Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL067025	A. BUILDING: _____ B. WING _____	R-C 01/08/2026

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

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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on 01/06/26 through 01/08/26. The Onslow County Department of Social Services initiated the complaints on 12/03/25, 12/10/25, 12/19/25 and on 12/23/25.	D 000	Response to cited deficiencies do not constitute an admission or agreement by the facility of the truth of facts alleged or the conclusions set forth in the corrective action report; the plan of correction is prepared solely as a matter of compliance with State Law.	
D 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 reviews, the facility failed to provide personal care assistance for 1 of 5 sampled residents (#3), who required staff assistance with incontinent care. The findings are: Review of Resident #3's FL2 dated 10/22/25 revealed: -Diagnoses included weakness, hypertension, constipation, osteopenia, overactive bladder, stress urinary incontinence, chronic kidney disease, and hyperlipidemia. -She was incontinent of bowel and bladder. -She required assistance from staff with bathing and dressing. -She was ambulatory. Review of Resident #3's Resident Register revealed she was admitted to the facility on	D 269	ED and SCC re-educate PCAs and MAs on the importance of providing care to residents according to the care plan and to attend to any personal care needs the resident is unable to attend to themselves. ED and SCC will monitor resident care during daily rounds. ED and SCC will conduct random overnight visits to ensure compliance on all shifts.	2/17/26 2/27/26

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE executive director (X6) DATE 2/18/26

Jamaal Willis Reviewed and Acknowledged 03/13/26

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D 269	Continued From page 1 10/24/25. Review of Resident #5's care plan dated 12/29/25 revealed: -She was ambulatory with a wheelchair. -She was incontinent daily of bowel and bladder. -She was oriented. -She required supervision with eating. -She was totally dependent with toileting. -She was totally dependent with ambulation and locomotion. -She was totally dependent with bathing. -She was totally dependent with dressing. -She was totally dependent with grooming and personal hygiene. -She was totally dependent with transferring. Interview with Resident #3 on 01/06/26 at 1:00pm revealed: -She had been at the facility for a little over 2 months. -She required assistance with all tasks except eating. -Some staff at the facility were helpful, others not so much. Second interview with Resident #3 on 01/08/26 at 10:10am revealed: -She could not walk or sit up and was dependent upon staff for toileting and bathing. -She was able to pull herself over in the bed some. -She was working with physical therapy and could sit on the side of the bed for a very short while, but it was very uncomfortable for her. -She understood that staff were to check on her every 2 hours for repositioning and toileting. -Staff had changed her this morning and she was to have a shower today, -Sometimes it was 4 or 5 hours before staff	D 269		

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D 269	Continued From page 2 checked her, it depended on who was on duty. -Some staff were better than others and quite often the facility was short staffed. -Sometimes in the evening staff would check on her at 10:30pm or 11:00pm and not check her again until the morning. -There were times when she had to wait hours to be changed. -She really did not like to complain and was not sure if she had notified anyone. Interview with a personal care aide (PCA) on 01/07/26 at 4:29pm revealed: -She mainly worked the 3:00pm to 11:00pm shift but worked the 7:00am to 3:00pm. -She checked on the residents every 1.5 to 2 hours to make sure they were clean and dry, to see if they wanted to get up or go back to bed, and to see if they needed anything. -Sometimes she got really behind in her duties or was the only PCA working and it may be closer to every 3 hours when she could check all the residents. -She had found residents soaked in urine when she came on duty including Resident #3, most recently on Christmas Day. -Resident #3 required total assistance with toileting. -Resident #3 could reposition herself in bed but required reminders to do so. -It frustrated her when she found the residents soiled because it was not fair to the residents. -She has frequently had to work a shift by herself and was told someone was coming to help but help never came. -She mainly found residents heavily soiled when management helped on the floor. -On occasion night shift left residents wet and she was blamed, so she now asked the medication aide coming on duty to make rounds on her	D 269		

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D 269	Continued From page 3 resident rounds with her. -Resident #3 was a two person assist and there was not always a second person available to help her with Resident #3 so she did the best she could. -She felt Resident #3 required a higher level of care than the facility could provide. Interview with a second PCA on 01/08/26 at 9:14am revealed: -He occasionally found residents saturated in urine from the night shift when coming on duty at 7:00am. -When he found residents heavily soiled, off-going staff said the resident refused care from them so he would get them cleaned up and go about his duties. Interview with a third PCA on 01/08/26 at 10:32am revealed: -The residents were checked by the PCAs every 2 hours to make sure they were clean and dry. -There were some residents that she tried to check more frequently including Resident #3 because she was bed bound. -She found residents soaked in urine daily. -She had not reported this to anyone because she did not know who to report it to. Interview with a medication aide (MA) on 01/07/26 at 10:54am revealed: -The residents were checked every 2 hours for incontinence care and to make sure they were safe. -The PCAs were mainly responsible for personal care and incontinence care for the residents but she tried to help when she could. Interview with the Physical Therapist (PT) on 01/08/26 at 12:07pm revealed:	D 269		

