STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL067025	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED R-C 03/26/2026

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 a follow up and complaint investigation from 03/24/26 to 03/26/26. The complaint investigations were initiated by the county on 02/23/26, 02/25/26, 03/20/26. The Adult Care Licensure Section initiated a complaint on 03/26/26.	D 000		
D 150	10A NCAC 13F .0501 (a & b) Personal Care Training And Competency 10A NCAC 13F .0501 Personal Care Training And Competency (a) The facility shall assure that staff who provide or directly supervise staff who provide personal care to residents complete an 80-hour personal care training and competency evaluation program established by the Department. For the purpose of this Rule, "directly supervise" means being on duty in the facility to oversee or direct the performance of staff duties. A copy of the 80-hour training and competency evaluation program is available online at https://info.ncdhhs.gov/dhsr/acls/training/index.html#80hr, at no cost. The 80-hour personal care training and competency evaluation program curriculum shall include: (1) observation and documentation skills; (2) basic nursing skills, including special health-related tasks; (3) activities of daily living and personal care skills; (4) cognitive, behavioral, and social care; (5) basic restorative services; and (6) residents' rights as established by G.S. 131D-21. (b) The facility shall assure that training specified in Paragraph (a) of this Rule is completed within	D 150		

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six months after hiring for staff hired after September 30, 2022. Documentation of the successful completion of the 80-hour training and competency evaluation program shall be maintained in the facility and available for review by the Division of Health Service Regulation and the county department of social services.

This Rule is not met as evidenced by:
Based on interviews, and record reviews, the facility failed to ensure 3 of 6 staff sampled (Staff A, Staff G, and Staff F)who provided personal care services to the residents had completed the state-approved 80-hour personal care training and competency evaluation program.

The findings are:

1. Review of Staff G's personnel record revealed:
-Staff G was hired as a personal care aide (PCA) on 09/18/24.
-Staff G was not found on the North Carolina Nurse Aide 1 registry per an inquiry on 09/16/24.
-The was a copy of a 80 hour personal care training certificate for Staff G dated 11/17/25.

Telephone interview with Staff G on 03/26/26 at 12:00pm revealed:
-She worked at the facility for over a year and worked third shift.
-She last worked on 03/25/26.
-Her duties included assisting residents with toileting, bathing and positioning.

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-She had never been certified as a certified nursing assistant and had never taken the class for the state-approved 80-hour personal care training and competency evaluation program.
-She did not complete the 80-hour training and competency evaluation program on November 17, 2025.
-She was taken off the work schedule in November 2025 (date unknown) until she completed the 80-hour personal care training and competency evaluation program which was scheduled for January 2026.
-She returned to work in December 2025 after the Executive Director (ED) called her and told her not to worry about the 80-hour training, that it was "taken care of".
-She was not sure the date she returned to work but she knew it was before Christmas.
-She completed shadowing of other staff when she was hired and she she felt confident providing care to residents despite not having the 80-hour training.

Interview with the Business Office Manager (BOM) on 03/25/26 at 8:40am revealed:
-She was responsible for compiling a list of staff who needed trainings and providing it to the ED.
-Staff G was taken off the schedule in November 2025 because she had not completed the state-approved 80-hour personal care training and competency evaluation.
-The nurse contracted to complete the training came into her office and told her she was placing a certificate for the 80-hour training on the the ED's desk for Staff G.
-Staff G had not actually completed the training but returned to work in December 2025.
-She did not report the concern about Staff G to anyone until the last week or so because she was afraid of retaliation.

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-She reported to the Regional Clinical Director (RCD) that Staff G had not completed the 80-hour personal care training and competency evaluation and that the certificate was false.

Interview with the Administrator on 03/26/26 at 11:08am revealed:
-Staff G worked on 03/25/26.
-She was not sure how she came to receive a 80-hour personal care training and competency evaluation certificate for Staff G but it was not emailed.
-She was not sure if the nurse with the contracted agency came in a conducted the training one-on-one with Staff G.
-If Staff G said she had not completed the training then she had not completed the training and should not be working.

Attempted telephone interview with the Registered Nurse (RN) for the facility's contracted training agency on 03/26/26 at 9:05am and 1:12pm was unsuccessful.

Refer to interview with the Regional Clinical Director (RCD) on 03/26/26 at 10:09am.

Refer to interview with the Administrator on 02/26/26 at 11:08am.

2. Review of Staff A's personnel record revealed:
-Staff A was hired as a Medication Aide (MA) on 02/21/25.
-Staff A was not found on the North Carolina Nurse Aide 1 registry per an inquiry on 02/17/25.
-The was no documentation of Staff A completing the state-approved 80-hour personal care training and competency evaluation program.

Interview with the Administrator on 03/26/26 at

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11:08am revealed she thought Staff A was a rehire of less than 6 months.

Updated personnel records were requested for Staff A on 03/26/26 at 11:08am but were not provided.

Attempted telephone interview with the Registered Nurse (RN) for the facility's contracted training agency on 03/26/26 at 9:05am and 1:12pm was unsuccessful.

Refer to interview with the Regional Clinical Director (RCD) on 03/26/26 at 10:09am.

Refer to interview with the Administrator on 02/26/26 at 11:08am.

3. Review of Staff D's personnel record revealed:
-Staff D was hired as a personal care aide (PCA) on 5/4/2024.
-Staff D was not found on the North Carolina Nurse Aide 1 registry per an inquiry on 5/22/2024.
-There was no documentation of Staff D completing the state-approved 80 hour personal care training and competency evaluation program.

Attempted telephone interview with Staff D on 3/29/2026 at 2:26pm and 3:02pm was unsuccessful.

Attempted telephone interview with the Registered Nurse (RN) for the facility's contracted training agency on 3/25/26 at 3:36 pm, 3/29/2026 at 9:05 am and 1:12 pm was unsuccessful.

Refer to interview with the Regional Clinical Director (RCD) on 03/26/26 at 10:09am.

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Refer to interview with the Administrator on 02/26/26 at 11:08am.

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Interview with the Regional Clinical Director (RCD) on 03/26/26 at 10:09am revealed:
-The Business Office Manager (BOM) was responsible for ensuring trainings were completed.
-Trainings, including 80-hour personal care training and competency evaluation, were completed by a Registered Nurse with a contracted agency.
-The contracted agency conducted a state-approved 80-hour personal care training and competency evaluation class in October 2025 and was scheduled to do another in April 2026.
-The BOM reported in the last 1-2 weeks that there were staff that had not completed PCA training and was allowed to work.
-She reported the concerns to her supervisor and talked with the ED of the facility.
-She instructed the ED to take any staff that had not completed PCA training and was not certified was not to work until training was completed.

Interview with the Administrator on 03/26/26 at 11:08pm revealed:
-A state-approved 80-hour personal care training and competency evaluation was to be completed within 6 months unless staff had been a certified nursing assistant.
-She and the BOM were responsible for ensuring staff were scheduled for PCA training when they were due.
-PCA trainings were conducted by a nurse from a contracted agency.
-Trainings were conducted in person and certificates were emailed to her for the staff that attended.

