STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL067025	A. BUILDING: _____ B. WING _____	R 10/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SWANSBORO	280 SWANSBORO LOOP ROAD SWANSBORO, NC 28584

(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 the Onslow County Department of Social Services conducted an annual and follow-up survey and complaint investigations on 10/27/25 through 10/31/25. The Onslow County Department of Social Services initiated complaints on 9/19/25, 9/29/25, 10/10/25 and on 10/14/25.	D 000	Response to cited deficiencies do not constitute an admission or agreement by the facility of the truth of facts alleged or the conclusions set forth in the corrective action report; the plan of correction is prepared solely as a matter of compliance with State Law.	
D 113	10A NCAC 13F .0311 (d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall supply hot water to the kitchen, bathrooms, laundry, housekeeping closets, and soiled utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F and shall not exceed 116 degrees F. Notwithstanding the requirements of Rule .0301 of this Section, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for the residents' fixtures pertaining to a lack of hot water for approximately 10 days in September 2025. The findings are: Review of the facility's current license effective 01/01/25 revealed the facility was licensed for a total capacity of 80 residents including 24 beds in a Special Care Unit (SCU).	D 113	Water temperatures will be checked 3 times per week by the Maintenance tech (MT). MT will review with the ED and the ED will sign off on the form acknowledging review. Any noted issues will be reported as to the RVPO and Divisional Maintenance Director (DMD). DMD will contact vendor if determined repairs cannot be completed by onsite personnel. RVPO and ED will coordinate and sister community to arrange for showers to be completed for the residents.	12/15/25 12/15/25 12/15/25 12/15/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

ED 12/16/25

Reviewed and acknowledged- MB on 12/18/25

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D 113	Continued From page 1 Review of the facility's census report provided on 10/27/25 revealed the current census was 57. Review of an email correspondence from a resident's family member dated 09/09/25 at 8:35pm revealed she was told by her family member that she had not had a showered because there had not been hot water in the facility for three days. Review of an email correspondence from the Administrator to the corporate maintenance group dated 09/10/25 at 11:23am revealed: -The facility did not have hot water outside the kitchen. -The facility's maintenance technician did a "flush" the previous night that brought the temperature up but it had returned to cold. Review of an email correspondence from the corporate maintenance Administrative Coordinator to the Regional Maintenance Director for the facility dated 09/10/25 at 1:21pm revealed there was no hot water outside of the kitchen at the facility. Review of an order detail dated 09/10/25 revealed there was an order for a circulator pump ordered to be sent to the facility. Review of a screenshot of the tracking details for the order dated 09/10/25 revealed the package was out for delivery at 3:38am on 09/16/25 and at 3:38am on 09/17/25. Review of an email correspondence from the Administrator to the corporate maintenance group dated 09/11/25 at 11:21am revealed the facility still did not have hot water and some of the	D 113	RVPO in-serviced ED and SCC on the importance of ensuring hot water is operational and and maintained at a minimum of 100 degrees F and shall not exceed 116 degrees F.	11/11/25

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D 113	Continued From page 2 residents reported the had not had not water in four days. Review of an email correspondence from a second resident's family member dated 09/14/25 at 6:22pm revealed: -She sent the email to the Administrator due to her "grave concern" about a hot water issue. -She stated that not having hot water for "this length of time" (length of time was not specified) presented an emergency and she requested information be shared as to what was being done and the time frame to resolve the issue. -She reported that her resident family member had been almost a week without a shower and then had a cold, barely warm shower on the previous Thursday which upset her family member (resident) a great deal. -She told the Administrator that it was not acceptable to not have facilities in which to shower and suggested the facility consider taking residents to the sister facility for showers during the emergency situation. -She stated that there was "absolutely no hot water in any resident's room no matter how long you let it run" and was disappointed at the lack of communication from the facility during the emergency situation. Review of the email response from the Administrator dated 09/15/25 at 10:58am revealed: -The facility had a circulation pump that was down which caused the hot water to take longer to travel to the resident rooms but was scheduled to be repaired the next day (09/16/25). -The hot water was not out and the water got hot faster in the spa shower rooms and was an option for showering. -She checked water temperatures that morning in	D 113		

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D 113	Continued From page 3 several rooms and the hot water temperature reached 100°F and over within a few minutes. -She reiterated to the team how to get the water hot while they waited for the pump repair. -She was not informed that the team's attempts were not successful until she received the email. Review of an email correspondence from the Regional Vice President of Operations (RVPO) dated 09/17/25 at 12:59pm revealed: -The RVPO sent an email to the Administrator asking if the pump had arrived. -She instructed the Administrator to begin coordinating transportation of the resident to a sister facility for showers. -The sister facility had 2 shower rooms and several empty rooms available for resident use. Review of the email response from the Administrator to the RVPO on 09/17/25 at 1:02pm revealed the part had not arrived and she would begin coordinating transport to the sister facility. Review of an environmental health inspection visit dated 09/17/25 revealed: -A visit was made to check the status of the hot water at the facility. -The Administrator reported the part needed to restore hot water had not arrived but updates indicated it would be delivered that day. -No transportation of residents had occurred to ensure residents had access to warm bathing facilities but the Administrator was working on coordinating with a sister facility. -The Administrator reported the SCU was receiving hot water but the AL side was not. Review of an environmental health inspection visit dated 09/18/25 revealed: -The visit was made to assess hot water to the	D 113		

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D 113	Continued From page 4 dietary kitchen and assess transport of residents to warm bathing facilities. -Three hands sinks, two preparations sinks and one three compartment sink for ware washing and the dish machine for ware washing in the dietary kitchen were checked. -The two hand sinks in the kitchen were peaking at 76 degrees Fahrenheit (°F) and the 2017 NC Food Code required the temperature to be at least 100°F. -The two hand sinks with hot water temperatures peaking at 76°F would need to have a temporary hand wash hygiene program until the hot water was prepared to reach at least 100°F. -The hand sinks should be stocked with hand sanitizer to be used after normal hand washing procedures as ser for in the the 2017 NC Food Code. -Environmental Health issued an intent to suspend giving 30 days for the hot water to be restored to the required standards. Review of an invoice dated 09/18/25 from the facility's contracted plumber revealed: -The customer replaced a CAD re-circulating pump and the technician found it was installed backwards. -Hot water was immediately restored throughout the building once the technician flipped the pump so it was installed correctly. -The pump was pushing cold water into the hot line and reduced the temperature. -There were 10 of 20 service valves for the hot water that were installed incorrectly, 2 expansion tanks were waterlogged and a dripping relief valve. Review of a second invoice dated 09/19/25 from the facility's contracted plumber revealed: -The technician removed and reinstalled 10	D 113		

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D 113	Continued From page 5 service valves that were not installed correctly. -The technician replaced a 4 gallon expansion tank. Telephone interview with a family member of a resident on the AL side of the facility on 10/29/25 at 9:49am revealed: -Her family member was unable to shower for 9-10 days in September 2025 because the hot water was not working at the facility. -Her family member told her she was offered transport to a sister facility for a shower but she was not sure when that happened or if the transport happened. -She did not know if other alternatives to a cold shower were offered while there was no hot water at the facility. Interview with a second resident on 10/30/25 at 4:33pm revealed: -The hot water was out for 10-12 days on the AL 100 hall in September 2025. -She attempted to shower during that time and the warm water suddenly turned cold while she was in the shower and it was the most horrible experience she had ever encountered. -She had been several days without a shower when she went with another resident and her family to their home to shower. -She did not remember being asked if she would have wanted to go to the sister facility to get a warm shower. -She was never told there was hot water in the spa rooms. Interview with a family member of the second resident on 10/30/25 at 4:01pm revealed: -She spoke with the Administrator several times during the time there was no hot water at the facility in September 2025 and was told the hot	D 113		

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D 113	Continued From page 6 water was never out at the facility. -She understood that things break but there seemed to be no sense of urgency in getting things fixed at the facility. Interview with a third resident on 10/27/25 at 8:55am revealed: -The facility was without hot water for at least 5 days. -She had to take cold showers during this time. -She went to her family's home on one occasion and had a hot shower. -It was her understanding that a plumber was not contacted until the day the hot water was restored. -She was offered to be transported to another facility for a shower, but she declined. Interview with a fourth resident on 10/28/25 at 2:15pm revealed: -The facility was without hot water for over a week. -No one in the facility had hot water for over a week. -She had to go to her family member's house on three occasions for a hot shower. Interview with the fourth resident's family member on 10/27/25 at 1:46pm revealed: -The facility was without hot water for 10 to 11 days and during this period there was a lack of communication with residents and family members regarding the hot water situation. -They were not alerted by the facility about the hot water issue for several days. -She contacted the health department and the health department came out and advised the facility either needed to bring out mobile shower units or transport the residents to a sister facility for showers.	D 113		

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D 113	Continued From page 7 -Her family member in the facility was taken to another family member's home on 3 occasions for a hot shower. -An alternative such as transport to another facility for a hot shower was not offered until the end when the hot water was restored. Second interview with the fourth resident's family member on 10/30/25 at 4:27pm revealed: -Her family member at the facility was mentally very frustrated and angry about the hot water situation. -As of 09/10/25, the facility still did not have hot water, and they were told a part had been ordered. -There was still no hot water on 09/11/25 and they were told all maintenance issues had to be handled by the corporate maintenance director located in the western part of the state. -The facility's maintenance person tried to fix the hot water situation, but the hot water was not restored until a plumber was called and came out on 09/18/25. -She felt the facility should have contacted a plumber once the hot water issue was discovered to correct the hot water issue. Interview with another family member of the fourth resident on 10/30/25 at 4:49pm revealed: -Her family member at the facility, notified her on 09/09/25 that the facility had been without hot water over the weekend and she had not had a shower in 3 days. -She emailed the Administrator on the evening of 09/09/25 about the hot water situation and received an email back the following morning 9/10/25 that the hot water was down for a couple of hours on 09/09/25 but had been restored and that she (the Administrator) was not informed of the hot water issue until the morning of 09/09/25.	D 113		

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D 113	Continued From page 8 -She was told verbally by the Administrator that a part had been ordered and was scheduled to arrive on 09/16/25 and the part arrived on 09/17/25. Interview with a fifth resident on 10/27/25 at 9:18am revealed: -The facility was without hot water for 10 days. -She heard the kitchen had a generator and that is how hot water was maintained in the kitchen. -Staff did not offer basins of warm or hot water from the kitchen for bathing. -Staff did offer transportation to a sister facility for a shower. Telephone interview with the Environmental Health (EH) Supervisor on 10/30/25 at 9:39am revealed: -She and a technician went to the facility on 09/11/25 to check on hot water. -The hot water temperatures were checked in each area of the facility and all hot water reached up to 116°F when water was allowed to run for 4-5 minutes. -She received several calls from residents' family members on 09/12/25: Residents resided on the 100 hall of the facilty. -EH returned on the 09/15/25 and there was no hot water at the facility at all. -She was informed the replacement pump was due to arrive the next day on 09/16/25. -She gave the facility instructions to begin transporting residents to the sister facility or obtain a portable shower facility and to begin with the residents on the SCU and then the residents on the 100 hall. -The instructions were verbally given to the Regional Maintenance Director and the Administrator. -EH returned to the facility on 09/16/25 and the	D 113		

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D 113	Continued From page 9 pump had not arrived. -She was informed that residents would begin being transported to a sister facility for warm water bathing on 09/17/25 but the facility did not transport residents until 09/18/25. -She did not know if residents had been informed to allow the hot water to run for awhile. -There were no alternatives offered to the residents by the facility for bathing and some family members took their resident home to bath. -The facility was issued an Intent to Suspend letter on 09/18/25. Interview with the Maintenance Director on 10/30/25 at 2:11pm revealed: -He first learned on 9/10/25 that the re-circulating pump was not working. -A resident complained there was no hot water. -He took a video of the pump that had gone bad and sent it to the Regional Maintenance Director at the corporate office. -There were two pumps that ran the system and the one pump never went out. -The facility was never without hot water until the day the pump came in. -Water was tested when the residents complained, and they had hot water in the spas. -He was not sure when residents were offered to go to the facility's sister facility to get showers. -Environmental Health came but he could not remember when and said that the water temperatures were good. -Environmental Health said water temperatures were good every time they came out except the day the pump came in. -Complaints were received on 10/7/25 that a resident was having trouble with hot water. -He checked the hot water and flushed the system because he believed the water system was clogged.	D 113		

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D 113	Continued From page 10 -Communication was terrible at the facility and said they do not tell him about issues for days. -He was able to locate the re-circulation pump was found online at a near by supply warehouse. -He did reach out through the corporate maintenance notification system regarding concerns with the hot water on 09/09/25 at approximately 5:00pm. -He did not receive a response from the email he sent on 09/09/25, so he wasn't sure if the email was sent. -There was an emergency credit card or ability to go buy the part, but the regional maintenance director had already made the decision and there was nothing he could do. Second interview with the Maintenance Director on 10/31/25 at 10:25am revealed: -The re-circulating pump arrived at the facility on 09/17/25. -He installed the pump but it was installed backwards and there was no hot water pumping through the facility. -A plumber was called the next day (09/18/25) and the hot water was restored. -It should not have taken so long to fix the hot water issue at the facility. Third interview with the Maintenance Director on 10/31/25 at 5:14pm revealed: -He would go to the Regional Maintenance Director directly if he needed to obtain parts in an emergency situation. -He did reach out through the corporate maintenance notification system regarding concerns with the hot water on 09/09/25 at approximately 5:00pm and the Administrator was also notified at that time. -He reported the concern because a staff member reached out to him to report a resident	D 113		

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D 113	Continued From page 11 complaint about the hot water. -He went to the facility on the weekend and flushed the water system but he was unsure if he went on Saturday (09/06/25) or Sunday (09/07/25). -He thought flushing the system would help and he thought the Administrator was aware on Monday 09/08/25. -He did not tell her he had been out the the facility over the weekend. -He did not have access to an emergency credit card in which to purchase parts immediately but hot water was a critical concern for residents at the facility. -He was told by the Regional Maintenance Director had been ordered through mail order business account. -He was unsure why the decision was made to order online and he did not ask for anything different to be done. Telephone interview with the facility's contracted plumber on 10/31/25 at 10:20am revealed: -The facility called the plumbing company on 09/18/25 regarding no hot water in the facility. -A technician was sent to the facility on 09/18/25. -The technician found that the re-circulating pump had been installed backward and hot water was restored when he reinstalled the pump on 09/18/25. Interview with a personal care aide (PCA) on 10/28/2025 at 9:50 am revealed that one Monday they were told there was no hot water and they went without hot water a solid week. Interview with the Administrator on 10/29/25 at 10:51am revealed: -There were approximately 10-15 residents on the AL that required assistance with bathing.	D 113		

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D 113	Continued From page 12 -The hot water was never completely out but was not consistent within the facility. -She became of aware of an issue with the facility's hot water on 09/10/25 when she received an email from a resident's family member. -Staff had not reported any concerns with not having hot water prior to the email on 09/10/25. -She checked hot water in several resident rooms and spa rooms on the AL and the SCU and the water got hot after running the water for a minute or so. -The Maintenance Director investigated and reported that one of the 2 circulating pumps for the hot water had gone bad. -The Regional Maintenance Director was contacted regarding the water pump and he ordered a new pump that was set to arrive on 09/16/25. -She thought she instructed staff to take residents to the spa rooms for showers as the water got hot much quicker in the shower rooms than it did in resident rooms. -Environmental Health (EH) inspector went to the facility on 09/11/25 or 09/12/25 and verified they had hot water after letting the water run for a few minutes. -The water would get hot quicker in rooms that were closer to the water heaters than those rooms furthermost away which was on the 100 hall. -On 09/14/25 or 09/15/25, she received an email from a resident's family member informing her that the water would hardly get warm even after letting it run. -On 09/15/25, she checked hot water temperatures and the water got hot so she educated staff staff that the spa rooms were still getting hot water at 110°F to 114°F. -On 09/16/25, the EH Supervisor came out to the facility and she and the EH Supervisor checked	D 113		

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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 113	Continued From page 13 water temperatures in the facility; Some areas were getting hot water and some were not. -The pump that was ordered and due to arrive on 09/16/25 did not arrive so the facility planned to take residents to a sister facility so they could get a hot shower. -A plumber was contacted and scheduled to come out to the facility on 09/18/25. -On 09/17/25, the Administrator gathered a list of residents that wanted to go to the sister facility to bathe. -The replacement water pump arrived around lunch time on 09/17/25 and the Maintenance Director installed the pump but the system was unable to maintain heat. -EH returned to the facility on 09/17/25 and found hand wash sinks that were not hot enough. -On 09/18/25, the facility transported 8 residents to a sister facility for a hot bath while the Maintenance Director and the contracted plumber worked to successfully restore hot water to the facility. -On 09/19/25, the contracted plumber returned to the facility to fix service valves that had previously been installed incorrectly. -Hot water temperatures were checked weekly by the Maintenance Director -No staff reported issues with the hot water prior to the Administrator receiving the email from a resident's family member on 09/10/25 and, when asked by the Administrator, the staff denied knowledge of any issues. -Staff were expected to report concerns immediately, even on weekends, and had access to her at all times through a communication app and her telephone. Second interview with the Administrator on 10/31/25 at 6:27pm revealed: -She was not aware the Maintenance Director	D 113		

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D 113	Continued From page 14 went to the facility over the weekend on 09/06/25 or 09/07/25 to flush the water system due to a resident complaint of having no hot water. -She would have assessed the situation and contacted her Regional Vice President of Operations to see what needed to be done to get things fixed earlier. -Obtaining replacement parts was the responsibility of the Regional Maintenance Director. -She would have liked to have a plumber out on 09/10/25. -She asked the Regional Maintenance Director what the interim solution would be on 09/10/25 and she never got a response from him. -She could have requested petty cash to get the needed replacement part if it was something that could have been obtained more quickly. -She did not know if anyone had called to see if the pump was locally available for purchase. -Discussions began prior to 09/15/25 regarding taking residents to a sister facility for showering and residents were offered to shower in the spa rooms. -Hot water at the facility was out from 09/16/25 to 09/18/25. Attempted telephone interview with the Regional Maintenance Director on 10/31/25 at 11:12am and 2:14pm were unsuccessful.	D 113		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care	D 269		

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D 269	Continued From page 15 needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to provide personal care assistance for 2 of 7 sampled residents (#7, #9) who required staff assistance with incontinence care and personal hygiene. The findings are: Review of Resident #9's current FL2 dated 07/16/25 revealed: -Diagnoses included unspecified dementia, chronic kidney disease (CKD), spinal stenosis, major depressive disorder (MDD), nonrheumatic aortic stenosis, repeated falls, unspecified fracture of right femur. -Resident #9's recommended level of care was assisted living facility. -Resident #9 was semi-ambulatory and incontinent of bowel and bladder. Review of Resident #9's Resident Register revealed an admission on 01/05/22. Review of Resident #9's current care plan dated 07/09/25 revealed: -Resident #9 was semi-ambulatory with a walker or wheelchair. -Resident #9 required additional help with transfers, bathing, and dressing. -Resident #9 required limited assistance with eating, toileting, ambulation/locomotion and grooming/personal hygiene. -Resident #9 required extensive assistance with bathing, dressing and transferring. Review of Resident #9's September 2025 facility	D 269	ED and care mangers will make unannounced visits to the community during the nightshift at random times to ensure double briefing is not occurring. ED and care managers in-serviced PCA's and MA's on on the importance of providing personal care to residents according to the care plan and to attend to any personal care needs the resident is unable to attend to themselves.	12/15/25 12/1/25