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D 269	Continued From page 4 -She saw Resident #3 three times weekly since early December 2025. -Resident #3 required maximum assistance due to leg weakness. -She found Resident #3 in need of incontinence care occasionally and had to find staff to clean her before she could proceed with her physical therapy treatments. Interview with the Special Care Coordinator (SCC) on 01/08/26 at 10:54am revealed: -She covered the Assisted Living halls currently since there was no longer a Resident Care Coordinator (RCC) at the facility. -All the residents were checked every 2 hours for incontinent care or more frequently if needed. -Resident #3 was incontinent of bowel and bladder and required total assistance with toileting. -Resident #3 nor staff had reported to her that Resident 3 was not being provided with incontinent care at least every two hours. -She expected the residents to receive incontinence and personal care to keep them comfortable and clean. Interview with the Administrator on 01/08/26 at 11:21am revealed: -The PCAs and MAs were expected to check on the residents every two hours for safety, cleanliness, and location. -If there was an issue with residents being found excessively soiled, she expected to be notified. -The residents should be checked and personal and toileting care provided at least every two hours and as needed. Telephone interview with Resident #3's Responsible Party (RP) on 01/07/26 at 4:23pm revealed:	D 269		

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D 269	Continued From page 5 -If she had any concerns about Resident #3's care at the facility, she went directly to the Administrator and if the matter was not resolved then she would take it to a higher level. -She did not wish to answer any questions about the facility or Resident #3's care at the facility. Interview with Resident #3's primary care provider (PCP) on 01/07/26 at 4:50pm revealed: -Resident #3 was supposedly ambulatory when she came to the facility, but she had never seen her up and walking. -Staff tried to get her up in a chair but she refused, complaining of back pain as to why she does not want to get up. -Physical therapy had been ordered for Resident #3. -She felt Resident #3 could reposition herself in bed but refused to do so. -She had never found Resident #3 soaked in urine or stool and had no concerns about the resident's personal care at the facility.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.	D 270		

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D 270	Continued From page 6 This Rule Is not met as evidenced by: FOLLOW-UP TO A TYPE A1 VIOLATION The Type A1 Violation was abated. Non-compliance continues. THIS A TYPE A2 VIOLATION Based on observations, interviews, and record reviews the facility failed to provide supervision in accordance with the residents' assessed needs for 2 of 7 sampled residents (#1, #9) related to a resident who had multiple falls, and a resident who ingested non-food substances (#1). The findings are: 1. Review of the facility's Safety Measure for Falls Reduction policy dated September 2021 revealed: -The Community will evaluate fall risk on admission and readmission and document interventions according to care needs and physician orders. -On admission and re-admission, the resident is evaluated by management for fall risk. -The resident is evaluated at each fall, and appropriate reports are completed with documentation of each new intervention. -Fall Risk Admission Evaluation, management completes on the day of admission or day of return from a hospital admission (not an ER visit). -When a fall/fall related accident/incident occurs a Fall Related Accident/Incident Report will be completed by the Resident Care Coordinator or designee in Matrix Care at which time the 72 Hour Fall Management Follow-up will be added in Matrix Care (both orders). -Vital signs and observation for any changes are completed every shift by Medication Aides (MAs)	D 270	ED and SCC will pull and review the falls report during morning meeting to ensure a new intervention has been implemented to assist the resident with their current care needs. RCD and Director of Rehab. in-serviced ED, SCC and MAs on the importance of ensuring a new meaningful intervention is put in place each time there is a fall to include increased supervision for residents with a patter of repeated falls. ED and SCC will round at least twice daily to monitor compliance with staff providing supervision to residents based on their current assessed needs. SCC and MAs will ensure that increased supervision is in place for residents that have been identified to place non-food items in their mouth. Continued care plan meetings and PCP communication will occur for the safety of the resident. Residents noted to have more than 6 falls in 30 days will have a care plan meeting scheduled with the family/resident and PCP when available to discuss the current needs of the residents and next steps to ensure the safety of the resident.	2/7/26 2/17/26 2/7/26 2/7/26 2/7/26

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D 270	Continued From page 7 and documented using the Shift Progress Note. -Within 24-48 hours of each fall, a manager will complete the Post Fall Care Plan Evaluation for Interventions. -A new intervention must be added for each additional fall. -The Resident Care Coordinator (RCC) or designee will add the Fall Risk Banner to the face sheet in Matrix Care. -The RCC or designee will add the Fall Risk Emblem to the door name plate. -The RCC or designee will add interventions to the orders in Matrix Care. Review of Resident #9's current FL-2 dated 11/17/25 revealed: -Diagnoses included muscle weakness, unsteadiness on feet, displaced fracture of right femur, cognitive communication deficit, and fibromyalgia. -The resident was semi-ambulatory. -Her level of care was assisted living. -There was no information documented for orientation. Review of Resident #9's Resident Register revealed: -She was admitted to the facility on 11/19/25. -She required assistance with dressing, bathing, ambulation, getting in and out of bed, and toileting. Review of an FL2 Medication Clarification form for Resident #9 dated 11/19/25 revealed: -There was a handwritten order for a hi-lo hospital bed, pads on the floor for safety X 2, and physical therapy for strengthening and balance. -The FL2 Medication Clarification form was signed by Resident #9's PCP on 11/20/25.	D 270		

