to observe each resident take their medications before documenting on the eMAR that medications have been administered. Interview with Resident #7's PCP on 10/23/25 at 1:55pm revealed: -She was concerned that Resident #7 was missing multiple doses of his evening medications. -She expected the MAs to remove the medications from the multi dose pill packs and place them in a cup to be administered to the residents. -She expected the MAs to observe each resident take their medications before documenting that the medications were administered. -She was most concerned that Resident #7 missed doses of levetiracetam which could have caused the resident to have a breakthrough seizure. -She was concerned that Resident #7 missed doses of gabapentin because it could have caused increased neuropathy (pain, weakness, or numbness in one or more body parts).	D 366		

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D 366	Continued From page 27 2. Review of Resident #1's FL-2 dated 02/06/25 revealed: -Diagnoses included gastroesophageal reflux disease (GERD), chronic obstructive pulmonary disease (COPD), nerve pain, hypertension, seizures, lumbar stenosis with neurogenic claudication, urinary retention, and benign prostatic hypertrophy (BPH). -He was listed as intermittently disoriented. -There was an order for levocetirizine 5mg one tablet at bedtime (levocetirizine is used to treat allergy symptoms). -There was an order for senna 8.6mg two tablets at bedtime (senna is used to treat constipation). -There was an order for tamsulosin 0.4mg two capsules after dinner (tamsulosin is used to treat enlarged prostate and prevent urinary retention). -There was an order for acetaminophen 500mg two tablets three times daily (acetaminophen is used to treat mild pain). -There was an order for famotidine 20mg one tablet twice daily (famotidine is used to treat symptoms of GERD). -There was an order for gabapentin 100mg one capsule four times a day (gabapentin is used to treat nerve pain). -There was an order for guaifenesin extended-release (ER) 600mg one tablet twice daily (guaifenesin is used to treat excess mucus production). Review of Resident #1's Resident Register revealed the resident was admitted 09/25/23. Review of Resident #1's physician orders dated 02/13/25 revealed there was an order for celecoxib 200mg one tablet twice daily (celecoxib is used to treat pain).	D 366		

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D 366	Continued From page 28 Review of Resident #1's physician orders dated 02/26/25 revealed there was an order for tizanidine 2mg one tablet twice daily and 2 tablets at bedtime (tizanidine is used to treat pain from tense muscles). Interview with Resident #1 on 10/21/25 at 9:20am revealed: -He decided over a week ago that he took too many pills and stopped taking his nighttime medication. -He stored the medication he did not take in his top dresser drawer. -At least one person on staff brought his medication in but did not stay to watch him take the medication. -He had not told any facility staff he stopped taking his nighttime medication or his concerns about getting too much medication. -He denied any symptoms or concerns other than a headache. Observation of Resident #1's room on 10/21/25 at 9:20am revealed: -There were 9 medication cups with 17 pills in each in the top dresser drawer. -The medications were identified as 4 acetaminophen tablets, 2 tamsulosin capsules, 1 celecoxib tablet, 2 gabapentin capsules, 3 tizanidine tablets, 1 famotidine tablet, 1 levocetirizine tablet, 1 guaifenesin tablet, and 2 senna tablets in each cup. -There was no date or marking on the medication cups and all were uncovered. -The medication aide (MA) assigned to the hall entered the room, saw the cups of medication, and took them from the room. Review of Resident #1's October electronic medication administration record (eMAR)	D 366		

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D 366	Continued From page 29 revealed: -There was an entry for acetaminophen 500mg two tablets documented as administered at 4:00pm and 7:00pm on 10/01/25 through 10/20/25. -There was an entry for celecoxib 200mg one tablet documented as administered at 8:00pm on 10/01/25 through 10/20/25. -There was an entry for famotidine 20mg one tablet documented as administered at 8:00pm on 10/01/25 through 10/20/25. -There was an entry for gabapentin 100mg one capsule documented as administered at 6:00pm and 12:00am on 10/01/25 through 10/21/25. -There was an entry for levocetirizine 5mg one tablet documented as administered at 8:00pm on 10/01/25 through 10/20/25. -There was an entry for guaifenesin 600mg ER one tablet documented as administered at 8:00pm on 10/01/25 through 10/20/25. -There was an entry for senna 8.6mg two tablets documented as administered at 8:00pm on 10/01/25 through 10/20/25. -There was an entry for tamsulosin 0.4mg capsule two capsules documented as administered at 6:00pm on 10/01/25 through 10/20/25. -There was an entry for tizanidine 2mg tablet with 1 tablet documented as administered at 4:00pm and 2 tablets documented as administered at 8:00pm on 10/01/25 through 10/20/25. Interview with another resident on 10/21/25 at 11:30am revealed: -Most MAs at the facility did not watch residents swallow medication. -The Resident Care Coordinator (RCC) was the only staff member who consistently watched her swallow medications.	D 366		