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D 150	Continued From page 6 -She was not aware of any staff working that had not completed the state-approved 80-hour personal care training and competency evaluation. -No one had reported that there were reports of staff that had not completed the state-approved 80-hour personal care training and competency evaluation that were working and needed to be pulled from the schedule. -She relied on the BOM to ensure trainings were completed and she had not reviewed staff records herself as she should have.	D 150		
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 needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on interviews and record review, the facility failed to provide personal care assistance for 1 of 5 sampled residents (#2) who required staff assistance with incontinent care. The findings are: Review of Resident #2's current FL-2 dated 02/12/26 revealed diagnoses included hypoglycemia, type 2 diabetes, hypertension, hypokalemia, hyponatremia, and pedal edema. Review of Resident #2's care plan dated 03/18/26 revealed:	D 269		

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-He was disoriented sometimes.
-He required extensive assistance with toileting.
-He needed assistance with all toileting needs.
-He required extensive assistance with personal hygiene.
-He needed assistance with all personal hygiene.

Observation of Resident #2 on 03/25/26 at 6:41am revealed:
-There was a blanket covering the resident.
-He was sitting in his recliner with his incontinence briefs and his thrombo embolic deterrent (TED) hose on.

Interview with Resident #2 on 03/25/26 at 7:38am revealed:
-He was soaked in urine one day that emergency medical services (EMS) came for him, but he could not remember all the details.
-Staff checked on him but they did not change him.
-"How often do they change me, they do not. I just have to wait until someone comes that will change me."

Interview with a personal care aide (PCA) on 03/25/26 at 6:41am revealed:
-Resident #2 was not a get up for third shift.
-A get up meant you were supposed to get a resident fully dressed.
-Dayshift would get Resident #2 fully dressed and put on his pants.
-Before shift change, she changed Resident #2's incontinence brief and put on his TED hose.

Interview with a second PCA on 03/25/26 at 9:08am revealed:
-Resident #2 was not difficult to work with and he did not refuse care.
-Some staff felt they could check Resident #2 for

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personal care every 2 hours, but you had to go more often.
-Resident #2 needed to be checked for personal care more frequently.
-Some days Resident #2 urinated more often than usual.
-Some days Resident #2 would get confused but staff needed to take time with him because he needed extra time.

Interview with the local fire department on 03/24/26 at 1:41pm revealed:
-EMS and the local fire department attempted to transfer Resident #2 from his chair.
-When Resident #2 was lifted urine ran out of the chair to the floor and his brief was so saturated that it fell off.

Interview with the Resident Care Coordinator (RCC) on 03/25/26 at 2:48pm revealed:
-She heard about the incident of Resident #2 being soaked in urine when EMS arrived, not sure of date.
-She asked staff when was the last time they had changed Resident #2.
-She was told Resident #2 had been changed not long before he went out.
-Staff were supposed to change Resident #2 every 2 hours.
-This put Resident #2 at risk for possible skin breakdown.

Interview with the Administrator on 03/25/26 at 3:09pm revealed:
-Staff were to check personal care for residents every 2 hours.
-A resident with a high level of incontinence support should be checked more often.
-Resident #2 had a high level of incontinence and he should be checked more often.

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D 269	Continued From page 9 -Staff were aware they should check on Resident #2 more often because they were aware of his needs. Interview with Resident #2's primary care provider (PCP) on 03/25/26 at 8:43am revealed Resident #2 had potential for skin breakdown if he was left with a wet incontinence brief on.	D 269		
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. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to respond in accordance with the facility's policy for 2 of 2 residents (#6, #7) with Do Not Resuscitate (DNR) orders who were found unresponsive and were administered cardiopulmonary resuscitation (CPR). The findings are:	D 271		

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Review of the facility's September 2021 Accident and Falls policy revealed:
-An accident was defined as an unexpected and unplanned event which may or may not cause injury.
-An emergency was any situation which arises suddenly and calls for prompt action.
-When an accident or emergency occurs, staff should remain calm, do not panic.
-Remove the resident from immediate danger, if possible.
-Send for or call for help and evaluate the situation.
-Call 911, or have someone call 911, if necessary and assess the resident.
-If injury is apparent or possible, do not move the resident.
-Determine if the resident is breathing, conscious, and check for pulse.
-Administer cardiopulmonary resuscitation (CPR) as appropriate, first check for a do not resuscitate (DNR) status.
-Administer first aid as appropriate and continue emergency intervention until Emergency Medical Services (EMS) arrives.
-Send appropriate information with the resident.
-Call and notify the resident's physician and responsible party.
-If injury, complete the Report of Accident and Incident (A/I) Form.

Review of the facility's September 2021 Emergency Training and Cardiopulmonary Resuscitation (CPR) policy revealed:
-If the Administrator was not present, an "in charge" staff person would be designated to respond to emergencies and ensure necessary care and supervision to residents.
-Each facility must have at least one staff

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member trained in CPR and choking management on duty and on the premises at all times.
-The staff person should always have access in the facility to a one-way valve pocket mask for use in performing CPR.
-The advance directive/DNR should be presented to responding EMS personnel.
-If a resident had an advance directive and/or request regarding resuscitative measures form on file experiences a medical emergency, facility staff should do one of the following: immediately call 911, present the advance directive/DNR and/or request regarding resuscitative measures form to the responding EMS personnel and identify the resident as the person to whom the order refers.
-If the resident was not enrolled in hospice and is was experiencing respiratory or cardiac arrest, EMS 911 should be called immediately.
-If the resident did not have a valid DNR order an appropriately trained facility staff member should initiate CPR.
-If a resident had a valid DNR order readily available, the facility staff members should honor the DNR order if done in good faith.

Observation of the medication cart on the Assisted Living (AL) unit on 03/24/26 at 4:00pm revealed the DNR binder was located on the medication cart.

Observation of the medication room on the Special Care Unit (SCU) on 03/24/26 at 4:04pm revealed:
-There was not a DNR binder on the medication cart.
-The DNR binder was on the top of a rolling cart in the medication room and was under 3 binders that were stacked on the rolling cart.

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D 271	Continued From page 12 1. Review of Resident #6's current FL-2 dated 07/15/25 revealed the resident had diagnoses of dementia, chronic kidney disease stage 3, history of falling, diabetes and atherosclerotic heart disease (coronary heart disease). Review of Resident #6's Report of Death to Department of Health and Human Services (DHHS) dated 10/09/25 revealed: -The resident was found deceased in her recliner by a personal care aide (PCA). -A medication aide (MA) was also working at the time. -The resident was observed by care staff at 6:30am on 10/09/25 during medication administration. -The resident was observed showing no signs of life at 7:05am during care staff rounds. -Emergency Medical Services (EMS) was called at 7:13am by the MA on duty. -EMS arrived to the community at 7:20am and began CPR. -EMS pronounced the resident deceased at 7:26am. Review of a staff statement from the MA who last administered medication to Resident #6 at 6:30am on 10/09/25 revealed: -She carefully administered and recorded all medications in strict accordance with the protocols outlined in the medication administration record (MAR) system. -The packets were scanned, as well as reading the medication and dosage to ensure it was correct. -All as needed (PRN) medications were checked on the MAR for when, how much and how often the resident was able to take them.	D 271		

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Review of an EMS report dated 10/09/25 revealed:
-Onset time of symptoms was 7:10am on 10/09/25.
-The chief complaint was an obvious death.
-The resident was assessed by EMS at 7:24am and time of death was pronounced at 7:26am on 10/09/25.