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D 269	Continued From page 16 progress notes revealed there were no entries in Resident #9's progress notes. Review of medication aide (MA) supervisor's witness statement on 09/01/25 revealed: -She reported to work at 11:15 pm on 08/31/25. -The personal care aide (PCA) reported to her after 1:00am on 09/01/25 that Resident #9 looked weak and looked like Resident #9 was not feeling well. -She checked on Resident #9 after receiving information that Resident #9 looked weak and was not feeling well and discovered Resident #9 sleeping. -The MA supervisor performed rounds with the PCA at 3:00am on 09/01/25. -The MA supervisor and the PCA changed Resident #9 during 3:00am rounds on 09/01/25. Review of a prior PCA witness statement on 09/01/25 revealed: -She worked the 11:00pm to 7:00am shift from 08/31/25 to 09/01/25. -She performed rounds between 3:00am and 3:30am and received assistance from the MA supervisor. -Resident #9 was breathing and sleeping. -On the last round Resident # 9 was checked and was found dry and was not changed. Interview with a MA on 10/29/25 at 9:50am revealed: -One brief was used on a resident at a time. -There had been times when a resident had put on two briefs if they had more awareness than other residents. -The PCA's checked on the residents to change their briefs -There were a lot of staff members who did not want to change residents briefs.	D 269		

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D 269	Continued From page 17 -There were a lot of staff who did not know how to redirect dementia residents. Interview with the Special Care Coordinator (SCC) on 10/29/25 at 10:18 am revealed: -She had instructed staff to not double brief residents. -There was never any reason for a resident to be double briefed. Interview with a second MA on 10/29/25 at 10:30 am revealed: -She never saw a resident double briefed. -She saw residents with an incontinence pad in their brief. Interview with a third MA on 10/31/2025 at 11:58am revealed: -She worked primarily on the special care unit (SCU) of the facility but worked on the assisted living side as well. -Residents were checked every two hours by all staff members. -The MAs were responsible for ensuring PCAs were changing residents. -Resident checks were to ensure that residents are breathing and dry. -Residents had been found saturated with urine. -Staff had reported some residents being double briefed. -She told the staff member to remove the second brief. Telephone interview with MA supervisor on 10/31/25 at 2:36pm revealed: -She had worked at the facility since 02/21/2025. -She normally worked the overnight shift from 7:00pm to 7:00am. -She worked 11:00pm to 7:00am shift from 08/31/25 to 09/01/25.	D 269		

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D 269	Continued From page 18 -Residents were checked every two hours to ensure they were present, accounted for and breathing. -She delegated duties during her shift since she was the only supervisor on the night shift. -She would perform resident checks as well. -Resident #9 needed assistance transferring, was incontinent, and was weak the night before he died. -Resident #9 was administered evening medications on 08/31/25. -She checked on Resident #9 during her shift on 08/31/25 and viewed Resident #9's chest rising and falling. -She delegated a PCA to perform checks on Resident #9 for the night shift beginning 08/31/25 to 09/01/25. -The PCA reported to her that checks were being done on Resident #9. -She did not have a conversation with the day shift staff regarding Resident #9 at shift change. -Resident #9 was on 72-hour monitoring. -She indicated charting notes were done within a 12-hour window. -She never saw any residents double briefed. -No one had reported to her that residents were being double briefed. -If she found someone was double briefing a resident she would use that as a teaching moment and have them remove the brief and report the incident to management. Telephone interview with the RCC on 10/31/25 at 3:22 pm revealed: -She saw staff double brief residents. -She saw a staff double brief a resident Friday night (10/24/25). -She met with the PCAs and let them all know that they could not double brief residents. -She did not report this to the Administrator	D 269		

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D 269	Continued From page 19 because she felt she did not have to since she was a manager at the facility. Interview with Administrator on 10/31/25 at 5:34pm revealed: -No staff members reported any concerns of resident being double briefed. -Double briefing residents was not allowed or permitted. Telephone interview with Resident #9's primary care provider (PCP) on 10/31/25 at 4:03 pm revealed: -She was not aware that Resident #9 was double briefed when he was found deceased on 09/01/25. -Double briefing increased the risk for yeast and skin breakdown. -Double briefing prevented staff from knowing how long a resident was in a dirty brief. 2. Review of Resident #7's current FL2 dated 07/29/25 revealed: -Diagnoses include dementia and frontotemporal neurocognitive disorder. -Her level of care was Special Care Unit (SCU). -She was incontinent of bowel and bladder. -She was constantly disoriented. -She required assistance with bathing and dressing. Review of Resident #7's Resident Register revealed: -She was admitted to the facility on 08/01/25. -She required assistance with dressing, bathing, nail care, shaving, toileting, mouth care, scheduling of appointments, and orientation to time and place. -She had significant memory loss and must be	D 269		

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D 269	Continued From page 20 directed. Review of Resident #7's care plan dated 08/25/25 revealed: -She had occasional urinary incontinence. -She required limited assistance with toileting, bathing, dressing, and grooming. -She was always disoriented. -She had significant memory loss and must be directed. Review of Resident #7's October 2025 Point of Care Completion summary revealed: -Under Miscellaneous Tasks, hygiene after toileting/incontinence was documented as not done on 10/11/25 for the 3:00pm to 11:00pm shift, with the exception documented as "deferred due to condition". -Under Miscellaneous Tasks, make bed every shift was documented as not done on 10/11/25 for the 3:00pm to 11:00pm shift, with the exception documented as "deferred due to condition". -Under Miscellaneous Tasks, mouth/oral/denture care every shift was documented as not done on 10/11/25 for the 3:00pm to 11:00pm shift, with the exception documented as "deferred due to condition". -Under Miscellaneous Tasks, put on clothing/socks/shoes every shift was documented as not done on 10/11/25 for the 3:00pm to 11:00pm shift with the exception documented as "deferred due to condition". -Under Miscellaneous Tasks, remove clothing/socks/shoes every shift was documented as not done on 10/11/25 for the 3:00pm to 11:00pm shift with the exception documented as "deferred due to condition". -Under Miscellaneous Tasks, remove/pullup/fasten garments every shift was	D 269		

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D 269	Continued From page 21 documented as not done on 10/11/25 for the 3:00pm to 11:00pm shift with the exception documented as "deferred due to condition". -Under the Miscellaneous Tasks, skin care (includes wash face/hands/foot care) every shift was documented as not done on 10/11/25 for the 3:00pm to 11:00pm shift, with the exception documented as "deferred due to condition". Interview with a personal care aide (PCA) on 10/31/25 at 10:40am revealed: -Staff checked on the residents every 2 hours for assistance with toileting and anything else they may need. -She checked on Resident #7 every 30 minutes because she was frequently incontinent of urine. -Resident #7 sometimes liked to sleep during the day but she still checked her every 30 minutes. -Resident #7 had behaviors and at times required two staff for toileting and dressing assistance. -She found Resident #7 double briefed on one occasion when the resident was first admitted to the facility but not since then. -Staff were never to double brief the residents. -There was one night when the third shift PCA came on duty and found Resident #7 soaked in urine and the second shift PCA blamed the first shift PCA. -She worked the first shift on that occasion, and it made no sense to her that if the second shift PCA found Resident #7 soaked with urine when she came on duty, why she would leave the resident wet all shift and not clean and change her. -She provided frequent incontinent care to Resident #7 on that day and every day she worked. -The second shift PCA was suspended for not providing care to Resident #7 on that occasion. Interview with a second PCA on 10/31/25 at	D 269		

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D 269	Continued From page 22 2:10pm revealed: -She worked mainly the 3:00pm to 11:00pm shift in the SCU for about six months. -Staff never did rounds at shift change and would just say "everyone is fine" and leave. -There was no communication between staff at shift change. -The facility was always short staffed. -The residents were checked every 2 hours. -Resident #7 was a two-person assist and was usually combative unless she was asleep. -When Resident #7 was combative, it was best to leave her alone. -On the 3:00pm to 11:00pm shift, there was a MA and two PCAs on duty. -On 10/11/25 during the 3:00pm to 11:00pm shift, Resident #7 was combative and received an "as needed" medication for behaviors and slept the entire shift. -On 10/11/25 there was another PCA working in the SCU with her and the other PCA refused to help her with Resident #7 and the medication aide (MA) would not help her with Resident #7 either. -Since no one would help her with Resident #7 on 10/11/25 she could not change her and all she could do was "lay eyes" on Resident #7 because she could not handle her by herself. -She was suspended on 10/11/25 but she had already planned to quit her position at the facility. -She was never told by the facility not to double brief residents, but she knew not to. -She frequently found residents double briefed and it was not uncommon for night shift to leave residents lying in urine. -She said "it did no good to report these incidents to management because if you reported something you would end up getting in trouble for reporting".	D 269		

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D 269	Continued From page 23 Interview with a medication aide (MA) on 10/31/25 at 3:02pm revealed: -Resident #7 was combative and had behaviors. -Resident #7 required constant one on one supervision and needed constant re-direction. -Resident #7 was a 2-person assist and required frequent incontinence care. -Resident #7 did not always cooperate with staff and she has had some PCAs refuse to change her. -There was an incident when a PCA told her she did not have time to change Resident #7, so she found another PCA and they provided incontinence care for Resident #7. -There was a second incident when a PCA refused to change Resident #7, so she found another PCA and they changed Resident #7. -Staff must go the "extra mile" to help change Resident #7 and she was always available to the PCAs to assist with Resident #7. -She had never found Resident #7 double briefed. Interview with a second MA on 10/31/25 at 11:58am revealed: -She mainly worked in the SCU. -The residents were checked at least every two hours. -The MAs were responsible to make sure the PCAs did their job. -It was a team effort of the PCAs and the MAs to check on the residents at least every two hours to make sure they were breathing and to make sure they were clean and dry. -Resident #7 drank a lot of fluid and was frequently incontinent and the PCAs checked her every 30 minutes. -Resident #7 frequently liked to sleep in the mornings but staff checked her frequently and made sure she received her meals.	D 269		

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D 269	Continued From page 24 -There were one or two times when she found Resident #7 incontinent of urine when she came in on day shift. -As best she could remember one staff had reported that they found a resident double briefed but she did not think it was Resident #7. Interview with the Special Care Coordinator (SCC) on 10/31/25 at 10:37am revealed: -Staff checked the residents every 2 hours to make sure they were clean and dry. -Resident #7 was frequently incontinent and staff checked her more frequently than every 2 hours. -Resident #7 liked to sleep during the day, especially in the morning but staff checked her frequently. Second interview with the SCC on 10/31/25 at 4:03pm revealed: -The residents were checked by staff every 2 hours to make sure they were dry and breathing and to see if they needed anything. -Resident #7 was sometimes a two-person assist depending upon her behavior. -Resident #7 was frequently incontinent and was checked more frequently than every 2 hours. -Double briefing was a "big no no" and she had never found a resident double briefed and staff had never reported double briefing to her. -Double briefing could cause skin breakdown and placed the resident at a higher risk for developing yeast. -There was one occasion that was reported to her that Resident #7 had not received incontinent care on the 3:00pm to 11:00pm shift and the PCA really did not have a reason for not changing Resident #7. Interview with the Administrator on 10/31/25 at 5:34pm revealed:	D 269		

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D 269	Continued From page 25 -Staff checked the residents at least every two hours to make sure they were clean, dry, and comfortable. -There was an occasion when it was reported to her that Resident #7 did not receive continent care on the 3:00pm to 11:00pm shift because the resident was asleep and this was unacceptable and the PCA was suspended. -Double briefing of residents was unacceptable and had never been reported to her. -Double briefing could cause skin breakdown and placed residents at risk for urinary tract infections. Telephone interview with Resident #7's primary care provider (PCP) On 10/30/25 at 2:32pm revealed: -Resident #7 had lots of behavior issues and liked to sleep during the day. -She had changed Resident #7's medications probably 5 or 6 times since she was admitted to try to help with her behaviors and her sleep schedule. -She was not aware that Resident #7 had not received care during a shift due to her sleeping. -She knew Resident #7 could be a handful and often refused care, but she expected staff to provide personal care and incontinence care for Resident #7. Second interview with Resident #7's PCP on 10/31/25 at 4:17pm revealed double briefing put residents at increased risk for yeast infections and skin breakdown. Based on observations, interviews, and record reviews, it was determined that Resident #7 was not interviewable.	D 269		

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D 270	Continued From page 26	D 270		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on record reviews, and interviews, the facility failed to ensure 1 of 8 sampled residents (#9) was appropriately supervised after numerous falls with physical injury and was found in his room deceased for several hours. The findings are: Review of Resident #9's current FL2 dated 07/16/25 revealed: -Diagnoses included unspecified dementia, chronic kidney disease (CKD), spinal stenosis, major depressive disorder (MDD), nonrheumatic aortic stenosis, repeated falls, unspecified fracture of right femur. -His recommended level of care was assisted living facility. -He was semi-ambulatory and incontinent of bowel and bladder. -He needed assistance with bathing and dressing. -He was verbally abusive and able to	D 270	ED and Care Managers will pull and review the falls report during morning meeting to ensure a new intervention has been implemented to assist the resident with their current care needs. Regional Clinical Nurse in-serviced ED, SCC and MA's on the importance of ensuring a new meaningful intervention is put in place each time there is a fall, answering the call lights timely and ensuring the room is free of clutter. ED and care managers will round at least twice daily to ensure staff are provide supervision to residents base on their current assessed needs.	11/30/25 11/14/25 11/30/25

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D 270	Continued From page 27 communicate verbally. Review of Resident #9's Resident Register revealed he was admitted to the facility on 01/05/22. Review of Resident #9's current care plan dated 07/09/25 revealed: -His last exam date was 06/04/25. -He was verbally abusive with disruptive behavior and was socially inappropriate. -He had limited strength and limited range of motion in upper extremities. -He had limited range of motion and strength in bilateral arms and legs and a torn meniscus in his knee. -He had daily bowel and bladder incontinence. -He required additional help from staff for transfers, bathing, and dressing. -He required limited assistance from staff for eating, toileting, ambulation, grooming and personal hygiene. -He required extensive assistance from staff for bathing, dressing, and transferring. -He was sometimes disoriented, was forgetful and needed reminders. Review of Resident #9's facilty progress notes dated 08/13/25 revealed: -There was an entry at 4:28pm, the primary care provider (PCP) was contacted and made aware of a fall. -There was an entry at 4:29pm, a message was left with his responsible party (RP) asking for a return call. -There was an entry at 4:33pm, a fall occurred at 3:30pm and the PCP and his RP were contacted. Review of Resident #9's facility incident/accident (I/A) report on 08/14/25 revealed:	D 270		

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D 270	Continued From page 28 -He had an unwitnessed fall in the dining room at 4:23pm. -He was found laying on his back on the dining room floor. -He indicated the fall happened while trying to sit on a chair and fell. -He did complain of pain. -Injury was noted to back of head, arm left/right side with skin tear. -First aid was not administered. -He was alert and oriented. -He was transported to the hospital by emergency medical services (EMS). - Record status of resident after emergency department (ED)/hospital indicated Resident #9 needed to follow up with PCP. -Orders received on 08/14/25 to check vital signs every shift for 72 hours. Special instructions: Check vital signs for three days every shift. -Orders received on 08/14/25 to monitor status for 72 hours for bruising, change in mental status/condition, pain, or other injuries related to fall. -Special instructions: complete a shift note for 72 hours. -Treatments on 08/16/25 included wheelchair. Special instructions: remind resident throughout the shift to lock wheelchair when standing/transferring and a sign was posted. -Evaluation notes indicate to ensure that Resident #9 would lock wheelchair when standing to prevent falls. -Fall prevention program was initiated. -Care plan did not need to be updated. Review of Resident #9's EMS record dated on 08/14/25 revealed: -Onset time of 4:00pm on 08/14/25. -Last known well at 4:20pm on 08/14/25. -Chief complaint: Fall/injury to lower back and	D 270		

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D 270	Continued From page 29 head. -Duration: 20 minutes. -Call received on 08/14/25 at 4:25pm. -At patient on 08/14/25 at 4:38pm. -Signs and symptoms: Injury to lower back (primary), injury to head, low back pain. -Injury: Falls-Fall from chair - 1 ft- Assisted living center on 08/14/25. -Resident #9 had head pain, swelling and tenderness. -Resident #9 had back, sacral, midline pain on range of movement (ROM) and tenderness. -Resident #9 had left elbow pain. Motor function was normal, pulse was normal, sensation was normal. Resident #9 had tenderness and swelling. -Resident #9 had right elbow pain, swelling and tenderness. -Resident #9 had normal motor function, pulse is normal and sensation is normal. -In narrative notes: EMS dispatched for a fall, upon arrival the FD was already on scene and made contact with Resident #9. -Resident #9 was found on the floor, laying on his back in no acute distress. -Resident #9 indicated the fall happened due to transitioning from walker chair to a dining room chair and lost balance. -Resident #9 fell to the floor hitting lower back and the back of head. Resident #9 denied any headache, loss of consciousness, blurry vision, nausea or chest pain. -Trauma assessment revealed swelling on the back of head, tenderness and pain upon palpation of lower back, minor skin tears and swelling bilaterally on elbows. -Trauma alert was activated and Resident #9 was placed in a c-collar. -Resident #9 was transported to the hospital.	D 270		

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D 270	Continued From page 30 Review of Resident #9's emergency department documentation from the trauma hospital dated 08/14/25 revealed: -Resident #9 fell out of roller chair when transferring to another chair. -Resident #9 struck head on floor but had no loss of consciousness. -Resident #9 reported lower back midline pain and mild occipital headache where head struck the floor. -Resident #9 had bilateral elbow abrasions. -Bleeding was controlled with gauze for the abrasions to the right and left elbows. -Resident #9 was cleared for discharge. Review of Resident #9's facility progress note dated 08/15/25 revealed an entry at 6:12 am indicating a follow up from a fall, Resident #9 did not complain of pain, no change in mental status was witnessed, no additional injuries since the fall were seen. Review of Resident #9 facility progress notes dated 08/17/25 revealed: -There was an entry at 7:31 pm and was recorded as a late entry on 08/18/25 at 2:34 am, for antibiotic therapy, Resident #9 had no adverse effects witnessed, did not have a temperature greater than 101 degrees, and had no changes in behavior since antibiotic therapy began. -There was an entry at 6:53 pm, follow up from a fall and antibiotic therapy, Resident #9 had not complained of any pain, there was no mental status change noted, no additional injuries since fall witnessed, no adverse effects seen from antibiotic therapy, no temperature greater than 101 degrees, and no change in behavior since antibiotic therapy began. Review of Resident #9's facility progress note	D 270		

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D 270	Continued From page 31 dated 08/18/25 revealed an entry at 6:53 pm, follow up for a fall, Resident #9 did not complain of pain, no mental status change was witnessed, no additional injuries since the fall were seen. Review of Resident #9's progress note dated 08/20/25 revealed an entry at 2:16 pm, the RP was contacted and a message was left asking for a return call and his PCP was contacted and informed of what happened. Review of Resident #9's facility progress note dated 08/21/25 revealed an entry at 3:09 am, follow up for a fall, Resident #9 did not report any pain, there was no mental status change witnessed, no additional injuries noted since fall. Review of Resident #9's facility progress note dated 08/27/25 revealed an entry at 2:57 pm that an activity was refused. Review of Resident #9's facility I/A report on 08/28/25 revealed: -He had an unwitnessed fall on 08/28/25 at 10:00 am. -He was found lying on the floor with knees up under to chest. -He indicated the fall occurred due to attempting to transfer to a recliner. -He did not complain of any pain. -First aid was not administered. -He roused when name was called. -He was transported to the hospital by EMS. -Record status of Resident after ED/hospital indicated Resident #9 had a urinary tract infection (UTI) and needed to follow up with his PCP. -Orders received on 08/29/25 check vital signs every shift for 72 hours. -Special instructions: Check vital signs for three days every shift.	D 270		