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D 270	Continued From page 8 Review of Resident #9's Fall Risk Admission Evaluation dated 11/20/25 revealed: -The description was documented as admission evaluation. -Yes was documented as the answer for the question" have you fallen in the last year". -Yes was documented as the answer for the question "are you unsteady when walking or standing". -Yes was documented as the answer for the question "do you worry or have a fear of falling". -If yes was answered to any of the questions, a Fall Risk Banner is placed in Matrix Care, print and give to Therapy for Therapy Screening, a safety emblem is placed on name plate, and complete a Fall Intervention Care Plan. Review of Resident #9's care plan dated 12/17/25 revealed: -She was ambulatory with the aid of a wheelchair. -She had limited strength in the upper extremities. -She had weakness in the lower extremities with limited range of motion. -She was occasionally incontinent of bowel and bladder. -She was oriented. -Her memory was adequate. -She required assistance with all tolleting needs. -She required limited assistance with ambulation/locomotion. -She required assistance with all bathing needs. -She required assistance with all dressing needs. -She required assistance with all grooming/personal/hygiene needs. -She required extensive assistance with transferring. Review of Resident #9's Incident/Accident (I/A) report dated 11/20/25 revealed: -The event date was 11/20/25 at 7:50pm.	D 270		

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D 270	Continued From page 9 -The description was documented as with injury, 11/20/25, resident bathroom. -The location was resident bathroom. -The I/A was unwitnessed by staff. -The I/A was reported by another staff member. -The resident was laying on her left side with a laceration to her nose and minimal bleeding. -The resident stated she fell out of bed. -She exhibited or complained of pain and/or injury related to this fall. -The location of injury was documented as face, left/right side, bridge of nose. -The type of injury was documented as laceration. -First aid was not administered. -She was alert and oriented. -She was sent to the emergency department (ED) on 11/20/25 at 8:10pm via emergency medical services (EMS). -She was not admitted to the hospital. -Status of Resident #9 after ED discharge was documented as no new orders, Dermabond (a medical grade liquid skin adhesive) was applied to the bridge of the nose. -The I/A was faxed to the county Department of Social Services (DSS). -Resident #9's responsible party (RP) and primary care provider (PCP) were notified. -Her vital signs were documented as pulse-94, respirations-20, blood pressure-182/89. -Under the Orders heading, check vital signs every shift for 72 hours, monitor status for 72 hours for bruising, change in mental status/condition, pain, or other injuries related to fall, complete a shift note every shift for 72 hours. -Under the evaluation heading, evaluation notes were post ED visit for fall on 11/20/25 at 7:50pm, monitor resident for any changes, bruising or other injuries. -Falls prevention program initiated was documented as yes.	D 270		

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D 270	Continued From page 10 -Care Plan updated was documented as N/A. -The I/A report was completed on 11/21/25 at 9:21am. Review of Resident #9's facility progress notes dated 11/20/25 at 8:20pm revealed: -The resident had an unwitnessed fall in her bathroom. -She was sent out via emergency medical services (EMS) and was transported to a local hospital. -The RP and the on-call PCP were notified. Review of Resident #9's 11/20/25 ED after visit summary (AVS) revealed: -The chief complaint was documented as fall injury. -The stated complaint was fall, face and neck pain. -The history of present illness was documented as the resident fell forward out of her wheelchair and landed on her face. -There was no known loss of consciousness. -She was not on any blood thinners. -She sustained a laceration on the bridge of her nose. -She had no pain in her hands, arms, back or chest. -She had some pain in the neck but was non-tender on exam. -The wound was closed with Dermabond. -A head CT scan showed no evidence of internal bleeding, midline shift or mass effect. -A CT scan of the cervical spine and a CT scan of the facial bones showed no acute process. -The resident was discharged with ED fall prevention instructions on 11/20/25 at 11:07pm. Review of Resident #9's Fall Risk Intervention Care Plan dated 11/21/25 at 9:33am revealed:	D 270		