Review of an EMS Care Report from the local fire department dated 10/09/25 revealed:
-The resident was last known well on 10/09/25 at 6:31am.
-Cardiac arrest date and time were listed as 10/09/25 at 7:20am.
-Initial CPR began on 10/09/25 at 7:26am.
-Resuscitation was discontinued on 10/09/25 at 7:26am.
-There was a narrative portion of the report that included the following, upon arrival staff were directed to the patient who was found sitting in a chair next to the bed in the far-right corner of the room.
-The resident was unconscious, unresponsive and had aspiration.
-Crew members verified the resident did not have a pulse and was not breathing.
-Emergency personnel asked for a DNR order that was reported by staff upon the crews arrival.
-Facility staff were unable to provide the original DNR order and were trying to obtain the DNR order.
-A working code was declared and emergency personnel started chest compressions.
-CPR was stopped once a signal 4 was called (a signal 4 meant to stop CPR because the resident was deceased).

Review of the police department's incident and investigative report dated 10/09/25 revealed:

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D 271	Continued From page 14 -The resident's cause of death was a natural death on 10/09/25 at 7:31am. -The officer responded to the facility on 10/09/25 at 7:25am for a cardiac arrest. -Prior to arrival he was advised that it was an obvious death, but the facility could not provide emergency personnel with a DNR order so emergency personnel performed life saving measures. -The local fire department and EMS were on the scene and advised they eventually received a copy of the DNR for the resident. -The resident was last known to be alive on 10/09/25 at 6:31am. Telephone interview with Resident #6's family member on 03/24/26 at 2:14pm revealed: -When his family member was admitted to the facility, he provided the facility staff with the original DNR form. -His family member did not want to receive CPR if she stopped breathing and was nonresponsive, she wanted to pass away peacefully and did not want any life saving measures performed if they were needed. -A staff member from the facility notified him of his family member's death on 10/09/25. -He wanted his family members wishes to be honored and expected the facility to follow the resident's DNR order. -He was upset that the facility performed CPR on his family member when they were unable to locate the resident's DNR order. -He had a difficult time getting images out of his mind regarding his family member receiving CPR when she wanted to die without life saving measures. -He felt that his family member suffered when CPR was performed by staff when it was against her wishes.	D 271		

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Telephone interview with a medication aide (MA) on 03/25/26 at 3:33pm revealed:
-She worked third shift on 10/09/25 and was assigned to Resident #6.
-There was a resident that lived a few rooms across from Resident #6 who yelled out a few nights which caused Resident #6 to have difficulty sleeping.
-On 10/09/25 at approximately 3:30am, she was with the resident a few rooms across from Resident #6 attempting to calm that resident down when she heard the microwave beeping in Resident #6's room.
-That was how she knew that Resident #6 was back up and was not sleeping.
-She checked on Resident #6 and saw she had heated up something to eat and then planned to go back to sleep.
-She checked on Resident #6 at 5:30am on 10/09/25.
-She checked Resident #6's finger stick blood sugar (FSBS) at 6:30am and entered her FSBS into the electronic medication administration record (eMAR) and thought she did not give the resident any insulin.
-Her shift ended at 7:00am.
-By the time she arrived home, which was approximately 30 minutes away from the facility, the Administrator called her to inform her that Resident #6 had passed away.
-The Administrator wanted to know when was the last time she checked on Resident #6 and observed her, she reported that she last saw the resident at 6:30am on 10/09/25.

Interview with a representative from the local fire department on 03/24/26 at 1:41pm revealed:
-The fire department arrived at the facility for Resident #6 on 10/09/25.

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D 271	Continued From page 16 -The 911 call came out as an interfacility transfer. -Interfacility transfer meant there was an emergency medical dispatch. -They initiated CPR on Resident #6 because the facility could not find the DNR paperwork. -After CPR started, they were able to get Resident #6 in the light and determined she had lividity (Lividity meant blood had started settling because Resident #6 had been in the position she was found in for a while and gravity was pulling the blood down). -Resident #6 was considered to be in rigor mortis in her jaw joints, which meant she was in this state for 20 minutes to 1 hour. (Rigor mortis was the stiffness of joints after death). -A person's jaw was the first thing they checked for rigor mortis because if it was locked, they would not start CPR. -The crew started CPR on Resident #6 because they could not see the lividity. -Once EMS arrived, CPR was stopped. -Their standard protocol was to start resuscitation efforts unless the criteria were met to not continue CPR. -Criteria to not start CPR were injuries that exposed brain matter, lividity, rigor mortis, decomposition, DNR, and an original living will within the date. Telephone interview with the previous Resident Care Coordinator (RCC) on 03/25/26 at 3:26pm revealed: -She was not at the facility when Resident #6 passed away. -There was a binder at the front receptionist area that contained all DNR's for all residents whether they were on the Assisted Living (AL) unit or the Special Care Unit (SCU). -DNRs could also be found in the electronic medical record on the resident's face sheet.	D 271		

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-There were no color coded stickers on residents doors with their names to indicate if they were a DNR or not.
-The resident's face sheet was printed to provide to local EMS when they arrived at the facility.
-The face sheet had information on whether a resident was a full code or a DNR.
-When staff found a resident that was unresponsive, staff were expected to call 911.
-Another staff member was expected to print the resident's face sheet and go to the receptionist area to locate a DNR.
-CPR should be started if the resident was not a DNR.

Interview with the Administrator on 03/26/26 at 11:30am revealed:
-When Resident #6 was found nonresponsive, staff should have gone to the front receptionist desk to locate the DNR binder in order to retrieve the resident's DNR.
-She was informed by a staff person (she could not recall their name) that someone told EMS they were not able to find the DNR for Resident #6 because it was locked in an office.
-To her knowledge the DNR book had always been located at the receptionist's desk, she never knew the DNR binder to be locked in anyone's office.
-She was not aware that staff were unable to locate the DNR for Resident #6 and would have wanted staff to notify her or the RCC if they were unable to locate the DNR for Resident #6.
-After staff had difficulties locating the DNR for Resident #6, she placed a DNR binder in each medication room on the AL unit and the SCU.

Attempted telephone interview with the personal care aide (PCA) for Resident #6 that worked on 10/09/25 from 7:00am to 3:00pm on 03/26/26 at

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8:57am was unsuccessful.

Attempted telephone interview with the MA for Resident #6 that worked on 10/09/25 from 7:00am to 3:00pm on 03/26/26 at 8:55am was unsuccessful.

Refer to interview with a medication aide (MA) on 03/24/26 at 3:57pm.

Refer to telephone interview with a second medication aide (MA) on 03/26/26 at 10:07am.

Refer to interview with the Administrator on 03/25/26 at 10:13am.

Refer to interview with the Administrator on 03/25/26 at 3:33pm.

Refer to interview with the Administrator on 03/26/26 at 11:30am.

2. Review of Resident #7's current FL-2 dated 07/15/25 revealed the resident had diagnoses of diabetes, hypertension, congestive heart failure, and pulmonary embolism.

Review of Resident #7's Report of Death to Department of Health and Human Services (DHHS) dated 03/15/26 revealed:
-The resident was found deceased in his bedroom on 03/15/26 at 7:47am by a medication aide (MA).
-At 7:30am the MA went down the 300 hall and heard a small moan.
-The MA looked in the resident's room and the resident was laying face down on the floor with a pool of blood under his face.
-The other MA working called all staff who were working while the MA who found the resident

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obtained his paperwork for Emergency Medical Services (EMS).
-The other MA attempted to get a blood pressure but was unsuccessful.
-EMS arrived and the resident was pronounced deceased at 7:47am.