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D 270	Continued From page 32 -Orders received on 08/29/25, monitor status for 72 hours for bruising, change in mental status/condition, pain, or other injuries related to fall. -Special instructions: complete a shift note for 72 hours. -Interventions on 08/29/25 included wheelchair. -Special instructions, remind resident throughout the shift to lock wheelchair when standing/transferring and a sign was posted. -Evaluation notes indicate to remind resident throughout the shift to lock wheelchair when standing/transferring and a sign was posted. -Fall prevention program was initiated. -Care plan did not need to be updated. Review of Resident #9's EMS record dated on 08/28/25 at 9:30am revealed: -Onset time of 9:30am on 08/28/25. -Last known well at 9:29am on 08/28/25. -Chief complaint: bilateral knee injuries secondary to fall. -Duration: 1 hour. -Call received on 08/28/25 at 9:55am. -At patient on 08/28/25 at 10:34am. -Signs and symptoms: injury to knee (primary), knee pain. -Injury: Falls-Fall on same level - 0 ft- Nursing home on 08/28/25. -He was oriented to event, person, place, and time. -His skin was dry and warm. -He reported 9/10 pain in the left and right knee. -Redness was noted to both knees. -A small skin tear was observed on the right knee. -In narrative notes: Responded in reference to a fall, upon arrival, the FD was already on scene with Resident #9. -Resident #9 was in a sitting position in	D 270		

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D 270	Continued From page 33 wheelchair. -Resident #9 had a chief complaint of bilateral knee injuries secondary to a fall. -Resident #9 indicated the fall happened while attempting to transfer from walker to wheelchair. -Resident #9 indicated that balance was lost, and this led to a fall. -Resident #9 denied hitting head or loss of consciousness. -Resident #9 indicated both knee's received the impact of the fall. -Redness was observed to right and left knee. -No deformities or swelling or tenderness was noted to either region. -Vital signs remained unremarkable until just before arriving at the hospital where a slight drop in blood pressure (BP) was noted, no other abnormalities or injuries observed. Resident #9 was non-diaphoretic, warm and dry. -Resident #9 appeared stable and was responding appropriately. Review of Resident #9's facility progress notes dated 08/28/25 revealed: -There was an entry at 2:57 pm, a message was left for his RP, asking for a return call and the PCP was contacted informing her that Resident #9 had a fall and was sent out. -There was an entry at 3:00 pm, Resident #9 was transported to the hospital via EMS for a fall, his PCP and RP were notified and an incident report was completed. -There was an entry at 6:34 pm, Resident #9 returned from an ED visit, his RP was contacted, a readmission skin assessment with full vital signs was completed and medication adjustment was not needed and no follow up appointments were added to the calendar. -There was an entry at 6:35 pm, Resident #9's RP was contacted and informed Resident #9 had	D 270		

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D 270	Continued From page 34 returned from the ED and his PCP was contacted, and informed Resident #9 had returned from the ED. Review of Resident #9's facility I/A report on 08/28/25 revealed: -He had an unwitnessed fall in room on 08/28/25 at 8:30 pm. -He was observed on the floor beside the bed. -He reported falling from the bed to the floor and hit head. -He reported pain from fall. -First aid was not administered. -Redness was observed on the front of Resident #9's head. -EMS was contacted and Resident #9 was transported to hospital. -He was alert and oriented. -Order for fall on 08/29/25: check vital signs every shift for 72 hours. Special instructions: Check vital signs for three days every shift. -Order for fall on 08/29/25: Monitor status for 72 hours for bruising, change in mental status/condition, pain, or other injuries related to fall and complete a shift note for 72 hours. -Intervention on 08/29/25: Toileting schedule-select appropriate schedule for the resident because Resident #9 needed scheduled toileting times for fall prevention. Review of Resident #9's EMS record dated 08/28/25 at 8:00pm revealed: -Onset time of 8:00pm on 08/28/25. -Last known well at 8:00pm 08/28/25. -Chief complaint: Fall with head injury. -Duration: 30 minutes. -Call received on 08/28/25 at 8:35pm. -At patient on 08/28/25 at 8:56pm. -Signs and symptoms: injury to head (primary), acute pain due to trauma, hip pain, injury to	D 270		

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D 270	Continued From page 35 elbow, repeated falls. -Injury: Falls-Fall from bed - 2 ft- Assisted living center on 08/28/25. -Resident #9 had head injuries, a one-inch head laceration on forehead. -A c-collar was placed on Resident #9 for neck injury prior to EMS arrival. -Resident #9 received bandaging from FD prior to EMS arrival. -Resident #9 had left elbow injury, right hip injury with normal motor function, normal pulse, and sensation. -Resident #9 had pain. -There was delayed contact with resident contact due to facility access. -Upon arrival, the FD was on scene and assessing Resident #9. -Resident #9 was found lying on the ground. -Resident #9 reported falling out of the bed onto the linoleum floor. -Resident #9 indicated laying on the ground for approximately 30 minutes before receiving help. -Resident #9 denied loss of consciousness and reported minor head pain, left elbow pain and right hip pain. -Resident #9's fall was unwitnessed. -Resident #9 was on blood thinners. -Resident #9 denied any other symptoms. -All vitals obtained in ambulance were within normal limits. -Enroute to the hospital, IV access attempted but was unsuccessful. Review of Resident #9's emergency department documentation from trauma hospital dated 08/29/25 revealed: -Resident #9 was found laying on the floor beside bed. -Resident #9 reported being on the floor for approximately one hour.	D 270		

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D 270	Continued From page 36 -Resident # 9 had complaints of lumbar back pain, various skin tears/lacerations. -Computed Tomography (CT) of the abdomen revealed subacute L1 vertebral body (the first lumbar vertebrae) compression fracture. -CT of the cervical spine negative for acute traumatic processes. -Urine analysis results are consistent with a urinary tract infection (UTI). -Resident #9 was recommended for follow up with PCP. -Cefpodoxime (cefpodoxime is an antibiotic used to treat bacterial infections) 200 mg oral tablet ordered, give every 12 hours for 10 days. Review of Resident #9's EMS record dated on 08/30/25 revealed: -Onset time of 1:34pm on 08/30/25. -Last known well at 1:45pm on 08/30/25. -Chief complaint: multiple skin tears. -Duration: 15 minutes. -Call received on 08/30/25 at 1:57pm. -At patient on 08/30/25 at 2:08pm. -Signs and symptoms: multiple injuries. -Injury: Falls-Fall from bed - 2 ft- Assisted living center on 08/30/25. -Resident #9 was oriented to person, time, place, and event. -Resident #9 had a contusion and tenderness to head. -Resident #9 had an abrasion on his face. -Resident #9 had a contusion on his right lower abdomen. -Resident #9 had left forearm other and left shoulder tenderness. -Resident #9 had right forearm other. -Resident #9 had right leg contusions on the whole foot and knee. -In narrative notes: EMS was dispatched for a fall. -Resident #9 was found lying on back on the	D 270		

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D 270	Continued From page 37 floor. -Resident #9 was alert and oriented x4 with airway patent, breathing adequate, and strong circulation. -The FD was on the scene. -Resident #9 indicated no serious injuries with only some skin tears and minor bumps. -Resident #9 had a hematoma and abrasion skin tear to the left forehead/frontal area of head. -Resident #9 had no problems breathing and no other injuries noted. -No step-off or neck pain noted. -On Resident #9's torso, mild tenderness was noted to the right chest wall, lung sounds are clear bilaterally. -Resident #9 had a red mark to the right hip/right lower quadrant area. -Resident #9 had a skin tear and small contusion on right knee with redness and tenderness to the right foot and ankle. -Resident #9 has bilateral skin tears on elbows, one of which is a couple of days old and already had bandaging on it that has come off. -Resident #9 also has a slight contusion and tenderness to the left shoulder. -In narrative notes: Resident #9 refused transport to the hospital, the facility insisted and required Resident #9 be transported to the hospital and that Resident #9 was being enforced to go as the power of attorney (POA) is Resident #9's family member. -EMS discussed with Resident #9 and was able to come to an agreement and Resident #9 agreed to transport to a specific hospital. -In narrative notes: Resident #9 indicated to EMS the reason for the fall was because Resident #9 was left sitting on the side of the bed. -Resident #9 indicated nursing staff left Resident #9 there for about an hour or an unknown amount of time.	D 270		

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D 270	Continued From page 38 -Resident #9 indicated that during this time, Resident #9 began to slide and feet went under the bed and Resident #9 fell forward to the right side and out of bed. -Resident #9 indicated that consciousness was not lost and denied back pain. -Resident #9 had weakness, which was normal. -Resident #9 was not in agreement with nursing staff and was upset because he felt nursing staff left him too long and this led to the fall as well as other incidents. -Resident #9 refused cervical spine collar (c-collar) and signed refusal. -Resident #9 was alert and oriented and transported non-emergent to the hospital. -Resident #9 noted to have poor circulation in fingers and vital sign erases were considered erroneous. Review of Resident #9's emergency department documentation from the trauma hospital dated 08/31/25 revealed: -History of Present illness: Resident #9 brought into the hospital for a fall after leaning against bed for 1.5 hours causing legs to become weak and Resident #9 slipped down and hit head, side and right leg. -Resident #9 denied losing consciousness. -Resident #9 had a lateral ankle contusion. -Resident #9 had advanced knee osteoarthritis. -Resident #9 had a fracture of right talus (ankle bone) which was a new development. -Resident #9 had compression fracture of lumbar spine, a subacute L1 fracture that was present on prior visit of 08/28/25. -A controlled ankle motion (CAM) boot was ordered and placed on Resident #9, as the talar avulsion fracture was non-operable. -A referral for orthopedics was ordered. -Resident #9 was discharged back to the facility.	D 270		

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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 270	Continued From page 39 -Medications were unchanged. Review of Resident #9's progress notes dated 08/31/25 revealed: -There was an entry at 1:08 pm, Resident #9 returned to the facility from the hospital. -There was an entry at 1:10 pm, Resident #9's RP was contacted and informed that Resident #9 returned from the hospital and was in bed. Review of Resident #9's September 2025 facility progress notes revealed there were no entries in the progress notes for September 2025. Review of Resident #9's Report of Death to the Department of Health and Human Services (DHHS) on 09/01/25 revealed: -His admitting diagnoses were vhronic kidney diesease, urinary retention, spinal stenosis, neuropathy, anxiety and obsessive features, hypertension (HTN), muscle weakness, excessive cerumen. -He had repeated falls and an unspecified fracture of right femur prior to death. -He was diagnosed with unspecified dementia. -He was admitted to an acute care hospital on 08/30/25. -He was not adjudicated incompetent. -Date and time of death was discovered at 09/01/25 at 7:41am. -A personal care aide (PCA) discovered Resident #9. -Resident #9 was discovered in bed. -The PCA alerted the medication aide (MA) of Resident #9's death. -Resident #9 was transferred to the hospital post fall. -Resident had a fall and was transported to the hospital on 08/28/25 and returned to the facility on 08/31/25.	D 270		

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D 270	Continued From page 40 -Resident was found unresponsive by staff on 09/01/25. -Law Enforcement (LE) arrived on scene around 8:00am and pronounced Resident #9 expired. Review of Resident #9's September 2025 electronic medication administration record (eMAR) revealed: -Medications scheduled at 8:00am were documented as administered. -A knee brace was documented as placed on Resident #9 at 8:30am on 09/01/25. -There was an entry to encourage Resident #9 to participate in activities within the facility as part of fall prevention during first shift on 09/01/25 and was documented as completed. -There was an entry to remind Resident #9 to use assistive devices between 7:00am and 7:00pm on 09/01/25 and was documented as completed. -There was an entry to check that Resident #9's call bell/pendent was within reach between 7:00am and 3:00pm on 09/01/25 and was documented as completed. -There was an entry to check that Resident #9 had on correct footwear between 7:00am and 7:00pm on 09/01/25 and was documented as completed. -There was an entry to provide Resident #9 with a calming/quiet area to avoid behaviors between 7:00am and 7:00pm on 09/01/25 and documented as completed. -There was an entry a one on one activity that was meaningful was provided for Resident #9 to avoid behaviors between 7:00am and 7:00pm on 09/01/25 and was documented as completed. -There was an entry to make sure ¼ or ½ rails were being used for Resident #9 between 7:00am and 3:00pm on 09/01/25 and was documented as completed. -There was an entry to provide redirection to	D 270		

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D 270	Continued From page 41 avoid behaviors with Resident #9 between 7:00am and 3:00pm on 09/01/25 and was documented as completed. -There was an entry for scheduled toileting in time for fall prevention for Resident #9 between 7:00am and 7:00pm on 09/01/25 and was documented as completed. -There was an entry to remind Resident #9 to lock his wheelchair when standing/transferring 7:00am and 3:00pm on 09/01/25 and was documented as completed. Review of Resident #9's vital signs report revealed: -Vital signs were recorded for Resident #9 on 09/01/25 at 11:46 am. -His vital signs were documented as pulse of 56/per minute, respirations of 16/per minute, blood pressure of 117/90. -No vital signs were documented on 08/31/25. -Vital signs were recorded for Resident #9 on 08/30/25 at 5:59 am. -His vital signs were documented as pulse of 70/per minute resting rate, respirations of 18/per minute resting rate, blood pressure of 138/86 while lying down resting. Review of a PCA witness statement dated 09/01/25 revealed: -She started passing breakfast to residents around 8:20am. -She entered Resident #9's room between 8:37am and 8:40am to attempt to wake Resident #9 up. -She attempted to move Resident #9 three to four times while calling Resident #9's name with no response. -Another staff member came to the room with her and she informed the other staff member Resident #9 was dead.	D 270		

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D 270	Continued From page 42 -She ran to get the MA to inform him Resident #9 was deceased. -She observed Resident #9 appeared to be calling for someone. Review of a MA witness statement dated 09/01/25 revealed: -A PCA alerted him around 9:00am on 09/01/25 that there appeared to be something wrong with Resident #9. -He went to Resident #9's room and found Resident #9 unresponsive and not breathing. -He contacted 911 and the care manager. -He attempted to check Resident #9's status when another MA ran up stating Resident #9 was a full code. -He stated that the county fire department (FD) showed up when they were going to start cardiopulmonary resuscitation (CPR). Review of a second MA witness statement dated 09/01/25 revealed: -She was alerted by a PCA around 8:00am on 09/01/25 to respond to Resident #9's room since it was reported that Resident #9 had no signs of life. -The FD had already arrived and repositioned Resident #9 on the floor to perform CPR. Review of Resident #9's EMS report dated 09/01/25 revealed: -Onset time of 3:00am on 09/01/25. -Last known well at 8:00pm on 08/31/25. -Chief complaint: possible death. -Duration: 4. -Call received on 09/01/25 at 8:46am. -At Patient 09/01/25 at 8:57am. -In the narrative notes, upon arrival EMS was greeted by the FD who indicated that Resident #9 was in obvious rigor with jaw locked and open	D 270		

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D 270	Continued From page 43 and with a stiff neck. (According to the National Institute of Health, rigor mortis is the stiffening of muscles that occurs after death. It begins approximately 2 hours after death in the muscles of the face and progressed to the limbs over several hours and is complete between 6 and 8 hours after death.) -It was stated that Resident #9 was found laying in bed and FD transferred him to the floor for possible CPR when signs of rigor were noted. -Once EMS arrived in the room, there were obvious signs of incapability with life and time of death was called. -Skin was noted as cold and pale. Telephone interview with EMS staff member on 10/29/25 at 2:30 pm revealed: -EMS responded to the facility for Resident #9 several times. -On 09/01/25, EMS was dispatched emergent. -EMS was called out to the facility for Resident #9 on 08/30/2025 for a fall. -The FD was already on scene and Resident #9 was in obvious rigor mortis, with obvious signs of death. -Time of death was called at the scene. -Resident #9 had been moved from the bed to the floor to attempt CPR. -EMS was called to the facility for Resident #9 for the following dates: 08/14/25, 08/28/25, 08/28/25, 08/30/25 and 09/01/25. Telephone interview with EMS staff member on 10/30/25 at 4:01 pm revealed "Last known well" is the last time EMS was notified on scene that a patient was known to be seen alive and well. Telephone interview with EMS Clinical Captain on 10/30/25 at 4:09 pm revealed 8:00pm on 08/31/25 was the last known time someone saw	D 270		

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D 270	Continued From page 44 Resident #9. Telephone interview with EMS Lead responder on 10/30/25 at 4:27 pm revealed: -The times indicated on EMS report from 09/01/25 were a guess. -Last known well time was noted as a guess based on information staff members relayed, staff felt Resident #9 had not been checked on during the night shift. -Resident #9 was double briefed and saturated. -The duration of the event on 09/01/25 was guess based on how stiff Resident #9 was when assessed by EMS. Telephone interview with the EMS driver on 10/30/25 at 4:59 pm revealed: -The FD was already on scene with Resident #9. -Resident #9 fell days before his death. -The death was obvious and he appeared to have passed peacefully. -Staff reported to EMS, Resident #9 was last seen at 8:00pm the night prior but this could have been the last time he was observed. -The FD identified the rigor mortis. -Resident #9 was very stiff and onset and duration were based on this information. -Facility staff wanted Resident #9 back on the bed to perform incontinent care since the adult brief had not been changed. -Resident #9's adult brief appeared to be saturated and full. -Resident #9 was double briefed. -Day shift staff was upset since it appeared night shift had not changed Resident #9's brief. Interview with a MA on 10/29/25 at 4:10pm revealed: -He was working at the facility on 09/01/25. -He was alerted by a PCA assigned to Resident	D 270		

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D 270	Continued From page 45 #9 that Resident #9 appeared to be deceased. -He accompanied the PCA to Resident #9's room. -He observed Resident #9 to be pale with mouth open. -He checked Resident #9 for a pulse and found none. -He stated Resident #9's skin was cold and the body felt stiff and did not move. -He did not give any medications to Resident #9 on 09/01/25 and did not know why he would have recorded giving medications and performing interventions for Resident #9. -He indicated that Resident #9 woke up later in the morning and received his medications later in the morning shift. -He indicated that Resident #9 was not on a list to be awakened later in the morning. -He indicated that the PCAs and the MAs would wake Resident #9. -He indicated that when resident checks were completed, the PCAs and MAs were laying eyes on the residents and then walking out. Interview with a second MA on 10/31/25 at 12:09pm revealed: -The residents were checked every two hours. -She indicated the MAs and PCAs were responsible for completing all facility I/A reports for all falls, even when there was no injury. -The Care Managers completed the facility I/A reports and they had 72 hours to complete it. Second interview with the second MA on 10/31/25 at 6:08pm revealed there were no interventions or increased supervision put in place for Resident #9 that she was aware of after his repeated falls and rapid decline. Telephone interview with the MA supervisor on 10/31/25 at 2:36pm revealed:	D 270		

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D 270	Continued From page 46 -She has worked at the facility since 02/21/25. -She normally worked the overnight shift from 7:00pm to 7:00am. -She worked 11:00pm to 7:00am shift from 08/31/25 to 09/01/25. -The residents were checked every two hours to ensure they were present, accounted for and breathing. -She delegated duties during her shift since she was the only supervisor on the night shift. -She performed resident checks as well. -Resident #9 needed assistance transferring. -Resident #9 was incontinent. -Resident #9 had a rapid decline a few weeks prior to Resident #9's death as evidenced by frequent falls. -Resident #9 would not use his call bell. -Staff would find Resident #9 on their rounds. -Resident #9 was very independent and of sound mind but had times of confusion. -Resident #9 at times had visible injuries and they would convince him to go to the hospital. -Resident #9 was administered evening medications on 08/31/25. -She checked on Resident #9 during her shift on 08/31/25 and viewed Resident #9's chest rising and falling. -He was monitored every 2 hours with no increased supervision or interventions put into place. -She did not have a conversation with the day shift staff regarding Resident #9 at shift change. -She was not sure if Resident #9's vital signs were checked during her shift. -Resident #9 was on 72-hour monitoring following a fall. -Charting notes were done within a 12-hour window. Interview with the Administrator on 10/31/25 at	D 270		

