STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE HOME OF TAYLORSVILLE	**360 WOOD ROAD TAYLORSVILLE, NC 28681**

(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 Alexander County Department of Social Services completed a follow up survey and complaint investigation from November 12, 2025 through November 14, 2025 and on November 17, 2025.	D 000		
D 225	10A NCAC 13F .0702 (c) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (c) The facility administrator or their designee shall assure the following requirements for written notice are met before discharging a resident: (1) The Adult Care Home Notice of Discharge with the Adult Care Home Hearing Request Form shall be completed and hand delivered, with receipt requested, to the resident on the same day the Adult Care Home Notice of Discharge is dated. These forms may be obtained at no cost from theDivision of Health Benefits, on the internet website https://policies.ncdhhs.gov/divisional/healthbenefits-nc-medicaid/forms. The Adult Care Home Notice of Discharge shall include the following: (A) the date of notice; (B) the date of transfer or discharge; (C) the reason for the notice; (D) the name of responsible person or contact person notified; (E) the planned discharge location; (F) the appeal rights; (G) the contact information for the long-term care ombudsman; and (H) the signature and date of the administrator. (2) A copy of the completed Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form shall be hand delivered, with receipt requested, or sent by certified mail to	D 225		

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D 225	Continued From page 1 the resident's responsible person or legal representative and the individual identified upon admission to receive a discharge notice on behalf of the resident on the same day the Adult Care Home Notice of Discharge is dated. For the purposes of this Rule "responsible person" means a person chosen by the resident to act on their behalf to support the resident in decision-making; access to medical, social, or other personal information of the resident; manage financial matters; or receive notifications. The Adult Care Home Hearing Request Form shall include the following: (A) the name of the resident; (B) the name of the facility; (C) the date of transfer or discharge; (D) the date of scheduled transfer or discharge; (E) the selection of how the hearing is to be conducted; (F) the name of the person requesting the hearing; and (G) for the person requesting the hearing, their relationship to the resident, address, telephone number, their signature, and date of the request. (3) Provide the following material in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to the resident and the resident's legal representative and the individual identified upon admission to receive a copy the discharge notice on behalf of the resident: (A) a copy of the resident's most current FL-2 form required in Rule .0703 of this Subchapter; (B) a copy of the resident's current physician's orders, including medication order; (4) Failure to use and simultaneously provide the specific forms according to Subparagraphs (c)(1) and (c)(2) of this Rule shall invalidate the discharge.	D 225		

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(5) A copy of the completed Adult Care Home Notice of Discharge, the Adult Care Home Hearing Request Form as completed by the facility administrator or their designee prior to giving to the resident and a copy of the receipt of hand delivery or the notification of certified mail delivery shall be maintained in the resident's record.

This Rule is not met as evidenced by:
Based on record reviews and interviews the facility failed to ensure an appropriate discharge notice was provided for 1 of 2 sampled residents when a written discharge notice was not hand delivered or sent certified mail to the resident's responsible party or legal representative (#3).

The findings are:

Resident #3's current FL2 dated 08/28/25 revealed diagnoses included asthma and schizophrenia.

Review of Resident #3's Resident Register revealed:
-Resident #3 was admitted to the facility on 01/28/25.
-Resident #3's responsible party was documented as "self."
-Resident #3 was discharged to a local hospital on 10/26/25.

Review of Resident #3's record revealed there was no Notice of Transfer/ Discharge form and

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D 225	Continued From page 3 Hearing Request form. Interview with the facility Manager on 11/14/25 at 4:40pm revealed: -Resident #3 received a 30-day discharge notice on 09/29/25 due to non-payment. -The 30-day discharge notice was issued on a computer-generated document and signed by Resident #3. -She did not know a Notice of Transfer/ Discharge form and Hearing Request form should have been issued. -Resident #3 was transferred to the hospital via law enforcement on 10/26/25 due to his behavior that endangered other residents. -She contacted Resident #3's family member and informed her that Resident #3 could not return to the facility after hospital discharge due to his behaviors. -She contacted the hospital and informed them Resident #3 could not return to the facility due to behaviors and non-payment. -She did not issue or deliver a Notice of Transfer/ Discharge form and Hearing Request form to Resident #3 while he was hospitalized. Interview with the Administrator on 11/17/25 at 10:00am revealed: -She signed Resident #3's transfer/discharge section of the Resident Register on 11/04/25. -Resident #3 was issued an immediate discharge when the facility Manager contacted the hospital and informed them the Resident could not return to the facility once he was discharged from the hospital, due to behaviors that endangered other residents and non-payment of rent. -She and/or the facility Manager were responsible for issuing a Notice of Transfer and Hearing Request form after the decision was made. -She did not realize Resident #3 did not receive a	D 225		

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D 225	Continued From page 4 Notice of Transfer/ Discharge and Hearing Request form and expected him and/or his responsible party to receive one in hand.	D 225		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions set forth in 15A NCAC 18A .1300 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure all food items stored and prepared by the facility were served under sanitary conditions, related to dried food and debris on the bottom of both refrigerators, a soiled and sticky floor, an open jar of mayonnaise located in the cabinet, multiple refrigerated items not labeled or dated, and an exposed drain container of discarded food that was located on	D 283		

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the floor.