Review of a 911 dispatch call made on 03/15/26 at 7:35am revealed:
-The dispatcher stated, "Okay, tell me exactly what happened."
-The MA responded, "I don't know the, the med tech walked in the room of the resident, and he's face down on the floor."
-The dispatcher stated, "Is he awake?"
-The MA yelled out the resident's name.
-The MA responded, "No not at all."
-The dispatcher stated, "Okay is he breathing?"
-The MA responded, "He's breathing, he's not responding but he's breathing, I see a shallow breath."
-The dispatcher asked, "Is he breathing (inaudible) normal?"
-The MA responded, "No."
-The dispatcher stated, "Okay and is he still unconscious is that correct?"
-The MA responded, "Yes."
-The dispatcher stated, "Okay we're gonna check his breathing together to make sure he is alright, when I say go, watch him closely and tell me each time his chest rises are you ready?"
-The MA responded, "He's on top of his chest," then called out the resident's name.
-The dispatcher asked, "Are you able to get him rolled over so we can check his breathing?"
-The MA responded, "No, I'm, I'm not gonna roll him over because he's a big man and all and I thought we ain't supposed to move him."
-The dispatcher stated, "Okay ma'am, if there is a defibrillator available, send someone to go get it

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now and tell me when you have it okay."
-The MA responded, "There is nobody around but me right now." The MA then called out loudly for two different staff, "do we got a defibrillator," one staff answered her and the MA yelled back nope.
-The MA responded, they did not have a defibrillator.
-The dispatcher asked, "Is he still breathing?"
-The MA could be heard yelling the resident's name four times in a row.
-The dispatcher asked, "Ma'am is he still breathing?"
-The MA could be heard yelling the resident's name and then stated, "I don't think so, trying to roll him over."
-The dispatcher stated, "If you don't think he's breathing, we need to do CPR ...are you able to roll him over onto his back?"
-The MA responded, "Trying," and called for the other MA at the facility, and stated "who is that (she called a staff person's name and asked them to come help her roll the resident over).
-The MA then yelled for a personal care aide (PCA) to come help her try to roll the resident over.
-The MA instructed the PCA to help her roll the resident over.
-The dispatcher asked, "Were you guys able to get him rolled over?"
-The dispatcher asked, "Are you guys still unable to roll him over?"
-The MA responded they were trying to roll the resident over.
-The dispatcher stated, "We have fire and an officer on the scene, just so you know, just let me know when someone is in there with you guys okay, were you able to get him onto his back?"
-The MA responded, "Yes, finally got him onto his back."
-The dispatcher stated, "Okay listen carefully, lay

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him flat on his back and remove anything from under his head okay."
-The MA asked, "Don't put a pillow under his head?"
-The dispatcher stated, "No ma'am, nothing under his head, now you've got him rolled over can you see if he's breathing?"
-The MA responded, "I don't think he's breathing," then she yelled out the resident's name.
-The dispatcher stated, "Okay listen carefully, I'm gonna tell you how to do chest compressions, place the heel of your hand on the breastbone in the center of his chest right between the nipples and put the other hand on top of that."
-The MA responded, "Ma'am, I don't even know if he is a DNR, I might not supposed to be doing it."
-The dispatcher asked, "Is my officer in there with you?"
-The MA responded, "Yes."
-The dispatcher stated, "Okay I'll let you go so you can talk to her okay."
-The MA responded, "Okay."

Telephone interview with Resident #7's family member on 03/26/26 at 10:25am revealed:
-Resident #7 was a DNR.
-There was a time in the past that the facility had the resident's DNR posted on his refrigerator, but he thinks the resident ripped it down and threw it away.
-He received a telephone call from a MA on 03/15/26 at 8:30am from a MA that the resident had a bad fall and family needed to come to the facility.
-He called another member who lived closer to the facility and explained to him he needed to go to the facility per the MA that called him.
-He received a call from his family member that the resident had passed away at the facility after his fall.

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D 271	Continued From page 22 Interview with a MA on 03/25/26 at 9:05am revealed: -She was working the morning that Resident #7 was found face down on the floor in his room. -She and another MA had just provided Resident #7 with a cup of water. -When they were leaving the room, the resident let them know that he dropped his water. -She cleaned up the water and provided the resident with another cup of water. -She was walking toward the dining area and heard the other MA that was working with her call out her name to help. -She observed Resident #7 on the floor face down and placed a blood pressure cuff on the resident to attempt to obtain his blood pressure, shook his shoulder and yelled his name several times and the resident did not respond. -She kept getting an error message on the blood pressure cuff. -She called 911 and the other MA went to gather the resident's DNR and paperwork for the local EMS. -The 911 dispatcher asked her the address, telephone number, what happened, was she there with the resident, was the resident breathing, and asked her to roll the resident over. -The resident had fallen face down and she explained to the 911 dispatcher that she was unable to roll the resident over by herself due to his size so she yelled for additional staff to come assist her. -She attempted to move the resident a few times by herself but was unsuccessful, she told the 911 dispatcher that they were not supposed to move a resident when they had a fall with a head injury due to the risk of causing further injury. -A personal care aide (PCA) entered the room and assisted her with turning over the resident on	D 271		

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their second attempt.
-The 911 dispatcher asked her to check if the resident was breathing, she responded she did not think he was breathing.
-She remembered the 911 dispatcher asking something about cardiopulmonary resuscitation (CPR) and DNR and told the 911 dispatcher she could not remember if he was a DNR or not.
-She told the 911 dispatcher that he did not have a red star or red circle beside his name on the door so he must not be a DNR and evidently was a full code.
-The 911 dispatcher asked her to begin CPR; she explained to the 911 dispatcher that she needed to go get the CPR face shield because there was blood on the resident's face.
-She went to the medication room to get a CPR face shield and returned to the phone with the 911 dispatcher.
-The MA that looked for the DNR order reported that she printed the residents' face sheet and a code status was not on file, there was no documentation on the face sheet that the resident was a DNR.
-The other MA spoke with hospice on the telephone, and the hospice nurse told her the resident was a DNR.
-The 911 dispatcher told her that EMS staff were in the building, she then observed the EMS staff walk into the room to begin to assess the resident.

Telephone interview with a second MA on 03/25/26 at 11:25am revealed:
-The morning of 03/15/26, she and another MA provided Resident #7 with water in his room at approximately 7:20am.
-When they left his room the resident shouted out he dropped his water.
-The other MA cleaned up the water from the

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floor and provided the resident with another cup of water.
-She went to check another resident's blood sugar two rooms down from Resident #7's room.
-A few minutes later she heard a loud sigh that she described as "a relief breath or sigh" come from Resident #7's room.
-She entered the resident's room and observed him face down on the floor.
-She called out for the other MA to come to the room; there was an emergency.
-The other MA came into the room and dialed 911 while she went to print the resident's paperwork for EMS to take when they transported the resident.
-There was no DNR on the resident's paperwork, no red star or red circle sticker on the name label by his door.
-She was not sure if the resident was a DNR or not so she called the hospice agency that provided him care.
-Hospice informed her that the resident was a DNR.
-She was finally located the resident's DNR in the DNR binder in the medication room and took it to the EMS responders and the MA that was with the resident.