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D 366	Continued From page 30 Interview with a MA on 10/22/25 at 2:45pm revealed: -She frequently found medication cups or multi-dose packs of medication in resident rooms from the prior evening. -When she found medications in resident rooms, she reported the findings to either the RCC or Administrator and took the medications to them. Interview with a second MA and the former RCC on 10/23/25 at 9:35am revealed: -She saw medications left in resident rooms "all the time" in drawers, dressers, and out on tables. -She had always reported these findings to the Administrator. -She did not do any medication error reports during her time as RCC for these errors, but completing medication error reports was the responsibility of the RCC or Administrator. Interview with the RCC on 10/23/25 at 2:10pm revealed: -She did not know there was an issue at the facility with some MAs not watching residents take medication. -MAs should always watch the residents swallow medication and not leave medications in the room. -She was in the process of addressing this concern now that she was aware. Interview with Resident #1's primary care provider (PCP) on 10/23/25 at 1:55pm revealed: -She was made aware of the 9 cups of medications being found in the resident's room on 10/21/25 and would see the Resident on 10/24/25 to discuss medications. -MAs not watching Resident #1 swallow medications was extremely concerning and her expectation was that residents were watched to	D 366		

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D 366	Continued From page 31 ensure medications were taken. -Resident #1 could have had increased gastrointestinal symptoms and pain from missing his nighttime medications. Interview with the Administrator on 10/21/25 at 10:00am revealed: -She was made aware of the medications found in Resident #1's room by the medication aide a few minutes earlier. -She would speak to Resident #1 about the importance of taking medication. -She would investigate the incident. -MAs were expected to watch residents swallow medication at each medication pass. Second interview with the Administrator on 10/21/25 at 3:45pm revealed: -She knew there was a problem with evening and night shift watching residents take medication. -She had spoken with one MA in particular about leaving medications in the room for patients to take instead of observing residents take medication. -She spoke to Resident #1 about the importance of taking medication as ordered and had asked his PCP to visit him on Friday, 10/24/25, to discuss his concern with the amount of medications that were ordered. Attempted telephone interview with a second shift MA on 10/23/25 at 2:20pm was unsuccessful. The facility failed to observe two residents (#1, #7) take their evening medications on multiple occasions, which included two medications to prevent seizures, a medication used to treat an enlarged prostate, a medication used to lower cholesterol, a medication to treat major depressive disorder, a medication to treat anxiety,	D 366	All medication packets found in the resident's 1 and 7 room were immediately retrieved and secured. Resident 1 and 7 were both assessed for negative effects from missed doses. The physician was notified of medication non-compliance. Resident was re-educated on the importance of taking medications as administered. Staff began directly observing all medication administration for resident 1 and 7 as well as all residents.	10-21-25 10-24-25 10-21-25 10-21-25 10-21-25

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D 366	Continued From page 32 which could have caused the resident to have a breakthrough seizure and increased neuropathy (#7), a medication used to treat constipation, medications used to treat pain, a medication used to treat allergies, a medication used to treat muscle tenseness, a medication used to treat excess mucus, and a medication used to treat gastrointestinal reflux disease (#1). This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/22/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 07, 2025.	D 366	Full facility room sweep was completed on 10-22-2023 to ensure no other residents were storing medications. Mar Audit completed. Staff re-educated to directly observe ingestion: watch, wait, witness meds Weekly room checks will be conducted to ensure residents are not storing meds. Meds found will be logged and investigated.	10-22-25 10-25-25 10-21-25 11-17-25 11-26-25 10-22-25
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 interviews and record reviews, the facility failed to complete incident/accident reports	D 451	Clinical Nurse will Inservice Executive Director and Resident Care Coordinator on Rule Area 10A NCAC 13F .1212(a) Reporting of Accidents and Incidents Each resident involved in missing incident report was assessed to confirm no ongoing injury or unmet needs. An audit of incident logs for the past 30 days were conducted to identify any other unreported incidents	11-26-25 10-24-25 10-24-25