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D 270	Continued From page 47 5:34pm revealed: -She thought the Care Manager put more safety measures in place for Resident #9. -The Care Manager should have added additional interventions in place for Resident #9. -More frequent checks should have been performed for Resident #9. The facility failed to ensure increased supervision for Resident #9 who experienced multiple unwitnessed falls with injuries which required transport to the emergency department. Resident #9 had several falls over a 3 week period resulting in an ankle fracture and a fracture of his L1 vertebrae. Resident #9 sustained 2 falls on 08/28/25 and another fall on 08/30/25 after being left on the side of the bed by facility staff. He was discharged back to the facility on 08/31/25 and was found deceased on the morning of 09/01/25. The facility's failure resulted in neglect which constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/31/25 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED NOVEMBER 30, 2025.	D 270		
D 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures.	D 271		

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D 271	Continued From page 48 This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews, the facility failed to ensure staff members initiated cardiopulmonary resuscitation (CPR) for 1 of 1 resident who was found unresponsive and not breathing (#9) and had a full code status. The findings are: Review of Resident #9's current FL2 dated 07/16/25 revealed: -Diagnoses included unspecified dementia, chronic kidney disease (CKD), spinal stenosis, major depressive disorder (MDD), nonrheumatic aortic stenosis, repeated falls, unspecified fracture of right femur. -Resident #9's recommended level of care was assisted living facility. Review of Resident #9's Resident Register revealed an admission on 01/05/22. Review of Resident #9's record revealed there was not a Do Not Resuscitate (DNR) order on file. Review of Resident #9's current care plan dated 07/09/25 revealed: -Resident #9 was semi-ambulatory with a walker	D 271	Care staff was re-educated by the RCN on the emergency response protocols. ED will ensure the DNR book is updated and staff have been educated on where to locate the binder as well as where to find the code status within the EHR system. ED will conduct emergency response drills with the staff at least quarterly to ensure correct emergency response procedures are followed.	11/11/25 11/30/25 11/30/25

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D 271	Continued From page 49 or wheelchair. -Resident #9 required additional help with transfers, bathing, and dressing. -Resident #9 required limited assistance with eating, toileting, ambulation/locomotion and grooming/personal hygiene. -Resident #9 required extensive assistance with bathing, dressing and transferring. Review of Resident #9's September 2025 facility progress notes revealed there were no entries in Resident #9's progress notes. Review of Resident #9's Report of Death to the Department of Health and Human Services (DHHS) dated 09/01/25 revealed: -Resident #9's admitting diagnoses as CKD, urinary retention, spinal stenosis, neuropathy, anxiety and obsessive features, hypertension (HTN), muscle weakness, excessive cerumen. -Resident #9 had repeated falls and an unspecified fracture of right femur prior to death. -Resident #9 was diagnosed with unspecified dementia. -Resident #9 was admitted to an acute care hospital on 08/30/25. -Resident #9 was not adjudicated incompetent. -Date and time of death was discovered at 09/01/25 at 7:41am. - A personal care aide (PCA) discovered Resident #9. -Resident #9 was discovered in bed. -The PCA alerted the medication aide (MA) of Resident #9's death. -Resident had a fall and was transported to the hospital on 08/28/25 and returned to the facility on 08/31/25. -Resident was found unresponsive by staff on 09/01/25. -Law Enforcement (LE) arrived on scene around	D 271		

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D 271	Continued From page 50 8:00am and pronounced Resident #9 expired. Review of Resident #9's vitals report revealed: -No vitals were recorded on 08/31/25. -Vitals were documented for Resident #9 on 08/30/25 at 5:59 am. -A MA recorded a pulse of 70/per minute resting rate, respirations of 18/per minute resting rate, blood pressure of 138/86 while lying down resting. Review of the PCA witness statement on 09/01/25 revealed: -She started passing breakfast to residents around 8:20am. -She entered Resident #9's room between 8:37am and 8:40am to attempt to wake Resident #9 up. -She attempted to move Resident #9 3 to 4 times while calling Resident #9's name with no response. -Another staff member came to the room with her and she informed the other staff member Resident #9 was deceased. -She ran to get the MA to inform him Resident #9 was deceased. Review of a MA witness statement on 09/01/25 revealed: -The PCA alerted him around 9:00am on 09/01/25 that there appeared to be something wrong with Resident #9. -He went to Resident #9's room and found Resident #9 unresponsive and not breathing. -He contacted 911 and care manager. -He attempted to check Resident #9's code status when prior MA ran up stating Resident #9 was a full code. -The county fire department (FD) showed up when they were going to start cardiopulmonary	D 271		

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D 271	Continued From page 51 resuscitation (CPR). Review of second MA witness statement on 09/01/25 revealed: -MA was alerted by a PCA around 8:00am on 09/01/25 to respond to Resident #9's room since it was reported that Resident #9 had no signs of life. -The FD had already arrived and repositioned Resident #9 on the floor to perform CPR. Review of county Emergency Medical Services (EMS) report dated on 09/01/25 revealed: -Onset time of 3:00am on 09/01/25. -The Resident was last known well at 8:00pm on 08/31/25. -EMS received a call on 09/01/25 at 8:46am for a possible death. -They arrived to the patient 09/01/25 at 8:57am. -Upon arrival EMS was greeted by the FD who indicated that Resident #9 was in obvious rigor (a medical term meaning a stiffening of muscles and joints a few hours after death), with jaw locked and open and with a stiff neck. -Resident #9 was found laying in bed and the FD transferred him to the floor for possible CPR when signs of rigor mortis was noted. -Once EMS arrived in the room, there were obvious signs of incompatibility with life and time of death was called. -Resident #9's skin was noted as cold and pale. Interview with MA on 10/29/25 at 4:10pm revealed: -He was working at the facility on 09/01/25. -He was alerted by a PCA assigned to Resident #9 that Resident #9 appeared to be deceased. -He accompanied the PCA to Resident #9's room. -He observed Resident #9 to appear pale with mouth open.	D 271		

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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 271	Continued From page 52 -He checked Resident #9 for a pulse and found none. -Resident #9's skin was cold and the body felt stiff and did not move. -He did not perform cardiopulmonary resuscitation (CPR) training on Resident #9 because his certification was expired. -Another MA was called to the room who had CPR training. -He did not observe any staff members initiate CPR on Resident #9. -He contacted 911. Telephone interview with a second MA on 10/31/25 at 11:20am revealed: -She was working on the Special Care Unit (SCU) when she was alerted by a PCA from the Assisted Living (AL) side of the facility who informed her Resident #9 was stiff around 8:00am on 09/01/25. -She began looking for a defibrillator. -She did not begin CPR because she was told by the Administrator not to touch Resident #9. -She did not observe any other staff members perform CPR on Resident #9. -She contacted 911 on 09/01/25. -The MA who was assigned to Resident #9 contacted the Administrator. Interview with a third MA on 10/31/25 at 11:58am revealed: -She did not respond to Resident #9 on 09/01/25. -When a resident was found unresponsive, staff contacted 911 as soon as possible. -A delay in contacting 911 could be caused by the facility being short staffed. -Staff should be checking the resident's vitals and performing CPR until EMS arrived. -Staff would not know if a resident was a DNR because it was not posted in the resident's room. -She received training from the Resident Care	D 271		

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	HAL067025	A. BUILDING: _____ B. WING _____	R 10/31/2025

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D 271	Continued From page 53 Coordinator (RCC) on when to perform CPR and when not to perform CPR when she was hired. Telephone interview with the MA supervisor on 10/31/25 at 2:34pm revealed: -She worked at the facility since 02/21/25. -She normally worked the overnight shift from 7:00pm to 7:00am. -She worked 11:00pm to 7:00am shift from 08/31/25 to 09/01/25. -Resident #9 had a rapid decline a few weeks prior to his death as evidenced by frequent falls. -Resident #9 was weak the night before he died. -Resident #9 was administered evening medications on 08/31/25. -She checked on Resident #9 during her shift on 08/31/25 and viewed Resident #9's chest rising and falling. -She did not have a conversation with the day shift staff regarding Resident #9 at shift change. Telephone interview with the RCC on 10/31/25 at 3:22 pm revealed: -911 should be contacted immediately when a resident was found unresponsive. -It was important to contact 911 immediately because staff was not aware of what was happening to that resident. Interview with the Administrator on 10/31/25 at 12:42pm revealed: -In an emergency situation, such as a resident being found unresponsive, a MA needs to be alerted and the care manager and the Administrator need to be notified. -EMS or hospice should be alerted after contacting a MA, care manager and the Administrator. -The resident's PCP would be notified after EMS or hospice.	D 271		

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D 271	Continued From page 54 -A staff member would need to wait with the resident and a staff member would need to be present at the front of the facility to allow entry for EMS into the building. -The resident's area would need to be secured. -MA's would need to check the resident's record or the MAR to determine if a resident was a DNR because it was not posted in resident's rooms. -She was notified that Resident #9 was deceased after EMS arrived on scene. -She was not informed if CPR was conducted on Resident #9 and was not aware if it had been performed. -She did not direct staff to not perform CPR because it was expected. -EMS was contacted for Resident #9 when meals were being given around 8:00am on 09/01/25. -There would not have been a delay in contacting EMS to respond to Resident #9 being found unresponsive. Telephone interview with Resident #9's primary care provider (PCP) on 10/31/25 at 4:03 pm revealed: -Resident #9 was a full code status though there had been discussion of making him a DNR. -Resident #9's wishes were to be a full code. -She was not aware that CPR was not performed on Resident #9. -The expectation for residents with a full code status is that CPR was performed on residents even when they were found without a pulse. -She indicated that performing CPR was important to save a life and the sooner CPR was started, the better the outcome. -Resident #9's wishes were to be a full code. -CPR had to be initiated immediately, because staff did not know if the resident was deceased. The facility's policy on responding to medical	D 271		

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D 271	Continued From page 55 emergencies was requested on 10/31/25 at 10:04am and was not provided. Interview with the Regional Vice President of Operations on 10/31/25 at 10:13am revealed the facility did not have a policy on responding to medical emergencies. The facility failed to provide immediate care and intervention to a resident (#9) who was found not breathing and unresponsive at 7:41am and staff who were certified in cardiopulmonary resuscitation (CPR) failed to initiate CPR on Resident #9 who was a full code status and failed to immediately call 911. Emergency Medical Services (EMS) was not called until 8:46am, approximately 1 hour and five minutes after the Resident #9 was found unresponsive. When EMS personnel arrived at the resident's room and began to prepare to initiate CPR, Resident #9 was found in a state of rigor mortis with jaw locked, open, with a stiff neck, cold and pale. This failure placed the resident at substantial risk of serious physical harm or death and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/31/25 for this violation. CORRECTION DATE FOR TYPE A2 VIOLATION SHALL NOT EXCEED November 30, 2025.	D 271		
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.	D 273		

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D 273	Continued From page 56 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure health care coordination and follow-up for 2 of 5 sampled residents (#1, #4) pertaining to no documentation provided to dietary staff for a resident with a diagnosis of lactose intolerance (#1) and a delay in obtaining ordered spine and chest xrays for a resident after sustaining a fall (#4). The findings are: 1. Review of Resident #4's current FL-2 dated 08/08/25 revealed: -Diagnoses included paralysis of left upper extremity, gait instability, and frequent falls. -She was intermittently disoriented. -Her level of care was domiciliary. Review of Resident #4's Resident Register revealed she was admitted to the facility on 08/11/25. Review of Resident #4's primary care provider (PCP) order dated 10/23/25 revealed: -There was an order for thoracic spine x-rays and chest x-ray with rib views. -The diagnosis was "pain with a fall". Review of Resident #4's PCP provider progress note dated 10/23/25 revealed: -The resident was seen today for a fall. -She sustained a fall a couple days ago but did not feel she needed to go out but now had bruising and discomfort in the left posterior rib area and low back.	D 273	ED and Care Managers will discuss all referrals received during the daily managers meeting to ensure timely follow-up. Care managers will utilized the order processing system. Orders will not be filed in the EHR until the referral has been sent and documentation has been completed in a progress note. Daily follow-up will be documented in the EHR for any noted delays in 3rd party providers receiving, processing or starting an order. PCP will be notified of any delays and communication will be documented in the EHR. RCN re-educated ED and Care Manager on assuring referral and follow-up to meet the routine and acute health care needs of the residents.	12/15/25 12/15/25 12/1/25

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D 273	Continued From page 57 -Diagnoses for the visit included unspecified fall, contusion of left back wall of thorax, sprain of ligaments of the lumbar spine. -Physical exam included moderate amount of ecchymosis (bruising) over left posterior ribs with mild tenderness. -Treatment plan included obtain left rib x-rays and lumbar spine x-rays. Review of Resident #4's staff progress notes revealed there was no entry pertaining to a fall for Resident #4 for October 2025. Review of Resident #4's x-ray results dated 10/28/25 revealed there were no acute fractures. Interview with Resident #4 on 10/27/25 at 8:55am revealed: -She had been at the facility for about 2 months. -Last week on 10/22/25 around 4:00am, she fell and hit her back and had to crawl to her door for help because she could not reach her call bell. -She had pain and bruising on her back and was supposed to have x-rays last Friday 10/24/25, but mobile x-ray had not come yet. Second interview with Resident #4 on 10/28/25 at 10:52am revealed: -She was still waiting for mobile x-ray to come and do the ordered x-rays. -Her back was some better, but she still had a bruise at her middle back on the left side. Observation of Resident #4 on 10/28/25 at 10:52am revealed a large purple to yellow discolored area to the left side of her back just below her middle back, the discolored area extended to the upper left lumbar region of her back.	D 273		

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D 273	Continued From page 58 Observation of the facility on 10/28/25 at 10:54am revealed the mobile x-ray provider arrived at Resident #4's room. Interview with the Administrator on 10/28/25 at 3:00pm revealed: -Resident #4 fell in the early morning hours of 10/22/25. -Resident #4 was seen by the facility's contracted PCP on 10/23/25 and x-rays were ordered. -She and the Resident Care Coordinator (RCC) were in the room with the PCP ordered x-rays for Resident #4. -It was the responsibility of the Care Managers either RCC or the Special Care Coordinator (SCC) to contact mobile x-ray for Resident #4. -The RCC should have contacted mobile x-ray on 10/23/25 for Resident #4. -She thought the RCC may have forgotten to contact mobile x-ray for Resident #4. -She just found out earlier today that Resident #4 had not had x-rays done when she spoke with Resident #4 earlier today on her rounds. -She called mobile x-ray earlier today and was told they were on their way to the facility to do Resident #4's x-rays. -She did not know why the RCC had not contacted mobile x-ray on 10/23/25 when Resident #4 was seen by the PCP. -There should not have been a delay in contacting mobile x-ray for Resident #4. -The RCC was out on sick leave currently. Interview with a representative with the facility's mobile x-ray provider on 10/29/25 at 1:51pm revealed: -A call was received on 10/26/25 at 12:26pm from the facility about x-ray orders for Resident #4. -They contacted the facility on 10/27/25 and advised that they did not have an x-ray technician	D 273		

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D 273	Continued From page 59 available on 10/27/25 and the x-ray technician would be out on 10/28/25 to do Resident #4's images. -A call was received from the facility on 10/28/25 at 10:41am and the facility was told the x-ray technician was on the way to the facility to do Resident #4's images. -Resident #4 images were done at 11:15am on 10/28/25. Second interview with the Administrator on 10/29/25 at 2:54pm revealed: -Resident #4 was seen by her PCP on 10/23/25. -She was certain she and the RCC were present when Resident #4 was seen by her PCP, and the x-rays were ordered. -The x-ray order for Resident #4 should have immediately been phoned to the mobile x-ray provider by the RCC. -She asked the RCC on 10/24/25 about the mobile x-ray order for Resident #4 and the RCC said she knew nothing about an x-ray order for Resident #4 but would take care of it. -She did not know why mobile x-ray was not notified of the Resident #4's x-ray orders until 10/26/25. Telephone interview with the RCC on 10/31/25 at 3:22pm revealed: -It was her responsibility to send orders for the residents residing on the assisted living hall. -Resident #4 was one of the last residents to be seen by the PCP on 10/23/25. -She did not know the PCP had ordered x-rays for Resident #4. -She did not see orders for Resident #4 for x-rays from the 10/23/25 visit. -She called the PCP on Friday 10/24/25 and was told Resident #4 needed x-rays but she did not have an order.	D 273		

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D 273	Continued From page 60 -She received an order for Resident #4's x-rays around 5:00pm on Friday 10/24/25. -On Friday 10/24/25, she was busy and worked on the medication cart, and on the floor and did not have time to phone in the order for Resident #4's x-rays. -She did not work on Saturday 10/25/25 and phoned Resident 4's x-ray orders on Sunday 10/26/25 when she returned to work. -She had not worked at the facility since Sunday 10/26/25. Telephone interview with Resident #4's PCP on 10/30/25 at 2:38pm revealed: -She saw Resident #4 on 10/23/25 after a fall with bruising had been reported to her. -She ordered x-rays for Resident #4 because she had bruising on her back and complained of pain in the area of the bruising. -She had received Resident #4's x-ray results back which were negative. -She did not order Resident #4's x-rays stat but expected that it would not have taken 5 days for Resident #4's x-rays to be done to be sure she did not have a fracture. 2.Review of Resident #1's current FL-2 dated 07/17/25 revealed: -Diagnoses included type II diabetes and muscle weakness. -Allergies included lactose in the attached physicians orders. -She was ordered a regular diet. Review of Resident #1's Resident Register revealed: -She was admitted on 06/12/25. -Lactose intolerant was listed in the food preferences section.	D 273		

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D 273	Continued From page 61 Review of the resident diet list in the kitchen on 10/27/25 revealed there was no documentation of lactose intolerance for Resident #1. Interview with Resident #1 on 10/27/25 at 3:37pm revealed: -She was lactose intolerant. -She had problems loose stools, 5-6 each day, and there were some days she had gas and stomach pains. -She refused to drink milk but loved to eat ice cream despite it hurting her stomach. -She felt like cheese was put on everything that was served. -Her primary care provider (PCP) was aware of her stomach issues and was prescribed medication to help with the loose stools but she thought it would help her stomach if the facility did not serve her dairy products. Second interview with Resident #1 on 10/28/25 at 12:01pm and 12:34pm revealed: -She did not plan to go to the dining room for her meal because her stomach was upset and she wanted to stay close to her bathroom. -She had spoken with medication aides in the past and told her provider about the problems she has with eating dairy and the facility continued to serve her dairy and give her medications instead of not serving dairy to her. Observation of Resident #1's lunch service on 10/28/25 at 12:34pm revealed: -Resident #1's meal tray was brought to her room and ice cream was served with her meal. -She told the staff to take the ice cream and give it to someone else because it made her sick. Telephone interview with Resident #1's primary care provider (PCP) on 10/30/25 at 2:19pm	D 273		