Second interview with the second MA on 03/26/26 at 9:03am revealed:
-She had a statement available that she and the other MA wrote for the Administrator about the incident with Resident #7 on 03/15/26.
-There was no red star sticker or red circle sticker on Resident #7's door by his name to indicate that the resident was a DNR.
-She took a photograph of the resident's door and would provide the surveyor with the photograph and the date and time stamp.
-When she printed Resident #7's face sheet that

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was sent with resident's when EMS arrives, there was no documentation that the resident was a DNR.
-She also took a photograph of the resident's face sheet and would provide the surveyor with the photograph and the date and time stamp.

Observation of the MA's cellular telephone on 03/26/25 at 9:05am revealed:
-There was a photograph on her cellular telephone with a time and date stamp of 03/15/26 at 12:46pm that showed a photograph of the resident's door with his name beside the door and there were no red stickers beside his name.
-There was a photograph on her cellular telephone with a time and date stamp of 03/15/26 at 12:47pm that showed the resident's face sheet.
-On page one, there was an entry for code status with "not on file" listed, there was an entry for advance care order with "none on file" documented, and there was an entry for advance directive with "none on file" documented.

Telephone interview with the Care Manager from Resident #7's hospice agency on 03/25/26 at 9:50am revealed:
-The hospice agency's triage call center received a telephone call from a MA inquiring if the resident was a DNR while the other MA was on the telephone with 911.
-The MA was advised that the resident was a DNR.
-She received a telephone call from a MA on 03/15/26 at 7:48am and the MA explained the resident had fallen face down, was nonresponsive and EMS was on the scene.
-The agency's on call hospice nurse arrived at the facility and EMS had pronounced the resident deceased.
-The hospice nurse remained with the resident

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until the medical examiner left the facility.

Interview with a representative from the local fire department on 03/24/26 at 1:41pm revealed:
-The fire department was called out to the facility on 03/15/26 due to cardiac arrest for Resident #7.
-Emergency medical services (EMS) and the fire department were both dispatched to the facility.
-The fire department arrived at the facility before EMS.
-The 911 call came out as an interfacility transfer.
-Interfacility transfer meant there was an emergency medical dispatch.
-When someone called 911 a series of questions were asked to determine how the call would be dispatched.
-The notes from the call on 03/15/26 specified the resident had fallen and there was no other information provided.
-The notes indicated the resident fell and it happened about 2 to 3 minutes before the facility called 911.
-There was a significant amount of blood on floor next to the resident.
-The blood had congealed which meant it had been there at least 20 to 25 minutes.
-It took blood 15 to 30 minutes for blood to congeal.
-The staff stated they had given Resident #7 his medications, left the room, and when they walked back in they found Resident #7 on the floor.
-Resident #7 was purple from his mid chest up which typically meant he had a pulmonary embolism.
-When the fire department arrived at the facility, they marked the call as a working code.
-A working code meant cardiopulmonary resuscitation (CPR) was being administered.
-The facility attempted to get the do not resuscitate (DNR) paperwork.

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-The facility informed them Resident #7 was on hospice.
-When they were informed Resident #7 was on hospice, they asked the facility for the DNR paperwork.
-They were told by the facility they had to find the DNR paperwork.
-In this case, the DNR was not produced to the fire department upon arrival but was later produced by the facility.
-The fire department conducted a signal 4 about 3 to 4 minutes later.
-A signal 4 meant to stop CPR because either the resident was dead on arrival (DOA), all measures of saving the resident were exhausted, or there was a DNR in place.

Interview with the Resident Care Coordinator (RCC) on 03/25/26 at 8:20am revealed:
-Staff should know if a resident was a DNR or a full code.
-The facility had a red star or red dot by the name beside each resident's door if they were a DNR.
-There were DNR binders on the medication carts or in the medication rooms on the Special Care Unit (SCU) and on the Assisted Living (AL) unit.
-There was also a large font at the top of the resident's electronic medication record (eMAR) that indicated if a resident was a DNR.
-When a resident was found unresponsive, the MA should first call 911.
-Then the MA or another staff person should located the resident's DNR and provide the DNR to Emergency Medical Services (EMS) staff after they arrived.
-Staff that was on the phone with 911 should remain on the phone with 911 because they tell staff exactly what to do.
-She expected staff to follow directions from 911, however staff were trained to not move a resident

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if they possibly had a head injury to avoid causing further injury.
-She expected staff to follow the DNR if a resident had one because it was their wishes and possibly the families wishes.
-If she had a family member who had a DNR and the DNR was not followed, she would be upset if staff attempted to resuscitate her family member, because she would be upset that their loved ones wishes were not honored.
-It was unacceptable that staff were unable to located a DNR for Resident #6 and Resident #7.

Interview with Resident #7's primary care provider (PCP) on 03/25/26 at 10:07am revealed:
-When a resident was a DNR, CPR should not be performed on the resident.
-If a resident was on hospice, had a fall and there was a head injury, staff should not move the resident to prevent the possibility of further injury.
-Staff should honor a resident's DNR, but she understood in a panic situation that staff may begin CPR until they could locate the DNR.
-Whether staff performed CPR on Resident #7 or they did not the outcome would have been the same.
-She expected staff to honor residents and/or families desire to have a DNR and to not perform CPR.

Interview with the Administrator on 03/26/26 at 11:30am revealed:
-When Resident #6 was found nonresponsive, staff should have gone to the front receptionist desk to locate the DNR binder in order to retrieve the resident's DNR.
-She was informed by staff that she could not recall their name that someone told EMS they were not able to find the DNR because it was locked in an office.

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-To her knowledge the DNR book had always been located at the receptionist's desk, she never knew the DNR binder to be locked in anyone's office.
-She was not aware that staff were unable to locate the residents' DNR and would have wanted staff to notify her or the RCC if they were unable to locate the DNR for Resident #6.

Refer to interview with a medication aide (MA) on 03/24/26 at 3:57pm.

Refer to telephone interview with a second medication aide (MA) on 03/26/26 at 10:07am.

Refer to interview with the Administrator on 03/25/26 at 10:13am.

Refer to interview with the Administrator on 03/25/26 at 3:33pm.

Refer to interview with the Administrator on 03/26/26 at 11:30am.
____
Interview with a medication aide (MA) on 03/24/26 at 3:57pm revealed:
-When a resident was found unconscious and unresponsive staff called 911 and sent the resident out to the emergency room.
-If a resident was a DNR there was supposed to be a red star or red dot affixed to their name label beside their room door.
-She was also able to look in a binder for a resident's DNR if needed.
-The Assisted Living (AL) unit and Special Care Unit (SCU) each had a binder with each resident's DNR order.
-The DNR binder was supposed to stay on the medication cart so staff could access the DNR quickly if needed.

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-If a resident had a DNR order, facility staff still called 911 but did not perform CPR on the resident.

Telephone interview with a second MA on 03/26/26 at 10:07am revealed:
-When a resident was not breathing the staff called 911 if they were not responding.
-If the resident was not a DNR, the staff should give CPR because they were a full code.
-If the resident was a DNR do not give CPR.
-The red heart or star on the residents' doors indicated they were DNRs.

Interview with the Administrator on 03/24/26 at 10:13am revealed:
-Each resident's room had their name on a label on the wall next to their door.
-If a resident had a red star or red dot it meant the resident was a DNR.

Interview with the Administrator on 03/25/26 at 3:33pm revealed:
-Staff panicked during the situation.
-The red dot or star on the name plate of a resident's room indicated DNR.
-The facility's electronic medical records system had the DNR status of residents.
-There was a book on the medication cart with the DNRs in it.
-Staff should have slowed down and not panicked.
-Staff did not think to look outside the residents' door for their DNR status.
-CPR should not have been initiated on residents with a DNR status.