The findings are:

Observation of the kitchen on 11/12/25 at 9:05am revealed:
-There were two opened boxes of dry cereal with no label and no dates.
-There was dried food and debris on the bottom of both refrigerators that stored food for resident consumption.
-The kitchen floor was soiled with debris and sticky stains.
-There was an open jar of mayonnaise located in a cabinet instead of the refrigerator.
-There were multiple refrigerated items that were opened, not labeled or dated (one jar bottle of ketchup, one bottle of salad dressing, two large jars of applesauce, one jar of jelly, sliced yellow cheese and 2 containers of mushrooms).
-There was an exposed drain container of discarded food that was located on the floor near the end of a kitchen sink drain pipe.

Interview with the Dietary Manager (DM) on 11/12/25 at 9:05am revealed:
-He started his role as dietary manager/ cook on 10/23/25.
-He worked Monday through Thursday from 6:00am to 6:00pm and prepared all resident meals.
-He did not have a cleaning schedule because he was the only kitchen staff Monday through Thursday and there was one part-time staff on the weekend.
-He did not know how an opened container of mayonnaise was found in the cabinet instead of the refrigerator and how long it had been there.
-He did not know all open containers of stored food needed to be labeled and dated.

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-He emptied the drain container that contained discarded food from the drain about every two days.
-He did not know why the drain container was exposed and not connected to a sewage drain.

Interview with the facility Manager on 11/14/25 at 4:40pm revealed:
-The DM was working on keeping the kitchen clean and in sanitary condition.
-She expected opened food containers or leftovers to be labeled, dated and discarded within a few days.
-She was not aware of any unsanitary concerns related to the food drain container that contained discarded food from the sink.

Interview with the Administrator on 11/17/25 at 10:00am revealed:
-She was not aware opened food stored in the kitchen were not labeled, not dated or stored in a sanitary manner.
-She was not aware there was an open drain container located on the floor near the kitchen sink.
-She expected the kitchen to be thoroughly cleaned weekly and maintained in a sanitary manner.

D 296 | 10A NCAC 13F .0904(c)(7) Nutrition And Food Service | D 296

10A NCAC 13F .0904 Nutrition And Food Service
(c) Menus in Adult Care Homes:
(7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff.

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This Rule is not met as evidenced by:
Based on record reviews and interviews the facility failed to have matching therapeutic diet menus for food service guidance for 3 of 3 sampled residents with physician orders for a pureed diet with honey thickened liquids (#4), a reduced concentrated sweets diet (#6) and a regular diet with chopped meats and no added salt (#7).

The findings are:

Observation of the kitchen on 11/12/25 at 9:05am revealed:
-There was a monthly menu notebook located in a cabinet.
-There were no matching therapeutic diet menus available for food service staff guidance.
-There was a diet order notebook located in a cabinet.
-There were no therapeutic diet recipes available for food service staff guidance.

1. Review of Resident #4's current FL2 dated 10/29/25 revealed:
-Diagnoses included altered mental status, hospital acquired pneumonia, chronic obstructive pulmonary disease (COPD) with oxygen, and congestive heart failure (CHF).
-Resident #4 had an active diet order for aspiration precautions, pureed diet and honey thickened liquids.

Review of Resident #4's Resident Register

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revealed an admission date of 03/05/19.

Observation of the dinner meal service on 11/13/25 at 4:45pm revealed:
-Resident #4 was served applesauce, pureed broccoli (thin consistency), pureed sausage, milk (not thickened) and iced tea (not thickened).
-Resident #4 was finishing a glass of milk and requested another glass of milk.
-A personal care aide (PCA) was asked to refrain from serving Resident #4 another glass of milk until she made sure the milk was thickened to a honey consistency.

Based on observation of the lunch meal service on 11/13/25 it could not be determined if Resident #4 was served the correct therapeutic diet because a pureed diet menu was not available for staff guidance.

Interview with the PCA on 11/13/25 at 4:50pm revealed:
-She did not know Resident #4 had an active order for honey thickened liquids.
-She did not know Resident #4's milk and other liquids were supposed to be thickened.
-She had prior training on how to thicken liquids for residents who were on a thickened liquid diet.
-She expected the kitchen staff or medication aides (MAs) to inform her if a resident was to receive thickened liquids.
-She was not aware of Resident #4 having any choking or coughing episodes since her diet order was changed.