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D 451	Continued From page 33 and notify the county Department of Social Services (DSS) for 2 of 6 residents sampled (#5, #8) who required emergency medical and hospital evaluations for falls. The findings are: 1.Review of Resident #5's current FL-2 dated 04/25/25 revealed diagnoses included arteriosclerotic cardiovascular disease, hyperlipidemia, essential hypertension, chronic obstructive pulmonary disease, gastro-esophageal reflux disease, anxiety disorder, depression, overactive bladder, partial bilateral paralysis, ambulatory dysfunction, and traumatic brain injury. Review of the Resident Register dated 04/22/25 for Resident #5 revealed: -The resident was admitted to the facility from home on 04/22/25. -The resident's special aid included a wheelchair and rollator walker. Review of an incident/accident report dated 10/10/25 for Resident #5 revealed: -Resident #5 was on the front porch at the facility when the Administrator saw her fall. -The resident sustained an open wound to the right side of the forehead. -Resident #5 was transported by emergency medical services (EMS) to the local hospital emergency department for evaluation and treatment. Interview with Resident #5 on 10/22/25 at 3:21pm revealed: -She had fallen since admission to the facility but did not know how many times. -She would lose her balance.	D 451	No additional residents were affected or identified, Staff Education includes: *Completion of incident report before shift ends. *supervisor review within 24 hours *final submission to DSS within 48hours All med aides received retraining on incident reports, documentation and follow-up	10-24-25 11-7-25 11-26-25

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D 451	Continued From page 34 -She went to the hospital one time about a month ago because she fell on the porch, hit and sustained a cut to her head. Interview with the Resident Care Coordinator (RCC) on 10/22/25 at 3:20pm revealed: -The medication aide (MA) on duty when an incident/accident occurred was responsible for completing the incident/accident report. -Either she or the Administrator completed incident/accident reports also. -She was not sure if Resident #5 had any incident/accident reports but believed there might have been one. Interview with the Adult Home Specialist (AHS) for the county Department of Social Services (DSS) on 10/22/25 at 3:07pm revealed she received an incident report by email on 10/21/25 regarding Resident #5's fall and hospital emergency room visit that occurred on 10/10/25. Interview with the Administrator on 10/23/25 at 10:40am revealed: -She remembered Resident #5 had a fall a week or so ago (no specific date provided), hit her head, and went to the local hospital emergency department. -She did not remember the exact date of the fall. -The incident/accident report was sent to the county DSS late because it did not get finished until 10/19/25. -She did not remember what needed to be finished to complete the incident/accident report. -She sent the incident/accident report to the county DSS on 10/21/25 and should have sent it with 48 hours of occurrence. -She was responsible for forwarding reportable incident/accident reports to the county DSS.	D 451		

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D 451	Continued From page 35 2. Review of Resident #8's current FL-2 dated 04/15/25 revealed diagnoses included unspecified dementia, gastrointestinal reflux disease (GERD), orthostatic hypotension, and gastritis. Review of Resident #8's care plan dated 04/16/25 revealed: -She was ambulatory with a walker. -She was independent with transfers, toileting, and ambulation and required limited assistance with bathing, dressing, and grooming. Review of Resident #8's primary care provider's (PCP) progress notes dated 08/22/25 revealed: -The patient fell on 08/22/25 and was sent to the emergency department (ED) due to hitting her head. -The testing in the ED was negative for head injury. -Resident #8 reported soreness from the fall. Interview with the Adult Home Specialist (AHS) for the county Department of Social Services (DSS) on 10/22/25 at 3:10pm revealed she received no incident and accident report from the facility for Resident #8 for the 08/22/25 fall with transfer to the ED. Interview with a medication aide (MA) on 10/22/25 at 5:05pm revealed: -The medication aide (MA) on duty when an incident/accident occurred was responsible for completing the incident/accident report. -The Resident Care Coordinator (RCC) or Administrator reviewed and finished the incident/accident report and sent to DSS. Interview with the RCC on 10/23/25 at 2:10pm revealed:	D 451		

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D 451	Continued From page 36 -The MA on duty should have started the incident/accident report and either the RCC or the Administrator would have signed off on the report. -The Administrator was responsible for sending the incident/accident report to DSS. -She was not in the RCC role on 08/22/25 and did not know why Resident #8's incident/accident report was not sent to DSS for Resident #8's fall and transfer to ED. Interview with the Administrator on 10/23/25 at 2:20pm revealed: -She did not realize there was no incident/accident report submitted to DSS for Resident #8's 08/22/25 fall. -She and the RCC should have ensured all incident/accident reports were submitted to DSS in a timely manner. Based on observations and record reviews it was determined that Resident #8 was not interviewable.	D 451		