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D 270	Continued From page 11 -The resident had a fall with injury on 11/20/25 at 7:50pm in the resident's bathroom. -The resident intervention plan was completed for a fall. -The resident was not admitted to the hospital. -No medical condition or medications were identified as factors in the fall. -No environmental factors were identified as possible causes for the fall. -The fall did not appear to be medication, blood sugar or blood pressure related. -Yes was documented as the answer to question, does it appear to be a medical/cognitive status change, recent admission, readmission, change in cognitive status, recent weight change, recent illness/infection or change in mobility. -The fall did not appear to be related to assistive devices, lighting or call bell/pendant. -The resident was not cognitively impaired. -Interventions were documented as "call light within reach and secured". Review of Resident #9's I/A report dated 11/26/25 revealed: -The event date was 11/26/25 at 7:30am. -The description was documented as fall with injury on 11/26/25 at 7:30am in the resident's room. -The location of the I/A was the resident's room. -The I/A was unwitnessed. -The I/A was reported by another staff. -She was alone. -She was observed sitting on the floor. -She stated she was trying to get up. -She did not exhibit or complain of pain and /or injury related to the fall. -First aid was not administered. -She was not sent to the ED. -Her RP was notified at 7:53am. -Her PCP was notified at 7:56am.	D 270		

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D 270	Continued From page 12 -There were no vital signs documented. -Under the Orders heading, check vital signs every shift for 72 hours, monitor status for 72 hours for bruising, change in mental status/condition, pain, or other injuries related to fall, complete a shift note every shift for 72 hours. -Falls prevention program initiated was documented as yes. -Care Plan updated was documented as N/A. -The I/A report was completed on 11/26/25 at 12:24pm. Review of Resident #9's facility progress notes dated 11/26/25 at 8:10am revealed: -Treatment refused, refused treatment from EMS. -She refused to be transported via EMS to the hospital post fall. -She refused treatment from EMS post fall three times. -The PCP was notified on 11/26/25 at 7:57am. -The PCP did not give new orders. -Her RP was notified on 11/26/25 at 7:53am. -Intervention put in place, 72 hour follow up and close monitoring to prevent falls. Review of Resident #9's facility progress note dated 11/26/25 at 8:12am revealed: -The resident had a fall with injuries. -The resident refused medical treatment and to be transported via EMS to the hospital. -Her RP and PCP were notified. -Staff would continue to monitor. Review of Resident #9's record revealed there were no facility progress notes for Resident #9 for the 3:00pm to 11:00pm shift on 11/26/25. Review of Resident #9's facility progress note dated 11/27/25 at 6:44am revealed: -The reason for the progress note was	D 270		

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

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D 270	Continued From page 13 documented as follow-up from a fall. -The resident had not complained of pain since the fall. -No mental changes were seen since the fall. -There were no additional injuries seen since the fall. Review of Resident #9's record revealed: -There were no further facility progress notes for 11/27/25. -There no facility progress notes for 11/28/25. -There were no facility progress notes for 11/29/25. Review of Resident #9's record revealed there was no Post Fall Care Plan Evaluation for Interventions for the fall on 11/26/25. Review of Resident #9's I/A report dated 12/02/25 revealed: -The I/A date and time was 12/02/25 at 6:30pm. -The description was documented as the resident fell out of bed onto her bottom without injury. -The location of the incident was the resident's room. -There was no medical treatment. -There was no apparent skin or wound injury, no injuries or concerns. -Her vital signs were documented as blood pressure 162/88, respirations 18, pulse 88. -No immediate action was taken. -The RP was notified at 6:40pm. -The PCP was notified at 6:45pm. -Care outcomes were documented as "monitor in house". -There were no apparent non-physical injuries. -There were no immediate concerns. Review of Resident #9's facility progress notes dated 12/02/25 revealed:	D 270		

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D 270	Continued From page 14 -There was an entry at 10:12pm that the RP was notified that the resident had a fall with no injuries. -There was an entry at 10:13pm that the PCP was notified that the resident had a fall with no injuries. -There was an entry at 10:14pm the resident had an incident that did not require a hospital visit and her RP and PCP were notified. -There was an entry at 10:28pm that the RP was notified Resident #9 had a fall with no injuries. -There was an entry at 10:29pm that there was an incident that did not require a hospital visit and her RP and PCP were notified. Review of Resident #9's I/A report dated 12/03/25 revealed: -The I/A date and time was 12/03/25 at 3:30am. -The description was documented as the resident was found by staff on the floor in her bedroom, she was sitting up next to her bed facing the window. -The location was the resident's room. -911 was called. -The wound type was a bruise, and the location of the wound was the head. -The resident stated that she hit her head, she did have some redness to the left of her forehead. -Her vital signs were documented as blood pressure 140/74, respirations 17, oxygen saturation 98%, pulse 72, and temperature 98.5. -The fall was unwitnessed. -Emergency Response System was activated, face sheet, emergency transfer sheet or documentation per policy was provided to EMS. -A message was left with the PCP at 4:00am. -Care outcomes were documented as transported to the to the ED, no major injury, no minor injury. -There were no apparent non-physical injuries. -There were no immediate concerns.	D 270		