Interview with the Administrator on 03/26/26 at 11:30am revealed:
-When a personal care aide (PCA) or staff other

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than a MA found a resident nonresponsive, they should go get a MA or the supervisor.
-If a MA found a resident nonresponsive, they should check to see if the resident was a DNR.
-Staff could look at the resident's door to see if there was a red star or red dot by their name label which indicated the resident is a DNR.
-Staff could also locate the resident's DNR in the DNR binder located in the medication room in the Assisted Living (AL) unit or in the Special Care Unit (SCU).
-If a resident was a DNR, staff should not initiate CPR because staff would not be honoring the resident or the responsible party's wishes.
-If a resident was not a DNR, staff should immediately call 911, start CPR, then notify her and the resident's primary care provider (PCP).
-When staff called 911, they normally gave directions to staff and stayed on the phone with staff, sometimes they gave instructions and would tell staff to call if they had any questions.
-Staff could also locate a resident's DNR when they printed a face sheet from the electronic medical record, there was a listing on the face sheet that had documentation if the resident was a full code or a DNR.

____

The facility failed to respond in accordance to the facility's policy during an emergency. Resident #6 and Resident #7 had Do Not Resuscitate (DNR) orders in place and the facility was unable to locate the DNR orders to provide to emergency medical services (EMS). The facility's failure was detrimental to the health, safety and welfare of residents and constitutes a Type B Violation.

____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/25/26 for this violation.

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D 271	Continued From page 32 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 10, 2026.	D 271		
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 observations, interviews and record reviews, the facility failed to have Do Not Resuscitate (DNR) orders available for 2 of 2 residents (#6, #7) who received cardiopulmonary resuscitation (CPR) against their advance directive wishes and failed to ensure a resident was treated with dignity and respect by failure to provide appropriate incontinence care (#2). The findings are: Review of the facility's resident contract revealed: -The resident/representative authorizes the facility to obtain emergency health care services for the resident, at the resident's expense, whenever in the facility's judgement, such emergency services are deemed necessary. -The facility will notify the representative or other person designated by the resident as soon as possible, after such emergency health services are provided. -The resident/representative will defend, indemnify, and hold harmless the facility and its	D 338		

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owners, directors, agents, managers, consultants, and employees against any losses, costs, expenses, claims, liabilities, damages, or judgements including without limitation legal fees, court costs, expert fees, and similar expenses incurred, associated with the provision of emergency health care services to the resident by an emergency responder.
-The community would honor the residents' right to make medical decisions.
-The facility would follow any resident advance directive provided that the resident/representative has provided it to the facility in writing.
-An original copy of the advance directive would be placed in the resident's file, and facility personnel caring for the resident would be notified of its contents.
-The resident/representative gives the facility permission to share the advance directive with other health care professionals involved in the resident's care.
-The resident/representative would provide the facility with notice of any revocation or changes to the resident's advance directive.
-The facility would not be liable if the most recent revocation or other changes to the advance directive were not provided to the facility.
-The resident was not required to have an advance directive in order to gain admission to the facility.

1. Review of Resident #6's current FL-2 dated 07/15/25 revealed the resident had diagnoses of dementia, chronic kidney disease stage 3, history of falling, diabetes and atherosclerotic heart disease (coronary heart disease).

Review of Resident #6's Report of Death to Department of Health and Human Services (DHHS) dated 10/09/25 revealed:

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-The resident was found deceased in her recliner by a personal care aide (PCA).
-A medication aide (MA) was also working at the time.
-The resident was observed by care staff at 6:30am on 10/09/25 during medication administration.
-The resident was observed showing no signs of life at 7:05am during care staff rounds.
-Emergency Medical Services (EMS) was called at 7:13am by the MA on duty.
-EMS arrived to the community at 7:20am and began cardiopulmonary resuscitation (CPR).
-EMS pronounced the resident deceased at 7:26am.

Review of an EMS Care Report from the local fire department dated 10/09/25 revealed:
-The resident was last known well on 10/09/25 at 6:31am.
-Cardiac arrest date and time were listed as 10/09/25 at 7:20am.
-Initial CPR began on 10/09/25 at 7:26am.
-Resuscitation was discontinued on 10/09/25 at 7:26am.
-There was a narrative portion of the report that included the following, upon arrival staff were directed to the patient who was found sitting in a chair next to the bed in the far-right corner of the room.
-The resident was unconscious, unresponsive and had aspiration.
-Crew members verified the resident did not have a pulse and was not breathing.
-Emergency personnel asked for a DNR order that was reported by staff upon the crews arrival.
-Facility staff were unable to provide the original DNR order and were trying to obtain the DNR order.
-A working code was declared and emergency

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personnel started chest compressions.
-CPR was stopped once a signal 4 was called (a signal 4 meant to stop CPR because the resident was deceased).

Review of the local police department's incident and investigative report dated 10/09/25 revealed:
-The resident's cause of death was a natural death on 10/09/25 at 7:31am.
-The officer responded to the facility on 10/09/25 at 7:25am for a cardiac arrest.
-Prior to arrival, the officer he was advised that it was an obvious death, but the facility could not provide emergency personnel with a DNR order so emergency personnel performed life saving measures.
-The local fire department and EMS were on the scene and advised they eventually received a copy of the DNR for the resident.
-The resident was last known to be alive on 10/09/25 at 6:31am.

Interview with the local fire department on 03/24/26 at 1:41pm revealed:
-The fire department arrived at the facility for Resident #6 on 10/09/25.
-They initiated CPR on Resident #6 because the facility could not find the DNR paperwork.
-After CPR was started, they were able to get Resident #6 in light and determined she had lividity (Lividity meant blood had started settling because Resident #6 had been in the position she was found in for a while and gravity was pulling the blood down).
-Resident #6 was considered to be in rigor mortis was in her jaw joints, which meant should was in this state for 20 minutes to 1 hour. (Rigor mortis was the stiffness of joints after death).
-A persons jaw was the first thing they checked for rigor mortis because if it was locked, they

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would not start CPR.
-The crew started CPR on Resident #6 because they could not see the lividity.
-Once EMS arrived, CPR was stopped.
-Their standard protocol was resuscitation efforts if the criteria were met do not continue CPR.
-Criteria to not start CPR were injuries that exposed brain matter, lividity, rigor mortis, decomposition, DNR, and an original living will within the date.

Telephone interview with Resident #6's family member on 03/24/26 at 2:14pm revealed:
-When his family member was admitted to the facility, he provided the facility staff with the original do not resuscitate (DNR) form.
-His family member did not want to receive CPR if she stopped breathing and was nonresponsive, she wanted to pass away peacefully and did not want any life saving measures performed if they were needed.
-A staff member from the facility notified him of his family members death on 10/09/25.
-Another staff member informed him by telephone that staff had performed CPR on his family member because staff had a difficult time locating the resident's DNR order.
-He wanted his family member's wishes to be honored and expected the facility to follow the resident's DNR order.
-He was upset that the facility performed CPR on his family member when they were unable to locate the resident's DNR order.
-He had a difficult time getting images out of his mind regarding his family member receiving CPR when she wanted to die without life saving measures.
-He felt that his family member suffered when CPR was performed by staff when it was against her wishes.