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D 273	Continued From page 62 revealed: -Resident #1 was ordered a regular diet and dairy was not addressed. -She was not aware dairy products were served to Resident #1. -Resident #1 was cognizant and could decide what she ate and did not eat. -The facility should not serve dairy to a resident that was lactose intolerant. -She thought one of Resident #1's medications was causing her stomach upset. Telephone interview with Resident #1's family member on on 10/29/25 at 9:49am revealed Resident #1 has had problems with eating dairy and stomach upset for as long as she could remember. Interview with a medication aide (MA) on 10/27/25 at 3:20pm revealed: -Resident #1 was on a regular diet and there was not notation of lactose intolerance or dairy restriction. -Resident #1 complained of an upset stomach frequently. -He had observed Resident #1 served ice cream and cheese. Interview with a cook on 10/28/25 at 12:43pm revealed: -There was currently no Dietary Manager for the facility. -Resident #1 was listed as lactose intolerant. -She was served ice cream at lunch. -There was no dairy free alternative to offer lactose intolerant residents. Interview with the Administrator on 10/28/25 at 2:34pm revealed: -The Dietary Manager was responsible for	D 273		

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D 273	Continued From page 63 ensuring the diet list was available to kitchen staff and included lactose intolerance. -There was currently no Dietary Manager at the facility. -The cooks were responsible for plating the residents' food and should not be serving dairy products to residents that were lactose intolerant because it could hurt their stomach. The facility failed to meet the acute health care needs for 2 of 5 sampled residents. Resident #1 had a history of lactose intolerance which was not communicated to dietary staff and the resident was repeatedly served dairy foods such as cheese and ice cream which resulted in frequent bouts of abdominal pain and diarrhea and a 5 day delay in obtaining spine and chest x-rays ordered after a fall with pain and bruising for Resident #4. The failure of the facility was detrimental to the health 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 10/29/25 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 15, 2025.	D 273		
D 315	10A NCAC 13F .0905 (a & b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to	D 315		

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D 315	Continued From page 64 require any individual to participate in any activity against his or her will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to develop and implement an activity program to engage residents with each other and the community. The findings are: Review of the facility's Life Journey Program policy dated September 2021 revealed: -The facility would have a program of activities designed to promote residents' active involvement with each other, their families and the community. -The facility would prepare a monthly calendar of planned group activities with a minimum of 14 hours of a variety of planned group activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills. -The Life Enrichment Coordinator would evaluate and document the overall effectiveness of the activities program at least every six months with input from the residents to determine what have been the most valued activities and to elicit suggestions of ways to enhance the program. -Resident would have the opportunity to participate in activities involving one to one interaction and activity by oneself that promote enjoyment, a sense of accomplishment, increased knowledge, learning of new skills and creative expression. -Each resident would have the opportunity to	D 315	ED, SCC and LEC were re-educated by the RVPO on the importance of developing and implementing a program of activities designate to promote the resident active involvement with each other, their families and the community. ED will monitor the activities program during daily rounds to ensure activities are occurring as scheduled on the calendar. LEC will ensure that changes to the calendar after it has been posted has been communicated to the residents. The calendar will be updated to reflect the change. In the event the LEC is unavailable to conduct the scheduled activity, the ED will ensure a the activity continues as scheldueled.	11/11/25 12/15/25 12/15/25 12/15/25

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THE LANDINGS OF SWANSBORO	280 SWANSBORO LOOP ROAD SWANSBORO, NC 28584

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D 315	Continued From page 65 participate in at least one outing every other month. -The Life Enrichment Coordinator would encourage the residents to attend compatible programs and assist with leisure activities. Observation of the facility on 10/27/25 from 9:00am to 5:00pm revealed: -An October 2025 activity calendar was posted on the wall in the dining room area. -There were nineteen hours of activities listed on the October 2025 calendar. -The activities were "Guess Who?" from 10:30m to 11:30am, Bingo from 1:30pm to 2:30pm, and Resident Council Meeting from 3:00pm to 4:00pm. -There were no activities offered on 10/27/25. Observation on 10/27/25 at 3:20pm revealed: -Resident council meeting was scheduled from 3:00pm to 4:00pm on the calendar. -Two residents were sitting at a table in the activities room coloring. -The surveyor asked about the resident council meeting and both residents said that they do not have resident council meetings. Interview with a resident on 10/27/25 at 9:09am revealed: -She did not go to activities in October 2025 because there were no activities to go to. -The Administrator got rid of a volunteer who was doing activities but did not know why about three months ago. -She enjoyed chair exercises, but that activity stopped about 3 months ago. -She enjoys activities and would like to see more of them. -She and another resident walk the halls twice a day every day as their activity.	D 315		

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D 315	Continued From page 66 Interview with a second resident on 10/27/25 at 9:41am revealed: -She went to activities when activities were offered. -Bingo was cancelled twice in the last week because the staff who do the activities had an appointment during that schedule time and at another time, there was no place to have it. -The volunteer was told not to return to do activities about three months ago and activities had been offered sporadically ever since. -The staff tend not to go by the activity calendar when activity was offered. Interview with a resident's family member on 10/28/25 at 10:10am revealed: -He visited the facility to see his family member four to five times a week. -He tried to keep his family member moving and engaged. -He took a picture of the monthly activities calendar monthly. -When he called his family member, he would tell her what the activity for the day was. -When he visited, activities were not being performed or what was on the calendar was not the activity being carried out. Interview with a family member of the third resident on 10/30/25 at 4:01pm revealed: -There used to be daily activities offered at the facility including chair exercises twice a week. -Activities were led by a volunteer but the volunteer was no longer allowed to conduct activities for the residents but she did not know why. Interview with the Life Enrichment Coordinator on 10/28/25 at 11:22am revealed:	D 315		

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D 315	Continued From page 67 -She was hired as the Life Enrichment Coordinator in August 2025. -She was part time prior to October 2025 and worked 16 hours a week. -Her hours increased to 35 hours a week Monday through Friday in October 2025. -In her absence staff are to help get residents engaged and assist in activities. -She reminds staff to help with activity engagement and help bring residents to activities during staff morning standup meetings. -Resident council meeting was once a month on the last Monday of the month. -She was not aware that the resident council meeting did not happen yesterday because she was off work. -She was aware that bingo was cancelled on two occasions because she had to work on the medication cart last Friday and earlier in the week the table was full of Halloween crafts, and she could not do bingo on that day either. Interview with the Administrator on 10/28/25 at 4:46pm revealed: -The Life Enrichment Coordinator was needed as a medication aide on Friday, and the bingo game was cancelled due to that. -She was not aware of any other cancelled bingo games. -When she needed to utilize the Life Enrichment Coordinator in a different capacity or if she was not working, the Administrator found another staff member to assist with activities, or she did it herself. -She participated in resident council meetings but did not have the meeting on 10/27/25 because the Life Enrichment Coordinator was off and she was busy with the surveyors in the facility. -She and the Life Enrichment Coordinator were responsible for the facility activity program.	D 315		

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D 315	Continued From page 68 Second interview with the Administrator on 10/31/25 at 6:27pm revealed: -She had received complaints from residents and family member regarding the lack of activities provided. -There was currently 1 full-time Life Enrichment Coordinator that conducted activities for both the Special Care Unit (SCU) and the Assisted Living (AL) sides of the facility but there had been some problems with the Life Enrichment Coordinator's attendance.	D 315		
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 interviews and record reviews, the facility failed to ensure resident's rights were maintained related to the facility not having adequate hot water available to the residents for an extended period of time. The findings are: Review of the facility's current license effective 01/01/25 revealed the facility was licensed for a total capacity of 80 residents including 24 beds in a Special Care Unit (SCU). Review of the facility's census report provided on	D 338	Regional Ombudsman in-serviced staff on the importance of assuring that the rights of all residents are maintained and exercised without hindrance. Water temperatures will be checked 3 times per week. MT will review with ED. ED will sign off completion.	11/14/25 12/15/25

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D 338	Continued From page 69 10/27/25 revealed the current census was 57. Review of an email correspondence from a resident's family member dated 09/09/25 at 8:35pm revealed she was told by her family member that she had not had a shower because there had not been hot water in the facility for three days. Review of an email correspondence from the Administrator to the corporate maintenance group dated 09/10/25 at 11:23am revealed: -The facility did not have hot water outside the kitchen. -The facility's maintenance technician did a "flush" the previous night that brought the temperature up but it had returned to cold. Review of an email correspondence from the corporate maintenance Administrative Coordinator to the Regional Maintenance Director for the facility dated 09/10/25 at 1:21pm revealed there was no hot water outside of the kitchen at the facility. Review of an order detail dated 09/10/25 revealed the facility had ordered a circulator pump. Review of a screenshot of the tracking details for the order dated 09/10/25 revealed the package was out for delivery at 3:38am on 09/16/25 and at 3:38am on 09/17/25. Review of an email correspondence from the Administrator to the corporate maintenance group dated 09/11/25 at 11:21am revealed the facility still did not have hot water and some of the residents reported the had not had not water in four days.	D 338	Any noted issues with the hot water will be reported to the DMD and RVPO. DMD will ensure a vendor has been contacted to assess and complete repairs if it has been determined that onsite personnel cannot complete. In the event repairs will take longer that 48 hours, the ED will coordinate with a sister community to transport residents for showers.	12/15/25 12/15/25 12/15/25

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D 338	Continued From page 70 Review of an email correspondence from a second resident's family member dated 09/14/25 at 6:22pm revealed: -She sent the email to the Administrator due to her "grave concern" about a hot water issue. -She stated that not having hot water for "this length of time" (length of time was not specified) presented an emergency and she requested information be shared as to what was being done and the time frame to resolve the issue. -She reported that her resident family member had been almost a week without a shower and then had a cold, barely warm shower on the previous Thursday which upset her family member (resident) a great deal. -She told the Administrator that it was not acceptable to not have facilities in which to shower and suggested the facility consider taking residents to the sister facility for showers during the emergency situation. -She stated that there was "absolutely no hot water in any resident's room no matter how long you let it run" and was disappointed at the lack of communication from the facility during the emergency situation. Review of the email response from the Administrator dated 09/15/25 at 10:58am revealed: -The facility had a circulation pump that was down which caused the hot water to take longer to travel to the resident rooms but was scheduled to be repaired the next day (09/16/25). -The hot water was not out and the water got hot faster in the spa shower rooms and was an option for showering. -She checked water temperatures that morning in several rooms and the hot water temperature reached 100°F and over within a few minutes. -She reiterated to the team how to get the water	D 338		

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D 338	Continued From page 71 hot while they waited for the pump repair. -She was not informed that the team's attempts were not successful until she received the email. Review of an email correspondence from the Regional Vice President of Operations (RVPO) dated 09/17/25 at 12:59pm revealed: -The RVPO sent an email to the Administrator asking if the pump had arrived. -She instructed the Administrator to begin coordinating transportation of the resident to a sister facility for showers. -The sister facility had 2 shower rooms and several empty rooms available for resident use. Review of the email response from the Administrator to the RVPO on 09/17/25 at 1:02pm revealed the part had not arrived and she would begin coordinating transport to the sister facility. Interview with a family member of a resident that resided on the SCU side of the facility on 10/27/25 at 9:47am revealed: -He visited his family member daily. -The facility was out of hot water for 3-4 days approximately 2 months prior. -He would bring in bath wipes to assist his family member with washing while the hot water was out. -He was not offered options to providing a shower for his family member while there was no hot water. -He was told after a few days that if he turned on other faucets it would help to circulate hot water, -Turning on the other faucets was some help but the water did not stay hot. Telephone interview with a second family member of a resident that resided on the SCU side of the facility on 10/29/25 at 9:21am revealed:	D 338		

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D 338	Continued From page 72 -The facility was out of hot water for a time the previous month (September 2025). -She did not know what the facility had done to provide for bathing of residents while there was no hot water for the residents. Interview with a resident on 10/27/25 at 9:10am revealed: -The hot water was messed up at the facility for a while in September 2025. -Resident #1 said that the shower was either real cold, or real hot. Telephone interview with a family member of a second resident on the AL side of the facility on 10/29/25 at 9:49am revealed: -Her family member was unable to shower for 9-10 days in September 2025 because the hot water was not working at the facility. -Her family member told her she was offered transport to a sister facility for a shower but she was not sure when that happened or if the transport happened. -She did not know if other alternatives to a cold shower were offered while there was no hot water at the facility. Interview with a third resident on 10/30/25 at 4:33pm revealed: -The hot water was out for 10-12 days on the AL 100 hall in September 2025. -She attempted to shower during that time and the warm water suddenly turned cold while she was in the shower and it was the most horrible experience she had ever encountered. -She had been several days without a shower when she went with another resident and her family to their home to shower. -She did not remember being asked if she would have wanted to go to the sister facility to get a	D 338		

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D 338	Continued From page 73 warm shower. -She was never told there was hot water in the spa rooms. Interview with a family member of the third resident on 10/30/25 at 4:01pm revealed: -She spoke with the Administrator several times during the time there was no hot water at the facility in September 2025 and was told the hot water was never out at the facility. -She expressed her concerns that her family member had not showered in approximately 5 days. -Her resident family member did end up taking a cold shower that was very disturbing to the resident. -Her resident family member was taken by another resident's family to their home so she could get a warm shower. -She understood that things break but there seemed to be no sense of urgency in getting things fixed at the facility. Interview with a fourth resident on 10/27/25 at 8:55am revealed: -The facility was without hot water for at least 5 days. -She had to take cold showers during this time. -She went to her family's home on one occasion and had a hot shower. -It was her understanding that a plumber was not contacted until the day the hot water was restored. -She was offered to be transported to another facility for a shower, but she declined. Second interview with the fourth resident on 10/29/25 at 9:24am revealed: -There was a period when the hot water was out at the facility, she had to go to a family member's	D 338		

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D 338	Continued From page 74	D 338		

house for a hot shower.
-She had to wash her hair in cold water while the hot water was out.
-The facility's Maintenance Director tried to fix the hot water situation first.
-The facility's hot water situation did not get resolved until a plumber was called and she was not sure why a plumber was not called sooner.

Interview with a the fourth resident's family member on 10/29/25 at 9:00am revealed:
-His family member that resided at the facility notified him of the hot water issue at the facility.
-He was not made aware of the hot water situation by the facility until just before the hot water was restored.
-He had to bring his family member who resided at the facility to his home for a hot shower.

Interview with a fifth resident on 10/28/25 at 2:15pm revealed:
-The facility was without hot water for over a week.
-No one in the facility had hot water for over a week.
-She had to go to her family member's house on three occasions for a hot shower.
-There was no hot water for hand washing.
-The hot water issue was not corrected until the media became involved.
-The residents were offered body wipes and cold sink baths.

Interview with the fifth resident's family member on 10/27/25 at 1:46pm revealed:
-The facility was without hot water for 10 to 11 days and during this period there was a lack of communication with residents and family members regarding the hot water situation.
-They were not alerted by the facility about the hot

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D 338	Continued From page 75 water issue for several days. -She contacted the health department and the health department came out and advised the facility either needed to bring out mobile shower units or transport the residents to a sister facility for showers. -Her family member in the facility was taken to another family member's home on 3 occasions for a hot shower. -An alternative such as transport to another facility for a hot shower was not offered until the end when the hot water was restored. Second interview with the fifth resident's family member on 10/30/25 at 4:27pm revealed: -Her family member at the facility was mentally very frustrated and angry about the hot water situation. -As of 09/10/25, the facility still did not have hot water, and they were told a part had been ordered. -There was still no hot water on 09/11/25 and they were told all maintenance issues had to be handled by the corporate maintenance director located in the western part of the state. -The facility's maintenance person tried to fix the hot water situation, but the hot water was not restored until a plumber was called and came out on 09/18/25. -She felt the facility should have contacted a plumber once the hot water issue was discovered to correct the hot water issue. Interview with another family member of the fifth resident on 10/30/25 at 4:49pm revealed: -Her family member at the facility, notified her on 09/09/25 that the facility had been without hot water over the weekend and she had not had a shower in 3 days. -She emailed the Administrator on the evening of	D 338		

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D 338	Continued From page 76 09/09/25 about the hot water situation and received an email back the following morning 9/10/25 that the hot water was down for a couple of hours on 09/09/25 but had been restored and that she (the Administrator) was not informed of the hot water issue until the morning of 09/09/25. -She was told verbally by the Administrator that a part had been ordered and was scheduled to arrive on 09/16/25 and the part arrived on 09/17/25. -It was concerning that it would take six or seven days for the needed part to arrive. -The county health department had been out to the facility and advised that the facility either needed to obtain a mobile shower unit or transport the residents to a sister facility for bathing. -It was extremely distressing that the facility was without hot water for 10 days and that a licensed plumber was not contacted to assess the hot water situation earlier than 09/18/25. -She brought her family member to her home on three occasions for a hot shower during the time the hot water was out at the facility. -She contacted the health department, building inspector and local officials about the hot water situation at the facility. Interview with another resident's family member on 10/30/25 at 4:03pm revealed: -She knew there had been issues with the facility's hot water. -The facility's Maintenance Director was great but sometimes you need a licensed professional to fix things. -She felt the facility wasted time by not calling a professional plumber sooner when the hot water was out. -It was her understanding the Administrator had to get permission from the corporate office to	D 338		

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D 338	Continued From page 77 contact a local repairman. -Her family member was with her for a portion of the time the hot water was out at the facility. -When she returned her family member to the facility, she was not told there was no hot water, she was told there was hot water, but you had to let it run for a while to heat up. -The only time the facility contacted her about the hot water was to let her know they were offering to take residents to a sister facility for showers just prior to the hot water being repaired. Interview with a sixth resident on 10/27/25 at 9:18am revealed: -The facility was without hot water for 10 days. -She heard the kitchen had a generator and that was how hot water was maintained in the kitchen. -Staff did not offer basins of warm or hot water from the kitchen for bathing. -Staff did offer transportation to a sister facility for a shower. Interview with a seventh resident on 10/27/25 at 9:38am revealed: -The facility was without hot water for several days. -The only option was a cold shower or body wipes were offered. -Staff did offer transport to a sister facility for a hot shower and she accepted but that was "a real pain". Interview with an eighth resident on 10/31/25 at 11:14am revealed: -She came to the facility in April 2025. -The facility was very slow to fix things that broke in the facility. -It seemed to her the corporate office did not want to spend a dime on the residents. -She was "freaked out" when there was no hot	D 338		

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	HAL067025	A. BUILDING: _____ B. WING _____	R 10/31/2025

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D 338	Continued From page 78 water in the facility. -She had to take cold showers or "bird baths" with cold water. -Some of the residents were taken to a sister facility located about a half an hour away for hot showers. -Other residents were taken home for showers by their family members. -The kitchen had hot water, she was told the kitchen was on a separate hot water system. -She was not offered a basin of hot water from the kitchen for a sink bath. -She felt the facility did not see fit to repair the hot water issue for the residents in a timely manner. -Whenever things broke at the facility, they were always told they were "waiting on a part". Telephone interview with the Environmental Health (EH) Supervisor on 10/30/25 at 9:39am revealed: -She and a technician went to the facility on 09/11/25 to check on hot water. -The hot water temperatures were checked in each area of the facility and all hot water reached up to 116°F when water was allowed to run for 4-5 minutes. -She received several calls from residents' family members on 09/12/25: Residents resided on the 100 hall of the facilty. -EH returned on the 09/15/25 and there was no hot water at the facility at all. -She was informed the replacement pump was due to arrive the next day on 09/16/25. -She gave the facility instructions to begin transporting residents to the sister facility or obtain a portable shower facility and to begin with the residents on the SCU and then the residents on the 100 hall. -The instructions were verbally given to the Regional Maintenance Director and the	D 338		