Interview with the Dietary Manager (DM) on 11/13/25 at 5:00pm revealed:
-He started his role as dietary manager/ cook on 10/23/25.
-He worked alone in the kitchen Monday through

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Thursday from 6:00am to 6:00pm.
-The facility Manager was responsible for informing him of diet order changes.
-He was aware Resident #4 had an active order for pureed diet.
-There were no matching therapeutic diet orders available in the kitchen.
-He used his prior knowledge with food preparation and guidance from the facility's manager to prepare Resident #4's pureed foods.
-He did not know Resident #4 had an active order for honey thickened liquids.
-The facility did not have thickener available to thicken Resident #4's liquids.
-There was not a recipe for preparing pureed foods located in the kitchen.
-He prepared Resident #4's pureed foods by using the puree feature on the blender and adding water or broth to obtain a pureed consistency.
-The PCAs were responsible for thickening liquids and serving thickened liquids to residents who had an order for thickened liquids.
-He was not aware of Resident #4 having any choking or coughing episodes since her diet order was changed.

Interview with the facility Manager on 11/14/25 at 4:40pm revealed:
-She was aware Resident #4 diet order changed to a pureed diet and communicated the change to the DM and staff.
-She missed Resident #4's diet order change to honey thickened liquids.
-She purchased a blender with a puree function and advised the DM to blend Resident #4's food to a "baby food" consistency.

Refer to the interview with the facility's consulting Dietician on 11/13/25 at 3:00pm.

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D 296	Continued From page 10 Refer to the interview with the facility Manager on 11/14/25 at 4:40pm. Refer to the interview with the Administrator on 11/17/25 at 10:00am. 2. Review of Resident #6's current FL2 dated 06/03/25 revealed: -Diagnoses included traumatic brain injury, hypertension, chronic pain syndrome, type 2 diabetes, and impulse control disorder. -Resident #6 had an active diet order for reduced concentrated sweets. Review of Resident #6's Resident Register revealed an admission date of 09/16/19. Observation of a lunch meal on 11/14/25 at 12:20pm revealed: -Resident #6 was served fish, green beans, a dinner role, water, a peanut butter and jelly sandwich and no dessert. -Resident #6 refused his lunch. Based on observation of the lunch meal service on 11/14/25 it could not be determined if Resident #6 was served the correct therapeutic diet because a reduced concentrated sweets menu was not available for staff guidance. Interview with the DM on 11/14/25 at 3:00pm revealed: -Resident #6 had an active diet order for a regular diet with reduced concentrated sweets. -Resident #6 often refused his meals due to his family bringing in food items and he preferred peanut butter and jelly sandwiches. -There was not a therapeutic diet menu for reduced concentrated sweets for staff guidance,	D 296		

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located in the kitchen.
-He did not know the difference between a reduced concentrated sweets diet and a diabetic diet.

Refer to the interview with the facility's consulting Dietician on 11/13/25 at 3:00pm.

Refer to the interview with the facility Manager on 11/14/25 at 4:40pm.

Refer to the interview with the Administrator on 11/17/25 at 10:00am.

3. Review of Resident #7's current FL2 dated 05/27/25 revealed diagnoses included acid reflux, kidney disease, and schizoaffective disorder.

Review of Resident #7's Resident Register revealed an admission date of 06/25/19.

Resident #7 had an active diet order dated 09/04/25 for a regular diet with chopped meats and no added salt.

Observation of a lunch meal on 11/14/25 at 12:20pm revealed Resident #7 was served rice, soft green beans, chopped fish, and no added salt.

Based on observation of the lunch meal service on 11/14/25 it could not be determined if Resident #7 was served the correct therapeutic diet because a regular diet with chopped meats and no added salt menu was not available for staff guidance.

Interview with the DM on 11/14/25 at 3:00pm revealed:
-There was no therapeutic diet menu for chopped

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foods.
-He relied on his prior knowledge of how to chop meats to a bite size consistency.
-Salt was not provided added to menu items and not provided to residents who were on no added salt diets.

Refer to the interview with the facility's consulting Dietician on 11/13/25 at 3:00pm.

Refer to the interview with the facility Manager on 11/14/25 at 4:40pm.

Refer to the interview with the Administrator on 11/17/25 at 10:00am.

____

Telephone interview with the facility's consulting Dietician on 11/13/25 at 3:00pm revealed:
-The facility started their services in October 2025.
-They provide the facility with monthly menus, therapeutic diet menus and menu recipes for all diets.
-She expected the therapeutic diet menus and recipes to be available in the kitchen for staff guidance.

Interview with the facility Manager on 11/14/25 at 4:40pm revealed:
-The process of therapeutic diets was new to her and she was learning.
-She was not aware therapeutic diet menus were not available in the kitchen for staff guidance.
-She expected diet orders to be followed and therapeutic diet menus/ menu recipes to be available for therapeutic diet orders to be prepared correctly.