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D 270	Continued From page 15 Review of Resident #9's facility progress notes dated 12/03/25 revealed: -There was an entry at 4:30am that the resident was found on the floor in her room and stated she hit her head and had a raised area to the left side of her forehead and was transported to the via EMS. -There was an entry at 4:31am the PCP's office was called and staff spoke to the after-hours nurse and reported that the resident was found on the floor and that she stated she hit her head and the resident had a raised area to the left of her forehead, and the nurse stated she would fax the information over to the PCP. -There was an entry at 4:34pm, attempted to call the RP regarding the resident's fall and transport to the ED, the call did not even ring but instead when straight to voice mail stating that the person was not accepting any calls and a voice mail could not be left. Review of Resident #9's ED documentation dated 12/03/25 revealed: -Chief complaint was the resident reported falling with trying to get out of bed, hit her head on the floor, denied loss of consciousness and not on blood thinners. -The resident rolled out of her bed onto the floor and struck the front of her head. -EMS and the resident reported no loss of consciousness, and she was not on anti-coagulants.. -The resident denied chest pain, shortness of breath, neck pain, abdominal pain, nausea/vomiting, headache or visual changes. -Primary survey was unremarkable for acute threat to life. -Secondary survey showed small frontal abrasion/hematoma with no spine tenderness.	D 270		

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D 270	Continued From page 16 -She had mild acute-on chronic right lower extremity pain but had femur surgery previously and was able to relay that this was not new pain. -With negative CT imaging, her cervical collar was cleared with full upper extremity motor and sensory function intact with no mid-line tenderness and full cervical range of motion without pain. -As she had negative imaging. She continued to feel asymptomatic and in no pain, she could be safely discharged. -She was recommended to follow-up with her PCP. Review of Resident #9's record revealed: -There were no further facility progress notes for 12/03/25 after the 4:34am entry. -There were no facility progress notes for 12/04/25. -There were no facility progress notes for 12/05/25. Review of Resident #9's record revealed there was no Post Fall Care Plan Evaluation for interventions for the falls on 12/02/25 and 12/03/25. Review of Resident #9's I/A report dated 12/06/25 revealed: -The date of the I/A was 12/06/25 at 11:30pm. -The description was documented as staff found the resident in her bedroom, she was sitting upright on a padded mat next to her bed. -The location was the resident's bathroom. -There was no medical treatment. -There was no apparent skin or wound injury, no injuries or concerns. -Her vital signs were documented as blood pressure 132/72, respirations 17, oxygen saturation 98%, and pulse 76.	D 270		

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D 270	Continued From page 17 -There were no witnesses. -The resident was assisted to standing and her vital signs were measured. -Her PCP and RP were notified at 11:45pm. -Care outcomes were documented as no apparent non-physical injuries. -There were no immediate concerns Review of Resident #9's facility progress notes dated 12/06/25 revealed: -There was an entry at 11:56pm, called the RP to report a fall for the resident, the RP did not answer, message left on voice mail with call back number. -There was an entry at 11:57pm, called PCP's office to report a fall without injury for the resident, message sent to the PCP. Review of Resident #9's record revealed: -There were no facility progress notes for 12/07/25. -There were no facility progress notes for 12/08/25. Review of Resident #9's record revealed there was no Post Fall Care Plan Evaluation for Interventions for the fall on 12/06/25. Review of Resident #9's I/A report dated 12/09/25 revealed: -The date of the I/A was 12/09/25 at 5:30pm. -The description was documented as the resident slipped out of bed onto the floor. -The location was the resident's room. -There was no medical treatment. -There was no apparent skin or wound injury, no injuries or concerns. -Her vital signs were documented as blood pressure 146/88, respirations 18, and pulse 80. -There were no witnesses.	D 270		

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D 270	Continued From page 18 -No immediate action was taken. -Care Outcomes was documented as monitor in house. -There were no apparent non-physical injuries. -There were no immediate concerns. Review of Resident #9's facility progress notes dated 12/09/25 revealed: -There was an entry at 6:43pm, left message for RP to call the facility. -There was an entry at 6:44pm, communication with provider, resident had a fall, no injuries. -There was an entry at 6:45pm, incident not requiring hospital visit, type of incident was a fall, the PCP and RP were notified. Review of Resident #9's record revealed there was no Post Fall Care Plan Evaluation for Interventions for the fall on 12/09/25. Review of Resident #9's facility progress notes dated 12/10/25 revealed: -There was an entry at 5:18am, that a voice mail was left for the RP. -There was an entry at 5:19am, incident not requiring hospital visit, the type of incident was a fall, the PCP and RP were notified. -There was an entry at 5:19am, the resident had a fall with no injury. Review of Resident #9's record revealed: -There were no additional facility progress notes for 12/10/25. -There were no facility progress notes for 12/11/25. -There were no facility progress notes for 12/12/25. There was no I/A report provided for Resident #9's fall on 12/10/25.	D 270		