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Interview with the Administrator on 03/26/26 at 11:30am revealed:
-When Resident #6 was found nonresponsive, staff should have gone to the front receptionist desk to locate the DNR binder in order to retrieve the resident's DNR.
-She was informed by a staff person (she could not recall their name) that someone told EMS they were not able to find the DNR for Resident #6 because it was locked in an office.
-To her knowledge the DNR book had always been located at the receptionist's desk, she never knew the DNR binder to be locked in anyone's office.
-She was not aware that staff were unable to locate the DNR for Resident #6 and would have wanted staff to notify her or the RCC if they were unable to locate the DNR for Resident #6.

Attempted telephone interview with the personal care aide (PCA) for Resident #6 that worked on 10/09/25 from 7:00am to 3:00pm on 03/26/26 at 8:57am was unsuccessful.

Attempted telephone interview with the MA for Resident #6 that worked on 10/09/25 from 7:00am to 3:00pm on 03/26/26 at 8:55am was unsuccessful.

Refer to interview with a medication aide (MA) on 03/24/26 at 3:57pm.

Refer to interview with a second medication aide (MA) on 03/25/26 at 10:07am.

Refer to interview with the Administrator on 03/25/26 at 3:33pm.

Refer to interview with the Administrator on

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03/26/26 at 11:30am.

2. Review of Resident #7's current FL-2 dated 07/15/25 revealed the resident had diagnoses of diabetes, hypertension, congestive heart failure, and pulmonary embolism.

Review of Resident #7's Report of Death to Department of Health and Human Services (DHHS) dated 03/15/26 revealed:
-The resident was found deceased in his bedroom on 03/15/26 at 7:47am by a medication aide (MA).
-At 7:30am the MA went down the 300 hall and heard a small moan.
-The MA looked in the resident's room and the resident was laying face down on the floor with a pool of blood under his face.
-The other MA working called all staff who were working while the MA who found the resident obtained his paperwork for Emergency Medical Services (EMS).
-The other MA attempted to get a blood pressure but was unsuccessful.
-EMS arrived and the resident was pronounced deceased at 7:47am.

Interview with a MA on 03/25/26 at 9:05am revealed:
-She was working the morning that Resident #7 was found face down on the floor in his room.
-She was walking toward the dining area and heard the other MA that was working with her call for her.
-She placed a blood pressure cuff on the resident to attempt to obtain his blood pressure, shook his shoulder and yelled his name several times and the resident did not respond.
-She kept getting an error message on the blood pressure cuff.

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-She called 911 and the other MA went to gather the resident's DNR and paperwork for the local EMS.
-The 911 dispatcher asked her to check if the resident was breathing, she responded she did not think he was breathing.
-She remembered the 911 dispatcher asking something about cardiopulmonary resuscitation (CPR) and DNR and told the 911 dispatcher she could not remember if he was a DNR or not.
-She told the 911 dispatcher that he did not have a red star or red circle beside his name on the door so he must not be a DNR and evidently was a full code.
-The MA that looked for the DNR order reported that she printed the residents' face sheet and a code status was not on file, there was no documentation on the face sheet that the resident was a DNR.
-The other MA spoke with hospice on the telephone, and the hospice nurse told her the resident was a DNR.

Telephone interview with a second MA on 03/25/26 at 11:25am revealed:
-The morning of 03/15/26 she heard Resident #7 make a loud sigh.
-She entered the resident's room and observed him face down on the floor.
-She called out for the other MA to come to the room; there was an emergency.
-The other MA came into the room and dialed 911 while she went to print the resident's paperwork for EMS to take when they transported the resident.
-There was no DNR on the resident's paperwork, no red star or red circle sticker on the name label by his door.
-She was not sure if the resident was a DNR or not so she called the hospice agency that

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provided him care.
-Hospice informed her that the resident was a DNR.
-She was finally located the resident's DNR in the DNR binder in the medication room and took it to the EMS responders and the MA that was with the resident.

Telephone interview with the Care Manager from Resident #7's hospice agency on 03/25/26 at 9:50am revealed:
-The hospice agency's triage call center received a telephone call from a MA inquiring if the resident was a DNR on 03/15/26.
-The MA was advised that the resident was a DNR.
-She received a telephone call from a MA on 03/15/26 at 7:48am and the MA explained the resident had fallen face down, was nonresponsive and EMS was on the scene.
-The agency's on call hospice nurse arrived at the facility and EMS had pronounced the resident deceased.
-The hospice nurse remained with the resident until the medical examiner left the facility.

Interview with the local fire department on 03/24/26 at 1:41pm revealed:
-The fire department was called out to the facility on 03/15/26 due to cardiac arrest for Resident #7.
-EMS and the fire department were both dispatched to the facility.
-The fire department arrived at the facility before EMS.
-When the fire department arrived to the facility, they marked the call as a working code.
-A working code meant cardiopulmonary resuscitation (CPR) was being administered.
-The facility attempted to get the do not resuscitate (DNR) paperwork.

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-The facility informed them Resident #7 was on hospice.
-When they were informed Resident #7 was on hospice, they asked the facility for the DNR paperwork.
-They were told by the facility they had to find the DNR paperwork.
-In this case, the DNR was not produced to the fire department upon arrival but was later produced by the facility.
-The fire department conducted a signal 4 about 3 to 4 minutes later.
-A signal 4 meant to stop CPR because either the resident was dead on arrival (DOA), all measures of saving the resident were exhausted, or there was a DNR in place.

Telephone interview with Resident #7's family member on 03/26/26 at 10:25am revealed:
-Resident #7 was a DNR.
-There was a time in the past that the facility had the resident's DNR posted on his refrigerator, but he thinks the resident ripped it down and threw it away.
-He received a telephone call from a MA on 03/15/26 at 8:30am from a MA that the resident had a bad fall and family needed to come to the facility.
-He called another family member who lived closer to the facility and explained to him he needed to go to the facility per the MA that called him.
-He received a call from the family member that the resident had passed away at the facility after his fall.

Interview with the Resident Care Coordinator (RCC) on 03/25/26 at 8:20am revealed:
-Staff should know if a resident was a DNR or a full code.

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-The facility had a red star or red dot by the name beside each resident's door if they were a DNR.
-There were DNR binders on the medication carts or in the medication rooms on the Special Care Unit (SCU) and on the Assisted Living (AL) unit.
-There was also a large font at the top of the resident's electronic medication record (eMAR) that indicated if a resident was a DNR.
-When a resident was found unresponsive, the MA should first call 911.
-Then the MA or another staff person should located the resident's DNR and provide the DNR to Emergency Medical Services (EMS) staff after they arrived.
-Staff that were on the phone with 911 should remain on the phone with 911 because they tell staff exactly what to do.
-She expected staff to follow directions from 911, however staff were trained to not move a resident if they possibly had a head injury to avoid causing further injury.
-She expected staff to follow the DNR if a resident had one because it was their wishes and possibly the family's wishes.
-If she had a family member who had a DNR and the DNR was not followed, she would be upset if staff attempted to resuscitate her family member, because she would be upset that their loved one's wishes were not honored.
-It was unacceptable that staff were unable to located a DNR for Resident #7.

Interview with Resident #7's primary care provider (PCP) on 03/25/26 at 10:07am revealed:
-When a resident was a DNR, CPR should not be performed on the resident.
-Staff should honor a resident's DNR, but she understood in a panic situation that staff may begin CPR until they could locate the DNR.
-She expected staff to honor residents and/or

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families desire to have a DNR and to not perform CPR.