Telephone interview with the Administrator on 11/17/25 at 10:00am revealed:

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D 296	Continued From page 13 -She visited the facility once or twice weekly to provide support to the facility Manager. -The facility Manager was responsible for notifying staff of diet order changes and training kitchen staff on how to prepare therapeutic food items. -She did not know therapeutic diet menus and menu recipes were not available in the kitchen for staff guidance. -She expected all food to be prepared and served as ordered according to the therapeutic menu recipes provided by the contracted food service provider.	D 296		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on record reviews and interviews the facility failed to serve therapeutic diets as ordered for 1 of 3 sampled residents who had an order for a pureed diet with honey-thickened liquids (#4). The findings are: Review of Resident #4's current FL2 dated 10/29/25 revealed: -Diagnoses included altered mental status, hospital acquired pneumonia, chronic obstructive	D 310		

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HERITAGE CARE HOME OF TAYLORSVILLE	**360 WOOD ROAD TAYLORSVILLE, NC 28681**

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pulmonary disease (COPD) with oxygen, and congestive heart failure (CHF).
-Resident #4 had an active diet order for aspiration precautions, honey thickened liquids, and pureed diet.

Review of Resident #4's Resident Register revealed an admission date of 03/05/19.

Observation of the kitchen on 11/12/25 at 9:05am revealed:
-There was a monthly menu notebook located in a cabinet.
-There were no extension (therapeutic diet) menus available for food service staff guidance.
-There was a diet order notebook located in a cabinet.
-There was no diet order for Resident #4 located in the kitchen.
-There were no therapeutic diet recipes available for food service staff guidance.

Review of Resident #4's hospital discharge summary dated 11/04/25 revealed:
-Resident #4 was admitted to the hospital on 10/22/25 and discharged back to the facility on 11/04/25.
-Resident #4 was treated for chronic hypoxic respiratory failure secondary to recurrent aspiration pneumonia and dysphagia (difficulty swallowing).
-Resident #4 received 4 liters of continuous oxygen and was discharged on 1 liter of oxygen via nasal canula.
-Speech therapy recommended pureed and honey thickened liquids.

Observation of the dinner meal service on 11/13/25 at 4:45pm revealed:
-Resident #4 was served applesauce, pureed

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broccoli (thin consistency), pureed sausage, milk (not thickened) and iced tea (not thickened).
-Resident #4 was finishing a glass of milk and requested another glass of milk.
-A personal care aide (PCA) was asked to refrain from serving Resident #4 another glass of milk until she made sure the milk was thickened to a honey consistency.

Interview with the PCA on 11/13/25 at 4:50pm revealed:
-She did not know Resident #4 had an active order for honey thickened liquids when she discharged from the hospital.
-She did not know Resident #4's milk and other liquids were supposed to be thickened.
-She expected the kitchen staff or medication aides (MAs) to inform her if a resident was to receive thickened liquids.

Interview with the Dietary Manager (DM) on 11/13/25 at 5:00pm revealed:
-He started his role as DM / cook on 10/23/25.
-He worked alone in the kitchen Monday through Thursday from 6:00am to 6:00pm.
-The facility Manager was responsible for informing him of diet order changes.
-He was aware Resident #4 had an active order for pureed diet.
-He had prior experience with food preparation and guidance from the facility's manager to prepare Resident #4's pureed foods.
-He did not know Resident #4 had an active order for honey thickened liquids.
-The facility did not have thickener available to thicken Resident #4's liquids.
-He had not received documentation in the kitchen of Resident #4's diet order change.
-There was not a recipe for preparing pureed foods located in the kitchen.

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D 310	Continued From page 16 -He prepared Resident #4's pureed foods by using the puree feature on the blender and adding water or broth to obtain a pureed consistency. -The PCAs were responsible for thickening liquids and serving thickened liquids to residents who had an order for thickened liquids. Telephone interview with the facility's Nurse Practitioner (NP) on 11/14/25 at 1:36pm revealed: -Resident #4 was discharged from the hospital on 11/04/25 after being treated for pneumonia related to her multiple chronic diagnoses (COPD, respiratory failure, and non-compliance with oxygen use) and dysphagia. -She assessed Resident #4 on 11/11/25 post hospital discharge. -Resident #4 had an active order for pureed diet with honey thickened liquids according to the hospital discharge summary. -The facility did not notify her that Resident #4 was not receiving a pureed diet with honey thickened liquids as ordered. -The result of Resident #4 not receiving a pureed diet and honey thickened liquids could cause fluid to build up in the lungs, aspiration, or choking. -She expected the facility to follow Resident #4's pureed diet and honey thickened liquids as ordered. Interview with the facility Manager on 11/14/25 at 4:40pm revealed: -She was responsible for reviewing hospital discharge summaries and communicating orders and changes to the Administrator and staff. -She was aware Resident #4's diet order changed to a pureed diet and communicated the change to the DM and staff. -She missed Resident #4's diet order change to honey thickened liquids.	D 310		