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D 270	Continued From page 19 Review of Resident #9's record revealed there was no Post Fall Care Plan Evaluation for Interventions for the fall on 12/10/25. Review of Resident #9's I/A report dated 12/15/25 revealed. -The date of the I/A report was 12/15/25 at 6:15am. -The description was documented as the resident was found in a seated position at the end of her bed. -The location was the resident's room. -There was no medical treatment. -There was no apparent skin or wound injury, no injuries or concerns. -Her vital signs were documented as blood pressure 132/75, respirations 18, and pulse 78. -There were no witnesses. -Action taken was documented as assisted to lying position and assisted to sitting position. -The PCP was notified and a message was left for her RP. -Care Outcomes was documented as monitor in house, and location outcomes was documented as stayed in community. -There were no apparent non-physical injuries. Review of a second I/A report for Resident #9 dated 12/15/25 revealed: -The date of the I/A was 12/15/25 at 12:15pm. -The description was documented as the resident slid out of bed onto buttocks, no injuries. -The location was the resident's room. -There was no medical treatment. -There was no apparent skin or wound injury, no injuries or concerns. -There were no vital signs documented. -Checklist items were listed as assistive devices, demonstration of proper utilization reviewed was	D 270		

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D 270	Continued From page 20 documented as N/A at 11:05pm, Assistive devices functionality checked was documented as N/A at 11:05pm, care plan /service plan updated was documented as N/A at 11:06pm, care plans adjusted for change in level of care needs was documented as N/A at 11:05pm, chart review was documented as N/A at 11:06pm, Emergency response functionality checked was documented as N/A at 11:06pm, notification logged of RP was documented as N/A at 11:06pm, notification logged of PCP was documented as N/A at 11:06pm. -Care Outcomes were documented as monitor in house. -There were no apparent non-physical injuries. -There were no immediate concerns. Review of Resident #9's facility progress notes dated 12/15/25 revealed: -There was an entry at 6:47am, left message for the RP to call back regarding the resident. -There was an entry at 6:13pm, the resident kept trying to get herself up out of bed or the chair and kept sliding down on her buttocks with no injuries. Review of Resident #9's record revealed there were no facility progress notes for 12/16/25. Review of Resident #9's record revealed there was no Post Fall Care Plan Evaluation for Interventions for the falls on 12/15/25. Review of Resident #9's I/A report dated 12/17/25 revealed: -The date of the I/A was 12/17/25 at 1:40pm. -The description was documented as the resident slipped out of chair onto the floor. -The location was the resident's room. -There was no medical treatment. -There was no apparent skin or wound injury, no	D 270		

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D 270	Continued From page 21 Injuries or concerns. -Her vital signs were documented as blood pressure 148/78, respirations 18, and pulse 78. -There were no witnesses. -There was no immediate action taken. -Notification of her RP was logged at 4:21pm. -Notification of the PCP was logged at 4:22pm. -Care outcomes were documented as monitor in house. -There were no apparent non-physical injuries. -There were no immediate concerns. Review of Resident #9's facility progress notes dated 12/17/25 revealed: -There was an entry at 2:16pm, left message for RP to call back. -There was an entry at 2:18pm, the PCP was notified the resident had a fall with no injuries. Review of Resident #9's record revealed: -There were no facility progress notes for the 11:00pm to 7:00am shift on 12/18/25. -There were no facility progress notes for the 7:00am to 3:00pm shift on 12/18/25. Review of Resident #9's record revealed there was no Post Fall Care Plan Evaluation for Interventions for the fall on 12/17/25. Review of Resident #9's I/A report dated 12/18/25 revealed: -The date of the I/A was 12/18/25 at 4:40pm. -The description was documented as the resident fell out of chair and landed on bottom. -The location was the resident's room. -There was no medical treatment. -There was no apparent skin or wound injury, no injuries or concerns. -Her vital signs were recorded as blood pressure 156/78, respirations 18, and pulse 89.	D 270		

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D 270	Continued From page 22 -There were no witnesses. -There was no immediate action taken. -Notification of her RP was logged on 12/19/25 at 11:32am. -Notification of the PCP was logged on 12/19/25 at 11:32am. -Care outcomes were documented as monitor in house. -There were no apparent non-physical injuries. -There were no immediate concerns. Review of Resident #9's facility progress notes dated 12/18/25 revealed: -There was an entry at 7:04pm. the PCP was notified the resident had a fall with no injuries. -There was a second entry at 7:04pm, the RP was notified the resident had a fall with no injuries. -There was an entry at 7:05pm, incident not requiring hospital visit, the type of incident was a fall, the RP and PCP were notified. Review of Resident #9's 12/19/25 facility progress notes revealed: -There were no facility progress notes for the 11:00pm to 7:00am shift. -There was an entry at 7:06pm, the resident was doing okay. Review of Resident #9's record revealed there was no Post Fall Care Plan Evaluation for Interventions for the fall on 12/18/25. Review of Resident #9's I/A report dated 12/20/25 revealed: -The date of the incident was 12/20/25 at 5:00pm. -The description was documented as the resident fell from wheelchair to the floor and hit her face on the closet door. -The location was the resident's room.	D 270		