Interview with the Administrator on 03/26/26 at 11:30am revealed:
-When Resident #7 was found nonresponsive, staff should have gone to the front receptionist desk to locate the DNR binder in order to retrieve the resident's DNR.
-She was informed by a staff member that someone told EMS they were not able to find the DNR because it was locked in an office.
-To her knowledge the DNR book had always been located at the receptionist's desk, and she never knew the DNR binder to be locked in anyone's office.
-She was not aware that staff were unable to locate the residents' DNR and would have wanted staff to notify her or the RCC if they were unable to locate the DNR for Resident #6.

Refer to interview with a medication aide (MA) on 03/24/26 at 3:57pm.

Refer to interview with a second medication aide (MA) on 03/25/26 at 10:07am.

Refer to interview with the Administrator on 03/25/26 at 3:33pm.

Refer to interview with the Administrator on 03/26/26 at 11:30am.

____
Interview with a medication aide (MA) on 03/24/26 at 3:57pm revealed:
-When a resident was found unconscious and unresponsive, staff called 911 and sent the resident out to the emergency department.
-If a resident was a DNR there was supposed to be a red star or red dot affixed to their name label

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D 338	Continued From page 44 beside their room door. -She was also able to look in a binder for a resident's DNR if needed. -The Assisted Living (AL) unit and Special Care Unit (SCU) each had a binder with each resident's DNR order. -The DNR binder was supposed to stay on the medication cart so staff could access the DNR quickly if needed. -If a resident had a DNR order, facility staff still called 911 but did not perform CPR on the resident. Telephone interview with a second MA on 03/25/26 at 10:07am revealed: -If the resident was a DNR staff did not start CPR. -The red heart or star on the residents' doors indicated they were DNR's. Interview with the Administrator on 03/25/26 at 3:33pm revealed: -Staff panicked during the situation. -Staff should have slowed down and not panicked. -Staff did not think to look outside the residents' door for their DNR status. -CPR should not have been initiated on residents with a DNR status. Interview with the Administrator on 03/26/26 at 11:30am revealed: -When a personal care aide (PCA) or staff other than a MA found a resident nonresponsive, they should go get a MA or the supervisor. -If a MA found a resident nonresponsive, they should check to see if the resident was a DNR. -Staff could look at the resident's door to see if there was a red star or red dot by their name label which indicated the resident was a DNR. -Staff could also locate the resident's DNR in the	D 338		

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D 338	Continued From page 45 DNR binder located in the medication room in the Assisted Living (AL) unit or in the Special Care Unit (SCU). -If a resident was a DNR, staff should not initiate CPR because staff would not be honoring the resident or the responsible party's wishes. -If a resident was not a DNR, staff should immediately call 911, start CPR, then notify her and the resident's primary care provider (PCP). -When staff called 911, they normally gave directions to staff and stayed on the phone with staff, sometimes they gave instructions and would tell staff to call if they had any questions. -Staff could also locate a resident's DNR when they printed a face sheet from the electronic medical record, there was a listing on the face sheet that had documentation if the resident was a full code or a DNR.	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.	D 346		

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D 346	Continued From page 46 This Rule is not met as evidenced by: Based on interviews and record review, the facility failed to obtain a stated indication for as needed medication used for 1 of 5 sampled residents (#2). The findings are: Review of Resident #2's current FL-2 dated 02/12/26 revealed diagnoses included hypoglycemia, type 2 diabetes, hypertension, hypokalemia, hyponatremia, and pedal edema. Review of Resident #2's signed primary care provider (PCP) orders dated 03/18/26 revealed: -There was an order for Acetaminophen 500mg tablet, take 1 every 8 hours as needed, dx: need diagnosis. (Acetaminophen is used to relieve mild to moderate pain and reduce fever). -The Acetaminophen did not have an indication for use. -There was an order for Antacid regular strength 500mg, take 2 every 8 hours as needed, dx: need diagnosis. (Antacid is used to relieve heartburn, indigestion, and acid reflux). -There was an order for Nystatin powder 100000, apply topically to affected area(s) every 8 hours as needed. (Nystatin powder is used treat diaper rash). Review of Resident #2's March 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Acetaminophen 500mg tablet, take 1 every 8 hours as needed, dx: need diagnosis. -The Acetaminophen did not have an indication for use. -There was an entry for Antacid regular strength 500mg, take 2 every 8 hours as needed, dx: need	D 346		

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diagnosis.
-The Antacid did not have an indication for use.
-There was an entry for Nystatin powder 100000, apply topically to affected area(s) every 8 hours as needed.
-The Nystatin powder did not have an indication for use.

Interview with a medication aide (MA) on 03/24/26 at 2:15pm revealed:
-She was responsible for administering medications, assisting the personal care staff when needed, and supervising 2 to 5 personal care aides (PCA), accepting verbal orders, communicating with the pharmacy and the Resident Care Coordinator (RCC).
-When the PCP wrote medication orders; the orders would go through to the RCC to approve them.
-If the medication order was on the electronic medication administration record (eMAR) it meant it was approved.
-She knew what as needed (PRN) medications were used for because the orders on the eMAR would state what it was used for.
-Some residents in the facility were able to ask for their PRN medications.
-If an eMAR stated needs diagnosis (dx) it meant the PCP did not put a reason for the medication.
-MAs would not know what a PRN medication was meant for if the medication order was not complete.
-If there were medication orders without a PRN indication the MAs should report that to the RCC.

Interview with the RCC on 03/24/26 at 2:26pm revealed:
-She was responsible for the leadership over the MAs, follow up of orders and referrals, ensuring residents were safe, and staff were doing what

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they were supposed to.
-When she received orders from the PCP, she faxed the orders to the pharmacy, pharmacy would put the orders in the eMAR system, and she followed up to ensure the medications were in the facility.
-When pharmacy put the medication orders in the eMAR system she or the Administrator approved the orders.
-When she approved medication orders, she ensured the orders matched the eMAR.
-If need diagnosis (dx) was on the eMAR, it meant there needed to be a reason the medication was given.
-If there was a PRN order it needed to state the reason it was being given.
-If there was no reason why the PRN was given, the facility needed to get clarification from the PCP and send the order back to the pharmacy.
-She was not aware there were no PRN indications for Resident #2's PRN medications.
-She conducted audits to ensure the medications were present in the facility, but she never conducted an audit to ensure there were reasonings indicated for PRN medications.

Interview with the Administrator on 03/24/26 at 2:54pm revealed:
-She was responsible for ensuring proper operation of the facility.
-She assisted with checking orders and verifying the medication orders.
-When new medication orders came in, they went to the pharmacy, pharmacy puts the orders in the system, and a popup came up for the facility to verify.
-When she verified the medication orders, she compared what pharmacy put in the system and the actual medication order from the PCP.
-When she had a PRN medication she checked

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for the dosage, route, time, and indication because it needed to say why the medication should be given.
-If there was no reason for the PRN medication, the medication order needed to be clarified.
-The PCP should be contacted, and the facility should check the medication order to ensure there was no mistake when it was put in the system.
-If the PRN medication order was in the eMAR system with no indication, the MAs should notify the RCC, Special Care Coordinator (SCC), or the Administrator to get the order clarified.
-The MAs could also contact the PCP if they thought a PRN was needed at that time and there was no indication.