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D 310	Continued From page 17 -She purchased a blender with a puree function and advised the DM to blend Resident #4's food to a "baby food" consistency. -The process of therapeutic diets was new to her and she was learning. -She expected diet orders to be followed. Telephone interview with the Administrator on 11/17/25 at 10:00am revealed: -She visited the facility once or twice weekly to provide support to the facility Manager. -The facility Manager was responsible for transcribing hospital discharge summaries and order changes, then communicating changes to staff. -She was aware Resident #4's diet order was changed to a pureed diet with honey-thickened liquids. -The facility Manager was responsible for notifying staff of diet order changes and training kitchen staff on how to prepare therapeutic food items. -She expected all food to be served as ordered. ________________________ The facility failed to ensure Resident #4, who had a history of recurrent aspiration pneumonia and a recent 12 day hospitalization related to respiratory failure secondary to aspiration pneumonia, was served honey-thickened liquids as recommended by a speech therapist and ordered by a physician. This failure increased the risk for aspiration of fluid in the lungs and choking. This failure resulted in risk for serious physical harm and constitutes a Type A2 Violation. ________________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/14/25 for this violation. THE CORRECTION DATE FOR THE TYPE A2	D 310		

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D 310	Continued From page 18 VIOLATION SHALL NOT EXCEED DECEMBER 17, 2025.	D 310		
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: Based on observations, interviews and record reviews, the facility failed to ensure 1 of 4 sampled resident's (#6) was treated with respect, consideration and dignity. The findings are: Review of Resident #6's current FL2 dated 06/03/25 revealed: -Diagnoses included traumatic brain injury, hypertension, chronic pain syndrome, diabetes type II and impulse control disorder. -The resident was ambulatory but used a wheelchair. -The resident was intermittently disoriented. Review of Resident #6's Care Plan dated 06/03/25 revealed: -The resident had a history of smoking. -The resident had a major depressive disorder. -The resident had a recurrent moderate mild neurocognitive disorder due to known physiological condition. -The resident had obsessive compulsive disorder. -The resident had chronic pain and sleep disturbance.	D 338		

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Observations of Resident #6 on 11/10/25 revealed:
-The resident was observed sitting in his wheelchair in front of the nurse's station speaking with a medication aide (MA).
-The resident asked the MA for cigars.
-The MA responded in a loud tone of voice to the resident that she did not have any cigars to give him.
-The MA told Resident #6 all the cigars she had belonged to other residents.
-Resident #6 told the MA that he had two dollars to pay for a cigar.
-The MA asked the resident if he would rather live at the facility or "go to jail".
-The MA told the resident not to ask her again for cigars.

Observation of the facility Manager on 11/10/25 at 10:00 am revealed:
-The facility Manager was standing at the medication room doorway across from the nurse's station.
-The facility Manager called the MA over to her and told her she needed to calm down.
-The facility Manager told the MA that she could not speak to the resident the way that she did.

Interview with Resident #6 on 11/14/25 at 9:30 am revealed:
-He asked the MA for cigars and she told him she was not allowed to give him anymore today.
-She told him she could only give him 10 cigars a day.
-She told him that they cost money.
-He told her to take it out of his personal account.
-She told him that the other residents paid for the cigars in stock and that she could not give them to him.

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-He could not remember her asking him if he would rather live in the facility or go to jail.
-He recently told the MA he had been in jail a long time ago.
-It made him feel terrible when the MA talked to him like that.

Interview with the MA on 11/14/25 at 9:42 am revealed:
-Resident #6 asked her 5 or 6 times to sell him a cigar.
-She told the resident that she couldn't because the other residents had already paid for them.
-She told him not to ask her again.
-Resident #6 was always "pestering" staff and other residents for cigars.
-The MA stated "I used to be gentle with him, but now I'm stern with him."

Interview with the facility Manager on 11/14/25 at 9:50am revealed:
-She was on the telephone at the medication room when she observed the MA talking in a loud voice to Resident #6.
-She hung up the telephone and motioned with her hand for the MA to calm down.
-The MA sometimes spoke with a loud tone of voice.
-The MA told the resident that he could not have any more cigars because he was out of money.
-The MA told the resident to not ask her for cigars again.
-She told the MA to walk away and "take a breather."