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D 270	Continued From page 23 -Treatment was documented as 911 was called. -The wound type was documented as bruise to the right eye, red spot on the side of right eye. -Her vital signs were documented as blood pressure 136/71, respirations 17, and pulse 67. -Another resident pulled the call bell for the resident that was on the floor because she was yelling for help from the floor. -EMS was contacted. -Under checklist, assistive devices demonstration of proper utilization reviewed was documented as N/A at 5:45pm. assistive devices functional checked was documented as N/A at 5:45pm, care plan/service plan updated was documented as N/A at 5:45pm, care plan adjusted for change in level of care needs was documented as N/A at 5:45pm, emergency response system functionality checked was documented as N/A at 5:45pm. -Care outcomes were documented as transported to the ED. Review of Resident #9's facility progress notes dated 12/20/25 revealed: -There was an entry at 4:37pm, the resident was doing fine. -There was an entry at 5:47pm, the resident gave 3 different stories on how she fell, she said her wheelchair was hung on the bed and she fell out of the chair, she said she was trying to get up and get on the bed, then stated she was getting up to get something out of her closet, the resident was really confused and sent to the hospital. -There was an entry at 5:49pm, left message for RP to call back regarding the resident being sent out to the hospital. Review of Resident #9's hospital visit summary dated 12/20/25 revealed: -The chief complaint was documented as "fall".	D 270		

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D 270	Continued From page 24 -The stated complaint of was fall and face pain. -The history of present illness (HPI) was documented as the resident presented to the ED status post fall, she reported she went to stand up from her wheelchair when she fell striking her face on a trash can, she denied any loss of consciousness, she was not on any blood thinners, she reported she had a recent hip fracture with surgery, she denied any pain to extremities or hip. -The ED course was documented as the resident presented to the ED status post fall, she reported she went to stand up from her wheelchair when she fell striking the right side of her head on a trash can, she denied any loss of consciousness, CT scan of the head and cervical spine were obtained as well as right hip images due to recent history of fracture. -Imaging was reviewed and there was no acute fracture or dislocation, however there was a thyroid nodule in which she was recommended to follow-up with her PCP for further management and ultrasound guidance, at this point she was hemodynamically stable for discharge and discharged back to her facility. Review of Resident #9 record revealed there was no Post Fall Care Plan Evaluation for Interventions for the fall on 12/20/25. Review of Resident #9's I/A report dated 12/21/25 revealed: -The incident date was 12/21/25 at 2:30pm. -The description was documented as the resident fell going from her wheelchair to her recliner, the resident never pulled the bell for assistance. -There was no medical treatment. -There was no apparent skin or wound injury, no injuries or concerns. -No immediate action was taken.	D 270		

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D 270	Continued From page 25 -Under checklist, assistive devices demonstration of proper utilization reviewed was documented as N/A at 3:39pm, assistive devices functionality checked was documented as N/A at 3:39pm, care plan/service plan updates was documented as N/A at 3:39pm, care plan adjusted for change in level of care needs was documented as N/A at 3:39pm, emergency response system functionality checked was documented as N/A at 3:39pm. -Care Outcomes were documented as monitor in house. -There were no apparent non-physical injuries. -There were no immediate concerns. Review of a second I/A report for Resident #9 dated 12/21/25 revealed: -The incident date was 12/21/25 at 5:00pm. -The description of injury was the resident slid out of bed onto the floor, right foot swollen. -The location was the resident's room. -Treatment was documented as 911 was called. -The wound type was swelling of the foot/toe on the right, right foot swollen around the ankle. -Her vital signs were recorded as blood pressure 172/68, respirations 17, and pulse 78. -Immediate action taken was documented as activated emergency response system at 5:15pm. -Message was left for the RP at 5:15pm. -Under checklist, assistive devices demonstration of proper utilization reviewed was documented as N/A at 11:14pm, assistive devices functionality checked was documented as N/A at 11:14pm, care plan/service plan updated was documented as N/A at 11:14pm, care plan adjusted for change in level of care needs was documented as N/A at 11:14pm, chart review was documented as N/A at 11:14pm, emergency response system functionality checked was documented as N/A at 11:14pm.	D 270		

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D 270	Continued From page 26 -Care Outcomes were documented as transported to ED. Review of Resident #9's facility progress notes dated 12/21/25 revealed: -There was an entry at 2:42am, the resident returned from ED/hospital/rehab via medical transport, spoke with RP was documented as N/A, medications clarified, faxed to pharmacy if needed was documented as N/A, any follow up appointments added to the calendar was documented as N/A, any diet order change was documented as N/A, any labs ordered was documented as N/A. -There was an entry at 2:33pm, the resident will not pull bell for assistance before moving from bed to chair or from chair to bed, she fell on her bottom when trying to get out of bed to get to her chair. -There was an entry at 3:40pm, the resident fell again, fell going from her wheelchair to her recliner, no bell was pulled and she never asked for help. -There was an entry at 5:03pm, the resident fell out of bed onto the floor and landed on her right ankle, called EMS and she went to the hospital, called the RP to make aware and left a voice mail. Review of Resident #9's hospital after visit summary (AVS) dated 12/21/25 revealed: -Diagnoses for the visit was contusion of foot and a fall. -Patient instructions were a packet for fall prevention in older adults, foot bruise, and rest, ice, compression, and elevation (RICE). -Activity restrictions or additional instructions included no acute fracture of the right foot, RICE therapy is recommended, Tylenol (used to treat mild to moderate pain) as needed for pain.	D 270		