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D 338	Continued From page 79 Administrator. -EH returned to the facility on 09/16/25 and the pump had not arrived. -She was informed that residents would begin being transported to a sister facility for warm water bathing on 09/17/25 but the facility did not transport residents until 09/18/25. -She did not know if residents had been informed to allow the hot water to run for awhile. -There were no alternatives offered to the residents by the facility for bathing and some family members took their resident home to bath. -The facility was issued an Intent to Suspend letter on 09/18/25. -Not having warm water bathing facilities available in the facility created sanitation concerns related to hand hygiene. -There were many residents at the facility that required adult incontinence briefs and the lack of effective hand washing increased the risk of cross contamination and fecal matter contamination. -Residents inability to bathe could have lead to skin problems for the residents. -She attempted to call regional maintenance director from corporate office, but he never returned her call. -She revealed facility did not heat water up in the kitchen for bed baths. -She revealed that on 9/16/2025 EHS went to the facility to verify the part was delivered, but it was not. The facility had not got showers set up. Interview with the Maintenance Director on 10/30/25 at 2:11pm revealed: -The Maintenance Director first learned on 9/10/25 that the re-circulating pump was not working. -A resident complained there was no hot water. -He took a video of the pump that had gone bad	D 338		

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D 338	Continued From page 80 and sent it to the Regional Maintenance Director at the corporate office. -There were two pumps that ran the system and the other pump never went out. -The facility was never without hot water until the day the pump came in. Water was tested when the residents complained, and they had hot water in the spas. -He was not sure when residents were offered to go to a sister facility to get showers. -Environmental Health came but he could not remember when and said that the water temperatures were good. -Environmental Health said water temperatures were good every time they came out except the day the pump came in. -Complaints were received on 09/07/2025 that a resident was having trouble with hot water. -He checked the hot water and flushed the system because he believed the water system was clogged. -Communication was terrible at the facility and said they did not tell him about issues for days. -He was able to locate the re-circulation pump was found online at a near by supply warehouse. -He did reach out through the corporate maintenance notification system regarding concerns with the hot water on 09/09/25 at approximately 5:00pm. -He did not receive a response from the email he sent on 09/09/25, so he wasn't sure if the email was sent. -There was an emergency credit card or ability to go buy the part, but the regional maintenance director had already made the decision and there was nothing he could do. Second interview with the Maintenance Director on 10/31/25 at 10:25am revealed: -The re-circulating pump arrived at the facility on	D 338		

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D 338	Continued From page 81 09/17/25. -He installed the pump but it was installed backwards and there was no hot water pumping through the facility. -A plumber was called the next day (09/18/25) and the hot water was restored. -It should not have taken so long to fix the hot water issue at the facility. Third interview with the Maintenance Director on 10/31/25 at 5:14pm revealed: -He would go to the Regional Maintenance Director directly if he needed to obtain parts in an emergency situation. -He did reach out through the corporate maintenance notification system regarding concerns with the hot water on 09/09/25 at approximately 5:00pm and the Administrator was also notified at that time. -He reported the concern because a staff member reached out to him to report a resident complaint about the hot water. -He went to the facility on the weekend and flushed the water system but he was unsure if he went on Saturday (09/06/25) or Sunday (09/07/25). -He thought flushing the system would help and he thought the Administrator was aware on Monday 09/08/25. -He did not tell the Administrator he had been out the the facility over the weekend. -He did not have access to an emergency credit card in which to purchase parts immediately but hot water was a critical concern for residents at the facility. -He was told by the Regional Maintenance Director the part had been ordered through mail order business account. -He was unsure why the decision was made to order online and he did not ask for anything	D 338		

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D 338	Continued From page 82 different to be done. Telephone interview with the facility's contracted plumber on 10/31/25 at 10:20am revealed: -The facility called the plumbing company on 09/18/25 regarding no hot water in the facility. -A technician was sent to the facility on 09/18/25. -The technician found that the re-circulating pump had been installed backward and hot water was restored when he reinstalled the pump on 09/18/25. Interview with a personal care aide (PCA) on 10/28/25 at 9:50 am revealed that one Monday they were told there was no hot water and they went without hot water a solid week. Interview with a second PCA on 10/30/25 at 9:55am revealed: -During the recent hot water outage at the facility, staff were told to let the hot water run for a while. -She was not told to provide hot water from the kitchen for the residents. -She tried to shower the residents in cold water, but they refused. -She used the personal cleansing wipes provided by the facility. -Hospice provided no rinse body wash for residents under their care and she tried to use the no rinse body wash for other residents as well. -There was no hot water in the building that she was aware of besides the kitchen. -She tried running the hot water in one resident's room for 20 minutes, but the water never got warm. Interview with medication aide (MA) on 10/28/2025 at 10:30 am revealed: -Residents were taken somewhere else to shower, or to the other side of the facility when	D 338		

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D 338	Continued From page 83 the hot water was not working. -When the hot water was not working, it was lukewarm or too hot. -One day it was cold, and then not working the next day. -Not having hot water available made it hard to clean. Interview with a second MA on 10/28/25 at 12:42pm revealed: -The facility had recent issues with the hot water. -All the hot water did not go out at the same time. -The spa on the 100-hall had hot water for a while. -Some of the residents' rooms had hot water but you had to let it run for a while to come in. -Staff went to the kitchen to wash their hands in hot water and used lots of hand sanitizer. -Showers were offered to the residents in the 100 hall spa. -The residents were also offered bed baths, body wipes, and later transport to a sister facility for showers. Telephone interview with the facility's contracted primary care provider (PCP) on 10/30/25 at 2:38pm revealed: -She was aware the facility was out of hot water for approximately 1 week in September 2025. -Not having hot water at the facility meant staff and residents could not effectively wash their hands and the residents could not shower. -Residents inability to shower increased the risk of skin infection and skin breakdown. -Ineffective hand washing increased the risk of cross contamination. Review of an environmental health inspection visit dated 09/17/25 revealed: -A visit was made to check the status of the hot	D 338		

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D 338	Continued From page 84 water at the facility. -The Administrator reported the part needed to restore hot water had not arrived but updates indicated it would be delivered that day. -No transportation of residents had occurred to ensure residents had access to warm bathing facility's but the Administrator was working on coordinating with a sister facility. -The Administrator reported the Special Care Unit was receiving hot water but the AL side was not. Review of an environmental health inspection visit dated 09/18/25 revealed: -The visit was made to assess hot water to the dietary kitchen and assess transport of residents to warm bathing facilities. -Three hands sinks, two preparations sinks and one three compartment sink for ware washing and the dish machine for ware washing in the dietary kitchen were checked. -The two hand sinks in the kitchen were peaking at 76 degrees Fahrenheit (°F) and the 2017 NC Food Code requirement was at least 100°F. -The two hand sinks with hot water temperatures peaking at 76°F would need to have a temporary hand wash hygiene program until the hot water was prepared to reach at least 100°F. -The hand sinks should be stocked with hand sanitizer to be used after normal hand washing procedures as ser for in the the 2017 NC Food Code. -Environmental Health issued an intent to suspend giving 30 days for the hot water to be restored to the required standards. Review of an invoice dated 09/18/25 from the facility's contracted plumber revealed: -The customer replaced a CAD re-circulating pump and the technician found it was installed backwards.	D 338		

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D 338	Continued From page 85 -Hot water was immediately restored throughout the building once the technician flipped the pump so it was installed correctly. -The pump was pushing cold water into the hot line and reduced the temperature. -There were 10 of 20 service valves for the hot water that were installed incorrectly, 2 expansion tanks were waterlogged and a dripping relief valve. Review of a second invoice dated 09/19/25 from the facility's contracted plumber revealed: -The technician removed and reinstalled 10 service valves that were not installed correctly. -The technician replaced a 4 gallon expansion tank. Interview with the Administrator on 10/29/25 at 10:51am revealed: -There were approximately 10-15 residents on the AL that required assistance with bathing. -The hot water was never completely out but was not consistent within the facility. -She became of aware of an issue with the facility's hot water on 09/10/25 when she received an email from a resident's family member. -Staff had not reported any concerns with not having hot water prior to the email on 09/10/25. -She checked hot water in several resident rooms and spa rooms on the AL and the SCU and the water got hot after running the water for a minute or so. -The Maintenance Director investigated and reported that one of the 2 circulating pumps for the hot water had gone bad. -The Regional Maintenance Director was contacted regarding the water pump and he ordered a new pump that was set to arrive on 09/16/25. -She thought she instructed staff to take residents	D 338		

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D 338	Continued From page 86 to the spa rooms for showers as the water got hot much quicker in the shower rooms than it did in resident rooms. -The Environmental Health (EH) inspector went to the facility on 09/11/25 or 09/12/25 and verified they had hot water after letting the water run for a few minutes. -The water would get hot quicker in rooms that were closer to the water heaters than those rooms furthermost away which was on the 100 hall. -On 09/14/25 or 09/15/25, she received an email from a resident's family member informing her that the water would hardly get warm even after letting it run. -On 09/15/25, she checked hot water temperatures and the water got hot so she educated staff staff that the spa rooms were still getting hot water at 110°F to 114°F. -On 09/16/25, the EH Supervisor came out to the facility and she and the EH Supervisor checked water temperatures in the facility; Some areas were getting hot water and some were not. -The pump that was ordered and due to arrive on 09/16/25 did not arrive so the facility planned to take residents to a sister facility so they could get a hot shower. -A plumber was contacted and scheduled to come out to the facility on 09/18/25. -On 09/17/25, the Administrator gathered a list of residents that wanted to go to the sister facility to bathe. -The replacement water pump arrived around lunch time on 09/17/25 and the Maintenance Director installed the pump but the system was unable to maintain heat. -EH returned to the facility on 09/17/25 and found hand wash sinks that were not hot enough. -On 09/18/25, the facility transported 8 residents to a sister facility for a hot bath while the	D 338		

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D 338	Continued From page 87 Maintenance Director and the contracted plumber worked to successfully restore hot water to the facility. -On 09/19/25, the contracted plumber returned to the facility to fix service valves that had previously been installed incorrectly. -Hot water temperatures were checked weekly by the Maintenance Director -No staff reported issues with the hot water prior to the Administrator receiving the email from a resident's family member on 09/10/25 and, when asked by the Administrator, the staff denied knowledge of any issues. -Staff were expected to report concerns immediately, even on weekends, and had access to her at all times through a communication app and her telephone. Second interview with the Administrator on 10/31/25 at 6:27pm revealed: -She was not aware the Maintenance Director went to the facility over the weekend on 09/06/25 or 09/07/25 to flush the water system due to a resident complaint of having no hot water. -She would have assessed the situation and contacted her Regional Vice President of Operations to see what needed to be done to get things fixed earlier. -Obtaining replacement parts was the responsibility of the Regional Maintenance Director. -She would have liked to have a plumber out on 09/10/25. -She asked the Regional Maintenance Director what the interim solution would be on 09/10/25 and she never got a response from him. -She could have requested petty cash to get the needed replacement part if it was something that could have been obtained more quickly. -She did not know if anyone had called to see if	D 338		

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D 338	Continued From page 88 the pump was locally available for purchase. -Discussions began prior to 09/15/25 regarding taking residents to a sister facility for showering and residents were offered to shower in the spa rooms. -Hot water at the facility was out from 09/16/25 to 09/16/25. Review of an email correspondence from the local Department of Social Services Adult Home Specialist to the Regional Maintenance Director dated 10/02/25 at 4:35pm revealed: -She informed the Regional Maintenance Director that she had attempted to reach him by phone three times. -She left two voice messages asking him to return her call. -She requested a return call as soon as possible. -There was no response from the Regional Maintenance Director. Attempted telephone interviews with the Regional Maintenance Director on 10/31/25 at 11:12am and 2:14pm were unsuccessful. _____ The facility failed to ensure residents were treated with respect and dignity related to hot water not being maintained and available for a period of approximately 10 days for bathing and hand washing purposes resulting in the residents having to go without showers, take cold showers/sink baths or leave the facility to bathe. The 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 10/31/25 for this violation.	D 338		

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D 338	Continued From page 89 THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 15, 2025.	D 338		
D 346	10A NCAC 13F .1002(c) Medication Orders 10A NCAC 13F .1002 Medication Orders (c) The medication orders shall be complete and include the following: (1) medication name; (2) strength of medication; (3) dosage of medication to be administered; (4) oute of administration; (5) specific directions of use, including frequency of administration; and (6) if ordered on an as needed basis, a stated indication for use. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure physician's orders for 1 of 5 sampled residents (#1) were completed and included an indication for use for medications that were ordered as needed (PRN). The findings are: Review of Resident #1's current FL-2 dated 07/17/25 revealed: -Diagnoses included type II diabetes and muscle weakness. -There was an order for acetaminophen 500mg	D 346	ED and SCC will complete cart audits weekly to ensure medication orders are complete and include the indication for use when the medication is a PRN order. MT will complete a daily cart audit and submit report to Care Managers for review. Any noted discrepancies with the medication order will be communicated to the PCP and/or Pharmacy for clarification.	12/15/25 12/15/25 12/15/25

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D 346	Continued From page 90 every 4 hours as needed (PRN) with no indication for use. -There was an order for Bisacodyl suppository 10 mg to be administered each day PRN with no indication for use. -There was an order for clear eyes drops, 1 drop to both eyes each day PRN with no indication for use. -There was a physician's order for Deep Sea spray, 1 spray to each nostril each day PRN with no indication for use. There was a physician's order for ondansetron 4mg every 6 hours PRN with no indication for use. Review of Resident #1's Resident Register revealed she was admitted on 06/12/25. Review of Resident #1's electronic medication administration record (eMAR) for August 2025 revealed: -There was a computerized entry for acetaminophen 500mg every 4 hours as needed (PRN) with no indication for use. -There was a computerized entry for Bisacodyl suppository 10 mg to be administered each day PRN with no indication for use. -There was a computerized entry for clear eyes drops, 1 drop to both eyes each day PRN with no indication for use. -There was a computerized entry for Deep Sea spray, 1 spray to each nostril each day PRN with no indication for use. -There was a computerized entry for ondansetron 4mg every 6 hours PRN with no indication for use. Review of Resident #1's eMAR for September 2025 revealed: -There was a computerized entry for	D 346		

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D 346	Continued From page 91 acetaminophen 500mg every 4 hours as needed (PRN) with no indication for use. -There was a computerized entry for Bisacodyl suppository 10 mg to be administered each day PRN with no indication for use. -There was a computerized entry for clear eyes drops, 1 drop to both eyes each day PRN with no indication for use. -There was a computerized entry for Deep Sea spray, 1 spray to each nostril each day PRN with no indication for use. -There was a computerized entry for ondansetron 4mg every 6 hours PRN with no indication for use. Review of Resident #1's eMAR for October 2025 revealed: -There was a computerized entry for acetaminophen 500mg every 4 hours as needed (PRN) with no indication for use. -There was a computerized entry for Bisacodyl suppository 10 mg to be administered each day PRN with no indication for use. -There was a computerized entry for clear eyes drops, 1 drop to both eyes each day PRN with no indication for use. -There was a computerized entry for Deep Sea spray, 1 spray to each nostril each day PRN with no indication for use. -There was a computerized entry for ondansetron 4mg every 6 hours PRN with no indication for use. Interview with a medication aide (MA) on 10/31/25 at 11:58am revealed: -Medications that were prescribed as needed should have a reason the medication was to be administered. -She was familiar with the medications and knew what most of them were administered for.	D 346		

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D 346	Continued From page 92 -If she did not know what a medication was administered for, she would ask. Interview with the Administrator on 10/27/25 at 4:50pm revealed: -Medications ordered PRN were expected to include the reason the medication was to administered. -The care managers should have caught that the medication orders did not include indications for use when they approved the medication on the eMAR system. Telephone interview with Resident #1's primary care provider (PCP) on 10/30/25 at 2:19pm revealed she felt that Resident #1's PRN medications were self-explanatory but should probably include an indication since nurses were not administering medications at the facility.	D 346	MA's will complete a cart audit daily with assigned rooms. Care Managers will review the MA's cart audits and continue to follow-up on any mediation that is not currently on hand.	12/15/25
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 The facility failed to administer medications as ordered for 2 of 5 sampled residents (#2, #5) pertaining to medications used to treat bacterial	D 358	Care Managers will complete a weekly cart to ensure ongoing compliance. Missing medications will be ordered by the MA's, and/or Care Managers. Care Mangers will pull and review with the ED during morning meeting the medication administration compliance report. Medications documented as unavailable will be followed-up on to ensure they have been reordered and documentation of attempts to reorder are in the residents EHR.	12/15/25 12/15/25

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D 358	Continued From page 93 infections (#2, #5), a medication used to treat electrolyte imbalance, and a medication used as an appetite stimulant (#2). The findings are: Review of the facility's Medication Administration Policy dated 11/2018 revealed: -Five Rights, right resident, right drug, right dose, right route and right time, are applied for each medication being administered. -A triple check of these five rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and put away. -Check #1, select the medication, label, container, and contents are checked for integrity and compared against the medication administration record (MAR) by reviewing the five rights. -Check #2, prepare the dose, the dose is removed from the container and verified against the label and the MAR by reviewing the 5 Rights. -Check #3, complete the preparation of the dose and re-verify the label against the MAR by reviewing the 5 Rights when putting the medication away. -The MAR is always employed during medication administration. -Prior to administration of any medication, the medication and dosage schedule on the resident's MAR are compared with the medication label. -If the medication label and MAR is different and the container has not already been flagged, indicating a change in directions, or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct	D 358	RCN re-educated Care Mangers, ED and MA's on assuring the preparation and administration of medications are in accordance with the prescribing practitioners order and following the facility's policies and procedures.	12/1/25

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D 358	Continued From page 94 dosage schedule. -When a medication order is changed, and the current supply can continue to be used, the container will be flagged right away and the order change communicated to the provider pharmacy so that the next supply of the medication is labeled with the current directions. -Medications are administered in accordance with written orders of the prescriber. 1.Review of Resident #2's current FI-2 dated 10/01/25 revealed: -Diagnoses included Alzheimer's disease, stage 3 chronic kidney disease and urinary retention. -She was constantly disoriented. Review of Resident #2's Resident Register revealed she was admitted on 05/30/25. Review of Resident #2's Accident and Incident report dated 08/30/25 revealed: -Resident #2 had an unwitnessed fall with injury on 8/30/25 at 10:30am in the dayroom. -She was found lying on the floor with an injury to her head. -She complained of pain and was transported to the hospital via local emergency medical services (EMS) and was to have a urinary tract infection and low potassium levels. Review of Resident #2's hospital discharge summary dated 08/31/25 revealed Resident #2 was diagnosed with a UTI and low potassium levels. Review of Resident #2's Accident and Incident report dated 09/09/25 revealed: -Resident #2 had an unwitnessed fall with injury in her bedroom at 9:45pm.	D 358		

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D 358	Continued From page 95 -Resident #2 was found on the floor on her left side and her left arm was bleeding. -She complained of pain and was transported to the hospital via local emergency medical services (EMS) and was admitted to the hospital. a. Review of Resident #2's physician's order dated 08/31/25 revealed ceflodoxime 200 mg was to be administered each day for 7 days. (Ceflodoxime is an antibiotic medication used to treat infection.) Review of Resident #2's September 2025 electronic medication administration record (eMAR) revealed: -There was an electronic entry for ceflodoxime 200 mg to be administered each day for 7 days and scheduled for 8:00am. -The start date for ceflodoxime 200 mg was set for 09/01/25 with an end date of 09/09/25. -There was documentation ceflodoxime 200 mg was administered on 09/02/25 to 09/04/25 and on 09/06/25. -There was documentation ceflodoxime 200 mg was not administered on 09/05/25 and from 09/07/25 to 09/09/25 because the order was complete. Observation of medications on hand for Resident #2 on 10/29/25 at 3:15pm revealed there was no ceflodoxime available for administration. Telephone interview with a pharmacy technician for Resident #2's clinic pharmacy on 10/30/25 at 8:57am revealed a 7 day supply of ceflodoxime 200 mg was dispensed on 08/31/25 for Resident #2. Telephone interview with Resident #2's primary care provider (PCP) on 10/30/25 at 2:19pm	D 358		