Telephone interview with the Administrator on 11/20/25 at 1:04 pm revealed:
-The Manager told her that there was an incident with the MA and Resident # 6.
-The Manager did not tell her that the MA was

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D 338	Continued From page 21 being loud and disrespectful to the resident. -The Manager did not tell her that she had to motion for the MA to calm down. -The MA told the resident that he did not have any more cigars. -The resident wanted to buy cigars that belonged to the other residents. -The MA told him that she could not sell those to him.	D 338		
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).	D 367		

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This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure electronic Medication Administration Records (eMARs) were accurate for 1 of 3 residents (#2) related to documentation of a medication to treat anxiety.

The findings are:

Review of Resident #2's current FL2 dated 06/05/25 revealed diagnoses included schizoaffective disorder and suicidal ideations.

Review of Resident #2's Mental Health Providers (MHP) orders dated 10/30/25 revealed an order for diazepam 5mg, one-half tablet every eight hours as needed for anxiety.

Review of Resident #2's November 2025 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for diazepam 5mg, one-half tablet three times daily as needed for anxiety.
-Diazepam 5mg, one half-tablet was documented as administered at 6:46am and 4:22pm on 11/05/25, at 6:13am and 5:57pm on 11/06/25 and at 7:19am and 3:25pm on 11/07/25.

Review of Resident #2's Control Substance Count Sheet (CSCS) for diazepam 5mg, one-half tablet three times daily as needed for anxiety dated 11/04/25 revealed:
-There was documentation diazepam 5mg, one-half tablet was signed out for administration for Resident #2 once on 11/05/25 at 6:46am.
-There was documentation diazepam 5mg, one-half tablet was signed out for administration for Resident #2 once on 11/06/25 at 6:11am.
-There was no documentation diazepam 5mg, one-half tablet was signed out for administration

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D 367	Continued From page 23 on 11/07/25. Observations of Resident #2's medications on hand on 11/13/25 at 3:07pm revealed there was a bubble pack containing 33 one-half tablets of diazepam 5mg. Interview with a medication aide (MA) on 11/17/25 at 11:04am revealed: -She only looked at the end of shift counts, and the beginning of shift counts and knew they were correct. -She was not aware of anyone auditing the charts but was not sure. Interview with the Manager on 11/17/25 at 3:03pm revealed: -MAs was responsible for accurately documenting on the residents eMARs. -The MAs were to check the order and document after the controlled substance was given. -She was not aware there was an issue with signing out the controlled substances. -There were no audits done on the controlled substance sheets. -Audits were completed weekly by the manager and Administrator but only checking the medication cart with controlled substance sheets, not checking the eMAR with the controlled substance sheets. Telephone interview with the Administrator on 11/17/25 at 3:30pm revealed: -She was not aware of the issue with the eMAR and the control substance count sheets having errors. -She never audited any charts or medication carts since she became the Administrator.	D 367		

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D 411	Continued From page 24	D 411		
D 411	10A NCAC 13F .1010 (d) Pharmaceutical Services 10A NCAC 13F .1010 Pharmaceutical Services (d) The facility shall assure the provision of medication for residents on temporary leave from the facility or involved in day activities out of the facility. The facility shall have written policies and procedures for a resident's temporary leave of absence. The policies and procedures shall facilitate safe administration by assuring that upon receipt of the medication for a leave of absence the resident or the person accompanying the resident is able to identify the medication, dosage, and administration time for each medication provided for the temporary leave of absence. The policies and procedures shall include the following provisions: (1) The amount of resident's medications provided shall be sufficient and necessary to cover the duration of the resident's absence. For the purposes of this Rule, sufficient and necessary means the amount of medication to be administered during the leave of absence or only a current dose pack, card, or container if the current dose pack, card, or container has enough medication for the planned absence; (2) written and verbal instructions for each medication to be released for the resident's absence shall be provided to the resident or the person accompanying the resident upon the medication's release from the facility and shall include: (A) the name and strength of the medication; (B) the directions for administration as prescribed by the resident's physician; and (C) any cautionary information from the original prescription package if the information is not on the container released for the leave of absence;	D 411		

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D 411	Continued From page 25 (3) the resident's medication shall be provided in a capped or closed container that will protect the medications from contamination and spillage; and (4) labeling of each of the resident's individual medication containers for the leave of absence shall be legible, include at least the name of the resident and the name and strength of the medication, and be affixed to each container. The facility shall maintain documentation in the resident's record of medications provided for the resident's leave of absence, including the quantity released from the facility and the quantity returned to the facility. The documentation of the quantities of medications released from and returned to the facility for a resident's leave of absence shall be verified by signature of the facility staff and resident or the person accompanying the resident upon the medications' release from and return to the facility. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the provision of medication for 1 of 1 sampled resident who went on temporary leave from the facility for five days without all of his medications (#2). The findings are: Review of Resident #2's current FL2 dated 06/05/25 revealed diagnoses included schizoaffective disorder and suicidal ideations. Review of Resident #2's Mental Health Provider's (MHP) orders dated 08/25/25 revealed: -There was an order for haloperidol (a medication	D 411		

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D 411	Continued From page 26 to treat mental health disorders) 1mg, one tablet daily at bedtime. -There was an order for lamotrigine (a medication to treat mental health disorders) extended release (ER) 200mg one tablet daily at bedtime. -There was an order for sertraline (a medication to treat depression) 100mg, two tablets daily. Review of Resident #2's November 2025 electronic Medication Administration Record (eMAR) revealed Resident #2 was out of the facility from 11/11/25 to 11/15/25. Review of Resident #2's Medication Transfer Sheet dated 11/11/25 revealed: -If a resident was to be gone longer than one dosage period the facility could give the full prescription container to the resident or responsible party. -There was no documentation haloperidol 1mg, one tablet at bedtime was released to Resident #2 on 11/11/25. -There was no documentation lamotrigine ER 200mg, one tablet at bedtime was released to Resident #2 on 11/11/25. -There was no documentation sertraline 100mg, two tablets daily was released to Resident #2 on 11/11/25. -The facility Manager signed the form as the staff member releasing the medication to Resident #2. Observations of Resident #2's medications on hand on 11/13/25 at 3:58pm revealed: -There was a bubble pack containing haloperidol 1mg, 30 tablets dispensed on 11/05/25. -There was a bubble pack containing lamotrigine ER 200mg, 30 tablets dispensed on 10/29/25. -There was a bubble pack containing sertraline 100mg, 60 tablets in 30 dose bubbles. -There was a bubble pack containing lamotrigine	D 411		

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100mg, 30 tablets dispensed on 10/29/25.

Interview with the facility Manager on 11/13/25 at 4:18pm revealed:
-She was training a new medication aide (MA) on 11/11/25.
-Resident #2 went on leave from the facility on 11/11/25 and expected to return to the facility on Sunday 11/16/25.
-She had the MA she was training pull Resident #2's medications from the cart and write them on the Medication Transfer Sheet while she pulled medications for a second resident who was going on leave from the facility
-She told the MA to look at Resident #2's eMAR, find each medication, pull it from the cart and write the medication name, dosage and number of pills released on the Medication Transfer Sheet.
-The MA placed the medications into a bag and gave it to her.
-She did not review Resident #2's medications the MA had pulled for him.
-She should have reviewed the medications but did not.
-She did not know haloperidol 1mg, lamotrigine ER 200mg and sertraline 100mg were not in the bag containing Resident #2's medications.
-The medications were given to Resident #2 when he left on leave on 11/11/25.

Telephone interview with a Pharmacist with the facility's contracted pharmacy on 11/14/25 at 10:28am revealed:
-If Resident #2 did not take his haloperidol 1mg, one tablet daily at bedtime he could experience mood instability and trouble sleeping.
-The longer Resident #2 went without his haloperidol 1mg, one tablet daily at bedtime the more at risk he was for mood issues.

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-If Resident #2 did not take his lamotrigine ER 200mg, one tablet daily at bedtime he could experience mood issues.
-If Resident #2 went greater than six days without his lamotrigine ER 200mg, he should be started back at a lower dose, and the dose should be increased gradually.
-If Resident #2 went without his sertraline 100mg, 2 tablets daily he could experience mood issues including depression.
-Sertraline 100mg, 2 tablets daily should not be stopped suddenly, but should be tapered, as it could cause headaches, nausea, and diarrhea.
-Resident #2 was at increased risk for mood issues with missing three medications that affected his mood.
-The facility should try and get these medications to him since it was planned for him to be out of the facility until 11/16/25.

Interview with the facility Manager on 11/14/25 at 11:38am revealed:
-She did not review the medications he had with him to ensure he had all his medications.
-After being notified the Pharmacist recommended Resident #2 get his haloperidol 1mg, lamotrigine ER 200mg, and sertraline 100mg as soon as possible, she stated she would call Resident #2 and attempt to get the medications to him.

Review of a second Medication Transfer Sheet for Resident #2 dated 11/14/25 revealed:
-There was no documentation lamotrigine ER 200mg, one tablet at bedtime was released to Resident #2 on 11/14/25.
-There was documentation haloperidol 1mg thirty tablets were released to Resident #2 on 11/14/25.
-There was documentation lamotrigine 100mg, thirty tablets were released to Resident #2 on

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11/14/25.
-There was documentation sertraline 100mg, sixty tablets were released to Resident #2 on 11/14/25.
-The Manager signed the form as the staff member releasing the medication to Resident #2.

Interview with Resident #2 on 11/17/25 at 10:18am revealed:
-Staff brought three additional medications on 11/14/25 to him when he was away from the facility on leave.
-The three medications staff delivered on 11/14/25 were medications he did not have when he left the facility on 11/11/25.