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D 358	Continued From page 96 revealed: -Ceflodoxime was ordered to treat a urinary tract infection (UTI). -If Resident #2 was not administered the full course of the medication, her UTI may not have been treated effectively. b. Review of Resident #2's physician's order dated 09/01/25 revealed potassium chloride extended release 20mEq was to be administered twice daily. (Potassium chloride is prescribed to supplement potassium levels in the blood.) Review of Resident #2's September 2025 electronic medication administration record (eMAR) revealed: -There was an electronic entry for potassium chloride extended release 20mEq was to be administered twice daily and scheduled for 8:00am and 8:00pm. -The start date for potassium chloride extended release 20mEq was 09/01/25 with an open ended stop date. -There was documentation potassium chloride extended release 20mEq was administered on 09/02/25 and on 09/08/25 at 8:00am and 8:00pm. -There was documentation potassium chloride extended release 20mEq was administered at 8:00pm but was not administered at 8:00am because the facility was waiting on medications on 09/03/25 and on 09/04/25. -There was documentation potassium chloride extended release 20mEq was administered at 8:00am but was not administered at 8:00pm because the facility was waiting on medications from 09/05/25 through 09/07/25. -There was documentation potassium chloride extended release 20mEq was not administered at 8:00am and 8:00pm because the facility was waiting on medications on 09/09/25.	D 358		

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D 358	Continued From page 97 -There was documentation potassium chloride extended release 20mEq was not administered at 8:00am and 8:00pm because she was in the hospital. Review of Resident #2's October 2025 electronic medication administration record (eMAR) revealed: -There was an electronic entry for potassium chloride extended release 20mEq was to be administered twice daily and scheduled for 8:00am and 8:00pm. -The start date for potassium chloride extended release 20mEq was 10/01/25 with an open ended stop date. -There was documentation potassium chloride extended release 20mEq was not administered at 8:00am from 10/01/25 through 8:00am on 10/03/25 because the resident was in the hospital. -There was documentation potassium chloride extended release 20mEq was administered at 8:00pm on 10/03/25. -There was documentation potassium chloride extended release 20mEq was not administered at 8:00am and 8:00pm on 10/04/25 and 10/07/25 because the facility was waiting on delivery. -There was documentation potassium chloride extended release 20mEq was administered at 8:00pm on 10/05/25 but was not administered at 8:00am because the facility was waiting on delivery. -There was documentation potassium chloride extended release 20mEq was administered at 8:00am on 10/06/25 but was not administered at 8:00pm because the facility was waiting on delivery. -There was documentation potassium chloride extended release 20mEq was not administered at 8:00pm on 10/12/25, at 8:00am and 8:00pm on	D 358		

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D 358	Continued From page 98 10/13/24 and 8:00am on 10/14/25 because the resident was unavailable. -There was documentation potassium chloride extended release 20mEq was not administered from 8:00pm on 10/14/25 through 8:00am on 10/17/25 because she was in the hospital. -There was documentation potassium chloride extended release 20mEq was administered from 8:00pm on 10/17/25 to 8:00am on 10/27/25. Observation of medications on hand for Resident #2 on 10/29/25 at 3:15pm revealed there was a prescription bottle labeled potassium chloride extended release 20mEq with instructions to administer twice daily with a fill date of 09/07/25 for a quantity of 60 tablets. Telephone interview with the patient care advocate for Resident #2's preferred pharmacy on 10/29/25 at 10:08am revealed: -They received an order for potassium chloride extended release 20mEq was to be administered twice daily on 09/04/25. -They dispensed 60 tablets (30 day supply) of potassium chloride extended release 20mEq on 09/11/25. Telephone interview with Resident #2's primary care provider (PCP) on 10/30/25 at 2:19pm revealed: -Resident #1 had a history of falls. -Resident #1 was prescribed potassium chloride extended release because of a low potassium level. -Low potassium levels could cause muscle weakness and increase risk of falls. c. Review of Resident #2's physicians order dated 07/30/25 revealed mirtazapine 7.5mg was to be administered each night at bedtime for 7 days	D 358		

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D 358	Continued From page 99 with documented order dates from 07/31/25 to 08/07/25. Review of a second order dated 07/30/25 revealed mirtazapine 15mg was to be administered each night at bedtime with documented order date to begin on 08/08/25. Review of Resident #2's August 2025 electronic medication administration record (eMAR) revealed: -There was an electronic entry for mirtazapine 7.5mg to be administered each night for 7 days and scheduled for 8:00pm with a start date of 07/31/25 and end date of 08/07/25. -Mirtazapine 7.5mg was documented as administered on 08/01/25 to 08/02/25 and on 08/07/25. -Mirtazapine 7.5mg was documented as not administered on 08/03/25 to 08/06/25 because they were waiting on delivery. -There was an electronic entry for mirtazapine 15mg to be administered each night at bedtime and scheduled for 8:00pm with a start date of 08/08/25. -There was documentation mirtazapine 15mg was administered on 08/11/25 to 08/12/25, on 08/15/25 to 08/16/25, on 09/19/25, on 08/22/25 to 08/23/25, on 08/25/25, on 08/27/25, on 08/29/25 and on 08/31/25. -There was documentation mirtazapine 15mg was not administered on 08/08/25 to 08/10/25, on 08/13/25 to 08/14/25, 08/17/25 to 08/18/25, 08/20/25 to 08/21/25, on 08/24/25, 08/26/25 and on 08/28/25 because they were waiting on delivery. -There was documentation mirtazapine 15mg was not administered on 08/30/25 because the resident was not available.	D 358		

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D 358	Continued From page 100 Review of Resident #2's September 2025 electronic medication administration record (eMAR) revealed: -There was an electronic entry for mirtazapine 15mg to be administered each night at bedtime and scheduled for 8:00pm with a start date of 08/08/25. -There was documentation mirtazapine 15mg was administered on 09/02/25 through 09/09/25 at 8:00pm. -There was documentation mirtazapine 15mg was not administered on 09/01/25 because they were waiting on delivery. -There was documentation mirtazapine 15mg was not administered on 09/10/25 to 09/30/25 because Resident #2 was in the hospital. Observation of medications on hand for Resident #2 on 10/29/25 at 3:15pm revealed: -There was a prescription bottle labeled mirtazepine 7.5mg with a fill date of 08/29/25 for a quantity of 90 tablets. -There was a sticker in red type indicating directions had changed with instruction to refer to the chart that had been placed over the original printed instructions. -"Give 2" was hand written on the bottle. Telephone interview with the patient care advocate for Resident #2's preferred pharmacy on 10/30/25 at 3:08pm revealed: -They had an order for mirtazapine 7.5mg to be dispensed each night at bedtime dated 01/27/25 and a 90 day supply was first dispensed on 02/03/25. -A 90 day supply was also dispensed on 05/08/25 and again on 09/02/25. -Mirtazapine 15mg had never been dispensed for Resident #2. -They had not received the orders for mirtazepine	D 358		

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D 358	Continued From page 101 15mg written on 07/30/25. Telephone interview with Resident #2's primary care provider (PCP) on 10/30/25 at 2:19pm revealed: -Resident #2 had lost weight and was ordered mirtazapine to increase her appetite. -The medication is not effective if it is not administered and Resident #2 could continue to lose weight. Interview with the Special Care Unit Coordinator (SCC) on 10/29/25 at 3:20pm revealed: -She wrote the dosage change on Resident #2's prescription bottle of mirtazapine the previous week after performing a cart audit. -Staff had not reported the discrepancy in the dosage prior to the cart audit. -Resident #2 did not use the facility's contracted pharmacy and her pharmacy took longer to deliver medications. -Resident #2's orders were sent to the facility's contracted pharmacy for them to enter the order onto the electronic medication administration record (eMAR) system. -Resident #2's preferred pharmacy would take 3-5 days to deliver medications. -Care managers were expected to pull missed medication reports each day which included refusals and medications that were not available for administration because of waiting on the pharmacy to deliver. -She did not remember when the missed medication report was last pulled but there had not been one pulled that week. -Staff were expected to contact the pharmacy if a medication was not available for administration and to let the care manager know if the medication was not received within 1 day. -She was not aware of medications not being	D 358		

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D 358	Continued From page 102 available for administration to Resident #2. -She would have called the pharmacy or obtained medications from a back-up pharmacy. -Care managers were responsible for sending orders to the pharmacy and for approving orders on the eMAR once a medication was received from the pharmacy. Interview with the Administrator on 10/29/25 at 3:00pm revealed: -Care Managers were responsible for sending new orders to the pharmacy. -The pharmacy would enter the new order onto the eMAR and the Care Managers were responsible for approving the order so the medication could be administered. -Care Managers were responsible for pulling daily reports for doses of medications that were not administered. -The Care Managers were expected to contact the pharmacy if a medication did not arrive at the facility or were not available for administration. Based on observations, interviews and record reviews, it was determined that Resident #2 was not interviewable. 2. Review of Resident #5's current FL2 dated 07/17/25 revealed diagnoses included type 2 diabetes, hyperlipidemia, atherosclerotic heart disease, sick sinus syndrome, hypertension, paroxysmal atrial fibrillation, and gastroesophageal reflux disease. Review of a handwritten prescription from Resident #5's primary care provider (PCP) dated 08/20/25 revealed an order to start azithromycin (azithromycin is an antibiotic used to treat bacterial infections) 500mg, take one tablet in the	D 358		

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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 358	Continued From page 103 morning for 5 days, the resident's responsible party will pick up from a local retail pharmacy. Review of Resident #5's August 2025 electronic medication administration record (eMAR) revealed: -There was an entry for azithromycin 500mg, take one tablet every morning for five days, scheduled at 8:00am with a start date of 08/22/25. -Azithromycin 500mg was documented as administered at 8:00am from 08/22/25 through 8/25/25. -Azithromycin 500mg was documented as not administered at 8:00am on 08/26/25, with the exception documented as discontinued. -Azithromycin 500mg was documented as not administered at 8:00am on 08/27/25 and 08/28/25, with the exception documented as "order complete" for both days. -Azithromycin 500mg was documented as administered for 4 days instead of 5 days as ordered. -Azithromycin 500mg was documented as started on 08/22/25, when the prescription was dated as 08/20/25. Interview with Resident #5 on 10/28/25 at 2:32pm revealed: -She saw an outside provider. -Her family transported her to her PCP appointments. -She had a respiratory infection back in August that turned into a sinus infection, and she had to take antibiotics. Telephone interview with a pharmacist from the facility's contracted pharmacy provider on 10/29/25 at 10:17am revealed: -A prescription was received for Resident #5's azithromycin 500mg, take one tablet every	D 358		

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D 358	Continued From page 104 morning for 5 days on 08/20/25 at 5:28pm. -The cut off for medications to be added to the eMAR the same day was 5:00pm. -Resident #5's azithromycin 500mg order was received after the cut-off time on 08/20/25 and was placed on the eMAR for 08/21/25 and profiled since the prescription was filled at a local retail pharmacy. -They placed the azithromycin order on Resident #5's eMAR to start on 08/21/25. -Once the new order was placed on the eMAR, the facility had to approve the order for it to become active. Second telephone interview with a pharmacist from a local retail pharmacy on 10/29/25 at 9:09am revealed: -An order was received for Resident #5 on 08/20/25 for azithromycin 500mg, take one tablet daily for 5 days. -Azithromycin 250mg, 10 tablets were dispensed to take 2 tablets each morning for 5 days (the pharmacy did not have 500mg azithromycin tablets available) on 08/20/25. -Resident #5's azithromycin prescription was picked up by her responsible party at 3:35pm on 08/20/25. Interview with a medication aide (MA) on 10/28/25 at 12:42pm revealed: -When a family member brought in outside medications for the residents, they were given to the medication staff and the facility's pharmacy was notified so the medication could be added to the eMAR. -It was possible that Resident #5's initial dose of azithromycin was documented on a paper medication administration record (MAR) until it could be added to her eMAR. -It was important for a resident to receive their	D 358		

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D 358	Continued From page 105 entire dose of antibiotic to ensure an infection was fully treated. Telephone interview with the Resident Care Coordinator (RCC) on 10/31/25 at 3:22pm revealed: -When a resident received an outside medication, the resident or their family were supposed to give the medication to the medication staff or her. -The order for the outside medication was faxed to the facility's pharmacy to add to the resident's eMAR. -When new orders were added to the resident's eMAR, she or the other care manager (the Special Care Coordinator) approved the orders so the MAs could administer the medication. -It was possible a paper MAR was started for Resident #5's azithromycin and there should not have been a delay in starting her azithromycin. Interview with the Administrator on 10/28/25 at 3:00pm revealed: -When a family member brought in outside prescriptions, the medications could be documented on a paper MAR until it could be added to the eMAR by the pharmacy. -She felt Resident #5 received the full 5 days of her azithromycin but could not locate documentation on a paper MAR for Resident #5 of the start date. -There should not have been a delay Resident #5 in starting her azithromycin and she should have completed the entire 5-day course of azithromycin. Telephone interview with the facility's contracted PCP on 10/30/25 at 2:32pm revealed: -A delay in starting antibiotics could mean a delay in treating an infection. -Not competing the entire dose of antibiotics	D 358		

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D 358	Continued From page 106 could result in an infection not being completely treated. Attempted telephone interview with Resident #5's primary care provider (PCP) on 10/29/25 at 2:21pm was unsuccessful. The facility failed to ensure medications were administered as ordered for 2 of 5 sampled residents. Resident #2 and Resident #5 received incomplete doses of antibiotics which could have lead to under treatment of bacterial infection. Resident #2 also missed multiple doses of potassium chloride and had a low potassium level and mirtazapine with weight loss in the months of September and October 2025. The failure was detrimental to the health, 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 10/28/25 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 15, 2025.	D 358		
D 375	10A NCAC 13F .1005 (a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and	D 375		

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D 375	Continued From page 107 documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 5 sampled residents (#4) had physicians' orders to self-administer medications used to treat mild to moderate pain. The findings are: Review of the facility's Resident Self-Management and Storage of Medications policy dated September 2021 revealed: -The procedures and criteria contained in this standard must be met prior to allowing a resident to manage, administer, and store his/her own medications. -A re-evaluation of the resident ability to self-manage medications will be conducted per standard. -Any prospective or current resident who desires to self-manage his/her medications must successfully complete the Self-Administration Assessment in the medication administration system completed by the Resident Care Coordinator or designee. -The Executive Director shall approve all self-management of medications. -File the completed Assessment for Medication Self-Management in the resident's chart with the resident's assessment. -Once the resident has satisfactorily passed the evaluation, the Resident Care Coordinator or	D 375	Care Managers and/or ED will ensure that all residents capable of of self-administering their medications have doctors orders to do so. The facility will also ensure that medications have the instructions for admiinstering those medications printed on the medication label. Medications found in a residents room not having an order to self-administer will be removed until an order has been obtained.	12/15/25 12/15/25

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D 375	Continued From page 108 designee will ensure there is a Physician's order in place that indicates the resident is able to store and self-administer his/her medications. -In addition, for residents who self-administer their medications, it is required that specific instructions for administration of prescription medications are printed on the medication label. -A re-evaluation of the resident's ability to safely store and self-administer his/her medications will be conducted quarterly, or sooner if indicated by change in status, and is required by State Regulations. -When there is a change in the resident's mental or physical ability to safely store and self-administer or resident's non-compliance with the physician's orders or the facility's medication standards and procedures, the facility shall notify the physician. -A resident's right to refuse medications does not imply the inability to self-administer medications. -Residents with a diagnosis of memory impairment will not be permitted to self-manage their medication. -The Resident Care Coordinator or the Executive Director will be authorized to implement medication management to any resident determined by him/her to be at risk for mismanaging their medication. -At any time a resident who desires to self-manage his/her medications is not able to pass the evaluation or should a Physician's order indicate that a resident is able to self-manage his/her medications and the Community disagrees due to the resident's inability to pass the evaluation, the Resident Care Coordinator in collaboration with the Executive Director will make the determination as to the resident's ability to have possession of his/her medications. Review of Resident #4's current FL-2 dated	D 375		

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D 375	Continued From page 109 08/08/25 revealed: -Diagnoses included paralysis of left upper extremity, gait instability, and frequent falls. -She was intermittently disoriented. -Her level of care was domiciliary. -There was no order for self-administration of medications. Review of Resident #4's Resident Register revealed she was admitted to the facility on 08/11/25. Review of Resident #4's local military hospital emergency department (ED) after visit summary dated 08/30/25 revealed: -Diagnoses from today's visit included fractured nasal bones, fall risk, dementia and history of cervical spine surgery. -New medication orders included acetaminophen (acetaminophen is used to treat mild to moderate pain) 325mg, 2 tablets every 6 hours as needed for pain for 7 days. -New medications orders included ibuprofen (ibuprofen is a non-steroidal anti-inflammatory medication used to treat mild to moderate pain) 600mg, take one tablet every six hours for 10 days. -There were no initials or signature on Resident #4's 08/30/25 ED after visit summary. Review of Resident #4's August 2025 electronic medication administration record (eMAR) revealed: -There was no entry for acetaminophen 325mg, take two tablets every 6 hours as needed for 7 days. -There was no entry for ibuprofen 600mg, take one tablet every 6 hours for 10 days. -There was no entry for self-administration of medications.	D 375		

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D 375	Continued From page 110 Review of Resident #4's September 2025 eMAR revealed: -There was no entry for acetaminophen 325mg, take two tablets every 6 hours as needed for 7 days. -There was no entry for ibuprofen 600mg, take one tablet every 6 hours for 10 days. -There was no entry for self-administration of medications. Telephone interview with a pharmacist with the facility's contracted pharmacy provider on 10/29/25 at 10:13am revealed: -No orders were received for Resident #4 dated 08/30/25 to take acetaminophen 325mg, 2 tablets every 6 hours as needed for pain for 7 days. -Acetaminophen 325mg was not dispensed for Resident #4 in August 2025 or September 2025. -No orders were received for Resident #4 dated 08/30/25 for ibuprofen 600mg, take one tablet every 6 hours for 10 days. -Ibuprofen 600mg was not dispensed for Resident #4 in August 2025 or September 2025. -Resident #4 had no orders for self-administration of medications. Telephone interview with a pharmacist at Resident #4's hospital pharmacy on 10/29/25 at 10:25am revealed: -An order was received for Resident #4 for acetaminophen 325, take two tablets every 6 hours as needed on 08/30/25. -Acetaminophen 325mg, #56 tablets were dispensed for Resident #4 to take 2 tablets every 6 hours as needed on 08/30/25 and was documented as picked up "by courier" at 3:12pm. -An order was received for Resident #4 for ibuprofen 600mg, take one tablet every 6 hours on 08/30/25.	D 375		

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D 375	Continued From page 111 -Ibuprofen 600mg; #40 tablets were dispensed for Resident #4 to take one tablet every 6 hours on 08/30/25 and was documented as picked up "by courier" at 3:12pm. Interview with Resident #4 on 10/29/25 at 9:24am revealed: -She had a fall last week, she fell in her bathroom and hit her back on a grab bar. -She saw her primary care provider (PCP) after her fall last week and x-rays and pain medication were ordered. -She did not request pain medication from the medication aide (MA) because she had her own supply that she took through the weekend. -She had a fall a month or so ago and had to go to the hospital she thought in another state and had two prescriptions for pain medications from that hospital visit. -She had acetaminophen, which she took two tablets as needed and she had ibuprofen and would take one of the ibuprofen when she took the two acetaminophen. -She kept these two medications in her purse. -She last took two acetaminophen and one ibuprofen this morning and ran out of the acetaminophen this morning. -She did not let staff know she had the medications because she knew staff would take them away from her. Observation of Resident #4's medication bottles in her room on 10/29/25 at 9:29am revealed: -Resident #4 removed two prescription bottles from her purse. -There was a prescription bottle with a screw top lid with a prescription label with Resident #4's name for ibuprofen 600mg, with instructions to take one tablet every 6 hours dispensed on 08/30/25 for 40 tablets.	D 375		

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D 375	Continued From page 112 -There were 10 white tablets remaining in the prescription bottle labeled ibuprofen 600mg. -There was a second prescription bottle with a screw top lid with a prescription label with Resident #4's name for acetaminophen 325mg, with instructions to take 2 tablets every 6 hours as needed for mild pain dispensed on 08/30/25 for 56 tablets. -There were no tablets remaining in the prescription bottle labeled acetaminophen 325mg. -Both prescription bottles were dispensed from Resident #4's hospital pharmacy. Telephone interview with the Resident Care Coordinator (RCC) on 10/31/25 at 3:22pm revealed: -A resident must have a medication self-administer assessment and a PCP order to self-administer medications. -Resident #4 did not have a self-administer assessment or self-administer order. -Resident #4 should not have had medications in her possession but there would not have been a way for staff to know she had medications because staff do not search a resident's personal belongings such as a purse. Interview with the Administrator on 10/29/25 at 9:50am revealed: -A resident had to have a self-administer assessment and order from their primary care provider to self-administer medications. -Resident #4 did not have a self-administer assessment or PCP order to self-administer medications. -Resident #4 should not have any over the counter or prescription medications in her room. -She was not aware that Resident #4 had acetaminophen and ibuprofen in her possession.	D 375		

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D 375	Continued From page 113 Telephone interview with Resident #4's PCP on 10/30/25 at 2:38pm revealed: -She typically did not allow residents to self-administer medications. -She was not aware that Resident #4 had self-administered acetaminophen and ibuprofen. -Resident #4 had dementia and should not self-administer medications. -Resident #4 did not have an order to self-administer medications.	D 375		
D 400	10A NCAC 13F .1009 (a)(1) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (a) An adult care home shall obtain the services of a licensed pharmacist or a prescribing practitioner for the provision of pharmaceutical care at least quarterly. The Department may require more frequent visits if it documents during monitoring visits or other investigations that there are medication problems in which the safety of residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes the following: (1) an on-site medication review for each resident which includes the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate	D 400	Pharmacy Reviews will be completed on each resident quarterly by a licensed pharmacist. Any recommendations by the pharmacist will be provided to the PCP for review. Documentation of the PCP's acceptance or declination to the recommendation will be kept in the residents EHR and sent to the pharmacy. Any outside provider that has not responded will have progress notes documenting attempts to obtain in the residents EHR.	12/15/25 12/15/25 12/15/25 12/15/25

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D 400	Continued From page 114 prescribing practitioner; and (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and (C) documenting the results of the medication review in the resident's record. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to follow up on a pharmacy review recommendation for 1 of 5 sampled residents (#1) . The findings are: Review of the facility's Pharmaceutical Care policy dated September 2021 revealed: -The facility would obtain the services of a licensed pharmacist or a prescribing practitioner for the provision of pharmaceutical care at least quarterly including review of the resident's physician's orders and include making recommendations for changes. -A written report of findings and any recommendation for change are made to the facility and the physician. -The facility would ensure action is taken as needed in response to the medication review and the response would be documented, including the physician has been informed of the findings. -The facility shall maintain the findings and reports including actions taken by the facility in	D 400		

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D 400	Continued From page 115 the resident record. Review of Resident #1's current FL-2 dated 07/17/25 revealed: -Diagnoses included type II diabetes and muscle weakness. -There was an order for acetaminophen 500mg every 4 hours as needed (PRN) with no indication for use. (Acetaminophen is used to treat mild to moderate pain.) -There was an order for Bisacodyl suppository 10 mg to be administered each day PRN with no indication for use. (Bisacodyl suppositories are used to treat constipation.) -There was an order for clear eyes drops, 1 drop to both eyes each day PRN with no indication for use. (Clear eyes eye drops are used to treat dry eyes.) -There was an order for Deep Sea spray, 1 spray to each nostril each day PRN with no indication for use. (Deep Sea nasal spray is used to treat nasal congestion.) There was an order for ondansetron 4mg every 6 hours PRN with no indication for use. (Ondansetron is used to treat nausea and vomiting.) Review of Resident #1's Resident Register revealed she was admitted on 06/12/25. Review of Resident #1's electronic medication administration record (eMAR) for August 2025 revealed: -There was a computerized entry for acetaminophen 500mg every 4 hours as needed (PRN) with no indication for use. -There was a computerized entry for Bisacodyl suppository 10 mg to be administered each day PRN with no indication for use. -There was a computerized entry for clear eyes	D 400		

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D 400	Continued From page 116 drops, 1 drop to both eyes each day PRN with no indication for use. -There was a computerized entry for Deep Sea spray, 1 spray to each nostril each day PRN with no indication for use. -There was a computerized entry for ondansetron 4mg every 6 hours PRN with no indication for use. Review of Resident #1's eMAR for September 2025 revealed: -There was a computerized entry for acetaminophen 500mg every 4 hours as needed (PRN) with no indication for use. -There was a computerized entry for Bisacodyl suppository 10 mg to be administered each day PRN with no indication for use. -There was a computerized entry for clear eyes drops, 1 drop to both eyes each day PRN with no indication for use. -There was a computerized entry for Deep Sea spray, 1 spray to each nostril each day PRN with no indication for use. -There was a computerized entry for ondansetron 4mg every 6 hours PRN with no indication for use. Review of Resident #1's eMAR for October 2025 revealed: -There was a computerized entry for acetaminophen 500mg every 4 hours as needed (PRN) with no indication for use. -There was a computerized entry for Bisacodyl suppository 10 mg to be administered each day PRN with no indication for use. -There was a computerized entry for clear eyes drops, 1 drop to both eyes each day PRN with no indication for use. -There was a computerized entry for Deep Sea spray, 1 spray to each nostril each day PRN with	D 400		

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D 400	Continued From page 117 no indication for use. -There was a computerized entry for ondansetron 4mg every 6 hours PRN with no indication for use. Review of Resident #1's pharmaceutical review dated 07/21/25 revealed: -There was a recommendation for Resident #1's primary care provider (PCP). -Recommendations stated that all PRN orders must contain a specific reason for administration and to please clarify acetaminophen 500mg PRN, Bisacodyl suppository 10 mg PRN, clear eyes drops PRN, Deep Sea spray PRN and ondansetron 4mg PRN. -There was no documentation of response from the primary care provider PCP. -There was no signature from the PCP that the pharmaceutical review. Telephone interview with Resident #1's primary care provider (PCP) on 10/30/25 at 2:19pm revealed: -The facility sent her pharmaceutical reviews with recommendations. -She would respond to the recommendations, sign the pharmaceutical review and fax it back to the facility. -She did not remember receiving a pharmaceutical review in July 2025 for Resident #1. Telephone interview with the Resident Care Coordinator (RCC) on 10/31/25 at 3:22pm revealed: -She was responsible for sending the pharmaceutical reviews to the PCP for follow-up. -She did not remember seeing a pharmacy review with recommendations for Resident #1 dated 07/21/25 and it was not sent to the PCP.	D 400		

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D 400	Continued From page 118 -It was important for pharmacy review recommendations be sent to the PCP for follow-up to ensure medications were appropriate and accurate. Interview with the Administrator on 10/27/25 at 4:50pm revealed: -The care managers were responsible for sending pharmaceutical reviews with recommendation to the PCP. -They are responsible for ensuring follow-up on all recommendations and PCP response. -She did not know why the RCC did not send the pharmacy review to Resident #1's PCP as she should have.	D 400		
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 (I/A) reports and notify the County Department of Social Services (DSS) of incidents resulting in injury requiring medical intervention greater than first aid with in 48 hours for 3 of 5 sampled	D 451	RVPO in-serviced the ED on the importance of reporting accidents and incidents to DSS for medical interventions greater than first aide. ED will keep a binder/file of confirmations where I/A reports have been submitted to DSS. RVPO and/or RCN will review binder during routine site visit to ensure ongoing compliance.	12/15/25 12/15/25 12/15/25

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D 451	Continued From page 119 residents (#3, #4, #9) resulting in multiple falls and multiple trips to the emergency department for falls (#3, #9), spine and chest x-rays (#4) The findings are: Review of the facility's Guidelines for Incident Reporting policy dated September 2021 revealed: -Incident Reports should be completed for any incident involving a resident. -Incident Reports must be sent to the Department of Social Services within 48 hours if the resident received medical intervention greater than first aid. 1. Review of Resident #9's current FL2 dated 07/16/2025 revealed: -Diagnoses included unspecified dementia, chronic kidney disease (CKD), spinal stenosis, major depressive disorder (MDD), nonrheumatic aortic stenosis, repeated falls, unspecified fracture of right femur. -Resident #9's recommended level of care was assisted living facility. -Resident #9 was semi-ambulatory and incontinent of bowel and bladder. Review of Resident #9's Resident Register revealed an admission on 01/05/22. Review of Resident #9's progress notes dated 08/13/25 revealed: -There was an entry at 4:28pm, the primary care provider (PCP) was contacted and made aware of a fall. -There was an entry at 4:29pm, a message was left with his responsible party (RP) asking for a return call. -There was an entry at 4:33pm, a fall occurred at 3:30pm and the PCP and his RP were contacted.	D 451		

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D 451	Continued From page 120 Review of Resident #9's progress note dated 08/14/25 revealed: -There was an entry at 4:27 pm recorded as a late entry on 09/23/2025 at 4:39pm that Resident #9 was sent to the hospital on 08/14/25 and was transported by emergency medical services (EMS) for a fall. -The PCP and RP were contacted and an incident report was completed on 08/13/25 at 4:23 pm. -This entry was marked invalid for incorrect data by the Resident Care Coordinator (RCC). Review of Resident #9's facility incident/accident (I/A) report on 08/14/25 revealed: -He had an unwitnessed fall in the dining room at 4:23 pm. -He was found laying on his back on the dining room floor. -He indicated the fall happened while trying to sit on a chair and fell. -He did complain of pain. -Injury was noted to back of head, arm left/right side with skin tear. -First aid was not administered. -He was alert and oriented. -He was transported to the hospital by EMS. - Record status of Resident after ED/hospital indicated Resident #9 needed to follow up with PCP. -Orders received on 08/14/25 to check vital signs every shift for 72 hours. Special instructions: Check vital signs for three days every shift. -Orders received on 08/14/25 to monitor status for 72 hours for bruising, change in mental status/condition, pain, or other injuries related to fall. -Special instructions: complete a shift note for 72 hours. -Treatments on 08/16/25 included wheelchair.	D 451		

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D 451	Continued From page 121 Special instructions: Remind Resident throughout the shift to lock wheelchair when standing/transferring and sign is posted. -Evaluation notes indicate to ensure that Resident #9 will lock wheelchair when standing to prevent falls. -Fall prevention program was initiated. -Care plan did not need to be updated. Review of Resident #9's facility I/A report on 08/28/25 revealed: -He had an unwitnessed fall on 08/28/25 at 10:00 am. -"He was found lying on the floor with knees up under to chest". -He indicated the fall occurred due to attempting to transfer to a recliner. -He did not complain of any pain. -First aid was not administered. -He roused when name was called. -He was transported to the hospital by EMS. -Record status of Resident after ED/hospital indicated Resident #9 had a urinary tract infection (UTI) and needed to follow up with his PCP. Review of Resident #9's facility I/A report on 08/28/25 revealed: -He had an unwitnessed fall in room on 08/28/25 at 8:30 pm. -He was observed on the floor beside the bed. -He reported falling from the bed to the floor and hit head. -He reported pain from fall. -First aide was not administered. -Redness was observed on the front of Resident #9's head. -EMS was contacted and Resident #9 was transported to hospital. -He was alert and oriented.	D 451		

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D 451	Continued From page 122 Review of Emergency medical services (EMS) records for Resident #9 revealed: -EMS responsed and subsequent hospitalizations on 08/14/25, 08/28/25 at 10am, 08/28/25 at 8:52pm and 8/30/25. Review of DSS Adult Home Specialist (AHS) records revealed: -That accident and incident reports were not received for resident #9 on 08/14/25, 8/28/25 at 10am and 08/30/25. Interview with the Administrator on 10/30/25 at 3:30pm revealed: -That accident and incident reports for Resident #9 was completed for all four reportable incidents. -The facility attempted to send the incident report for 08/14/25 to the DSS and the fax failed,there were no other attempts made to fax the accident and incident report. -The I/A report for 08/28/25 from 10:00am was completed and not sent to DSS. -The incident report for 08/30/25 was completed and not sent to DSS. 2. Review of Resident #4's current FL-2 dated 08/08/25 revealed: -Diagnoses included paralysis of left upper extremity, gait instability, and frequent falls. -She was intermittently disoriented. -Her level of care was domiciliary. Review of Resident #4's Resident Register revealed she was admitted to the facility on 08/11/25. Review of Resident #4's primary care provider (PCP) order dated 10/23/25 revealed: -The diagnosis was "pain with a fall". -There was an order for thoracic spine x-rays and	D 451		

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D 451	Continued From page 123 chest x-ray with rib views. Review of Resident #4's PCP provider progress note dated 10/23/25 revealed: -The resident was seen today for a fall. -She sustained a fall a couple days ago but did not feel she needed to go out but now has bruising and discomfort in the left posterior rib area and low back. -Diagnosis for the visit included unspecified fall, contusion of left back wall of thorax, sprain of ligaments of the lumbar spine. -Physical exam included moderate amount of ecchymosis (bruising) over left posterior ribs with mild tenderness. -Treatment plan included obtain left rib x-rays and lumbar spine x-rays. Review of Resident #4's staff progress notes revealed there was no entry pertaining to a fall for Resident #4 for October 2025. Observation of Resident #4 on 10/28/25 at 10:52am revealed a large purple to yellow discolored area to the left side of her back just below the mid-back, the discolored area extended to the upper left lumbar region of her back. Observation of the facility on 0/28/25 at 10:54am revealed the mobile x-ray provider arrived at Resident #4's. Review of Resident #4's x-ray results dated 10/28/25 revealed: -Chest x-ray impression no focal pneumonia by one view, chronic chest findings are present. -lumbar spine impression, no acute lumbar fracture or subluxation by plain radiography, and mild lumbar degenerative changes.	D 451		

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D 451	Continued From page 124 There was no I/A report provided for Resident #4's 10/22/25 fall. Interview with the Adult Home Specialist (AHS) with the local county Department of Social Services (DSS) on 10/28/25 at 2:08pm revealed: -An I/A report was not received from the facility for Resident #4's 10/22/25 fall. -I/A reports were important, to see if there were trends or patterns to resident falls and to determine if further investigation of the I/A was needed. Interview with a medication aide (MA) on 10/31/25 at 12:09pm revealed: -I/A reports were completed for all resident falls. -The I/A report was completed by the MA that responded to the incident. -Once the MA completed the I/A report, the I/A report was given to the Care Managers (Resident Care Coordinator or the Special Care Coordinator). -I/A reports were to be completed within 72 hours of an incident. Attempted telephone interview with the third shift medication aide (MA) on 10/30/25 at 10:44am was unsuccessful. Interview with the Administrator on 10/28/25 at 3:00pm revealed: -I/A reports were to be completed for all incidents involving the residents. -Resident #4 reported to her on rounds that she fell in the early morning hours on 10/22/25. -Resident #4 saw her primary care provider (PCP) on 10/23/25. -The MA that was on duty on the 11:00pm to 7:00am shift on 10/22/25 was responsible to	D 451		

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D 451	Continued From page 125 complete an I/A report for Resident #4's fall but the MA quit that same morning and said she was not coming back and did not complete Resident #4's I/A report. -She instructed the Resident Care Coordinator (RCC) to complete the I/A report for Resident #4's 10/22/25 fall. -She did not know why the RCC had not completed an I/A report for Resident #4's 10/22/25 fall. -The RCC was currently out of the facility and last worked on 10/26/25. Second interview with the Administrator on 10/31/25 at 7:06pm revealed: -The MA that responded to an incident was responsible to complete the I/A report. -Either the Resident Care Coordinator (RCC) or the Special Care Coordinator (SCC) closed the I/A reports, then the I/A reports were sent for corporate review and then were sent to DSS. 4. Review of Resident #3's current FL2 dated 10/17/25 revealed: -Diagnoses included dementia, hypertension, hyperlipidemia, anxiety disorder, and chronic embolism and thrombosis. -The resident was semi-ambulatory. -The resident was intermittently disoriented. Review of Resident #3's Resident Register revealed an admission date of 06/19/25. Review of Resident #3's hospital after visit summary (AVS) dated 08/04/25 revealed: -The reason for the visit was for a possible fall. -Resident #3 denied of any acute pain except for chronic back pain with history of herniated disc. -She did not recall any particular fall or injury. -She was discharged back to the facility on	D 451		

PRINTED: 11/24/2025
FORM APPROVED

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D 451	Continued From page 126 08/04/25. Review of Resident #3's hospital AVS dated 10/10/25 revealed: -The reason for the visit was for a fall. -Her testing consisted of a complete laboratory work up, an X-ray of the pelvis, an X-ray of the chest, and an X-ray of the femur. -She was discharged back to the facility on 10/10/25. Review of Resident #3's incident/accident (I/A) report dated 08/04/25 revealed: -There was a medical emergency in the dining hall regarding pain from a previous fall on 08/03/25. -The resident was sent to the emergency department (ED) for further evaluation on 08/04/25. -Resident #3's primary care provider (PCP) was notified. -Resident #3's responsible party was notified. -There was no documentation the county Department of Social Services (DSS) was notified. Review of Resident #3's facility progress notes revealed there were no entries for the date of 08/04/25. Review of Resident #3's I/A report dated 10/10/25 revealed: -Staff observed Resident #3 on the floor beside the toilet. -Resident #3 said that she stood up and fell. -The resident was sent to the ER for further evaluation. -Resident #3's PCP was notified. -Resident #3's responsible party was notified. -There was no documentation the county DSS	D 451		

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D 451	Continued From page 127 was not notified. Review of Resident #3's facility progress notes dated 10/10/25 at 2:53am revealed: -The reason for the progress note was for a specify unwitnessed fall with injury. -The PCP was notified at 2:30am on 10/10/25. -The responsible party was notified at 2:32am on 10/10/25. Interview with the county DSS on 10/25/25 at 4:35pm revealed: -She did not receive an I/A report for Resident #3 for incidents on 08/03/25 and on 10/10/25. -The facility faxed or emailed the I/A reports to the local DSS. -The processing assistant then sent the I/A report to her. -She reviewed the report and then filed the report. -It was important for the facility to send the I/A report to her to make her aware in case she needed to further investigate the I/A. Interview with the Administrator on 10/25/25 at 4:46pm revealed: -She was not aware that I/A reports on 08/03/25 and on 10/10/25 were not faxed or emailed to the county DSS. -She was aware that it was mandatory to notify the county DSS regarding any resident who needed medical attention greater than first aid. -The Administrator and the care managers were responsible to notify the county DSS of I/A reports. Based on observations, record reviews and interviews, it was determined that Resident #3 was not interviewable.	D 451		