Interview with the facility Manager on 11/17/15 at 11:43am and 3:03pm revealed:
-She signed out three additional medications for Resident #2 on Friday 11/14/25 and a MA delivered them to the resident that night (11/14/25).
-She pulled the three medications listed on the Medication Transfer Sheet dated 11/14/25: haloperidol 1mg, lamotrigine 100mg and sertraline 100mg.
-She did not realize she pulled lamotrigine 100mg instead of lamotrigine ER 200mg to deliver to Resident #2.
-She was unsure if the MA who delivered to Resident #2 reviewed the medications.
-She accidentally pulled lamotrigine 100mg instead of lamotrigine ER 200mg on 11/14/25.

Interview with a MA on 11/17/25 at 1:43pm revealed:
-She was a new employee and was training on 11/11/25 with another MA.
-She was instructed to pull medications for Resident #2 as he was going on leave from the

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D 411		D 411		

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facility while the other MA pulled medications for a second resident going on leave.
-She pulled the medication from behind Resident #2's name in the medication cart and wrote them on the Medication Transfer Sheet.
-She was not instructed to review Resident #2's eMAR to know what medications he took.
-She was not instructed to look in the overstock medications for any of Resident #2's medications.
-The MA training her did not review the medications she pulled from the cart for Resident #2.
-The MA training her did not review the Medication Transfer Sheet.
-The MA training her put the medications and the Medication Transfer Sheet in a bag for the resident.

Telephone interview with the Administrator on 11/17/25 at 3:34pm revealed:
-She became the Administrator at the facility in September 2025 and was in the facility once or twice a week.
-The MAs were responsible to ensure residents going on leave from the facility had all their medications.
-When the MAs pulled a resident's medication who was going on leave from the facility, the MA was responsible to look at the eMAR to ensure all of the resident's medications were pulled.
-The newly hired MA should not have been pulling Resident #2's medications for leave as she was not familiar with the resident nor the process.
-She was unsure if the process at this facility for pulling medications for residents going on leave included a second MA reviewing the medications and Medication Transfer Sheet.

Attempted telephone interview with Resident #2's Mental Health Provider (MHP) on 11/17/25 at

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D 411	Continued From page 31 2:35pm was unsuccessful.	D 411		
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 observations, record review and staff interviews, the facility failed to notify the local county Department of Social Services (DSS) of an incident for 1 of 7 sampled residents who required emergency medical evaluation after he hit another resident and attempted to hit staff (#3). The findings are: Resident #3's current FL2 dated 08/28/25 revealed diagnoses including asthma and schizophrenia. Review of Resident #3's Resident Register revealed Resident #3 was admitted to the facility on 01/28/25. Review of Resident #3's Accident and Incident report dated 10/26/25 9:30am revealed:	D 451		

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D 451	Continued From page 32 -A medication aide (MA) overheard some commotion between Resident #3 and another resident. -Resident #3 picked up a metal trash can lid and threatened to hit the other resident. -Staff intervened, de-escalated the incident and placed Resident #3 on 30-minute safety checks due to his behaviors. Review of Resident #3's Accident and Incident report dated 10/26/25 revealed: -There was no documentation of the time the incident took place. -A MA reported Resident #3 hit another resident and attempted to hit staff several times. -Resident #3 was transferred to the hospital via law enforcement for an involuntary evaluation due to endangering other residents and staff. Review of Resident #3's record dated 10/26/25 through 11/12/25 revealed there was no documentation the local county DSS had been notified of Resident #3's hospitalization. Interview with the local county Adult Home Specialist (AHS) on 11/12/25 at 10:05am revealed she did not receive an Accident and Incident report from the facility related to a hospitalization on 10/26/25 for Resident #3. Interview with the facility's Manager on 11/14/25 at 4:40pm revealed: -She was responsible for sending Accidents and Incident reports, discharge notices and resident behaviors to the local county DSS and placing a copy in the residents' records. -She reviewed two Accident and Incident reports dated 10/26/25 for Resident #3's and did not realize she sent only one report to DSS. -She mistakenly overlooked the second Accident	D 451		

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D 451	Continued From page 33 and Incident report related to Resident #3's transfer to the hospital later in the day on 10/26/25. -She could not locate an email confirmation that an Incident and Accident report for Resident #3's 10/26/25 hospitalization was sent to the local county DSS. Interview with the Administrator on 11/17/25 at 10:00am revealed: -The facility Manager was responsible for sending Accidents and Incident reports, discharge notices and resident behaviors to the local county DSS and placed a copy in the facility chart. -She did not know Resident #3's Accident & Incident report related to his transfer to a hospitalization was not sent to DSS. -She expected all reportable Accident and Incident reports to be sent to DSS in a timely manner.	D 451		