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D 270	Continued From page 27 Review of Resident #9's facility progress notes dated 12/22/25 revealed: -There was an entry at 1:30am, returned from ED via medical transport, spoke with RP was documented as N/A, medications clarified and faxed to pharmacy if needed was documented as N/A, any follow up appointments added to calendar was documented as N/A, any diet order changes given to dietary was documented as N/A, any labs ordered have been scheduled was documented as N/A. -There was an entry at 3:38am, the resident had no complaints of pain since the fall, there were no mental status changes since the fall, there were no additional injuries seen since the fall. -There was an entry at 4:39pm, incident reports for 12/21/25 and 12/20/25 were sent to the PCP and the County Department of Social Services (DSS), discharge summaries were sent to the PCP. Review of Resident #9's record revealed there were no facility progress notes for 12/23/25. Review of Resident #9's facility progress notes for 12/24/25 revealed: -There was an entry at 10:12am, paperwork was given to RP on 12/15/25 to take to Resident #9's PCP to sign, the RP has not returned the paperwork. -There were no further facility progress notes for 12/24/25. Review of Resident #9's record revealed there were no progress notes for 12/25/25. Review of Resident #9's record revealed there was no Post Fall Care Plan Evaluation for Interventions for the falls on 12/21/25.	D 270		

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D 270	Continued From page 28 Review of Resident #9's I/A report dated 12/26/25 revealed: -The date of the incident was 12/26/25 at 11:30am. -The description of the I/A was documented as resident stated she fell going from her bed to the wheelchair. -There was no medical treatment. -There was no apparent skin or wound injury, no injuries or concerns. -No immediate action was taken. -Under checklist, assistive devices demonstration of proper utilization reviewed was documented as N/A at 12:35pm, assistive devices functionality checked was documented as N/A at 12:35pm, care plan/service plan updated was documented as N/A at 12:35pm, care plan adjusted for change in level of care needs was documented as N/A at 12:35pm, chart review was documented as N/A at 12:35pm, and emergency response functionality was documented as N/A at 12:35pm. -Care outcomes were documented as monitor in house. -There were no apparent non-physical injuries. -There were no immediate concerns. Review of Resident #9's facility progress notes dated 12/26/25 revealed: -There was an entry at 12:37pm, the resident was doing fine, fell from the bed to wheelchair and did not pull call bell, -There was a second entry at 12:37pm, incident not requiring hospital visit, the resident fell from bed to wheelchair. -There was an entry at 12:38pm, spoke face to face with RP about a fall from bed to wheelchair. -There were no further facility progress notes for 12/26/25.	D 270		

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D 270	Continued From page 29 Review of Resident #9's facility progress noted dated 12/27/25 revealed: -There was no facility progress note for the 11:00am to 7:00am shift on 12/27/25. -There was no facility progress note for the 7:00am to 3:00pm shift on 12/27/25. -There was an entry at 5:18pm, order, waiting on delivery. -There was an entry at 10:40pm, order, waiting on delivery. Review of Resident #9's record revealed there was no Post Fall Care Plan Evaluation for Interventions for the fall on 12/26/25. Review of Resident #9's I/A report dated 12/28/25 revealed: -The date of the incident was 12/28/25 at 12:00pm. -The description of the incident was documented as the resident fell from her bed to the floor, she stated she was trying to get her phone. -The location was the resident's room. -There was no medical treatment. -The wound type was documented as abrasion head/neck, small abrasion on back of head. -No immediate action was taken. -Under checklist, assistive devices demonstration of proper utilization reviewed was documented as N/A at 2:29pm, assistive devices functionality checked was documented as N/A at 2:29pm, care plan/service plan updated was documented as N/A at 2:29pm, care plan adjusted for change in level of care needs was documented as N/A at 2:29pm, chart review was documented as N/A at 2:29pm, emergency response system functionality checked was documented as N/A at 2:29pm. -Care outcomes were documented as transported to ED.	D 270		

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D 270	Continued From page 30 -Other suspected injury was documented as laceration to the back of the head. Review of Resident #9's facility progress notes dated 12/28/25 revealed there was an entry at 2:32pm, resident sent out to the hospital, the resident fell off her bed trying to get her phone and had a laceration to the back of the head, she was transported by EMS and her RP was notified. Review of Resident #9's ED documentation dated 12/28/25 revealed: -HPI was documented as female with unknown medical history (brought from assisted living-EMS unable to obtain history) with some degree of dementia, brought in by EMS after a ground-level mechanical fall, fell from bed, trauma work up to date was negative for any significant acute injuries, work up was notable for multiple foot fractures which by patient report are old and pre-existing, she was non-ambulatory, bruising on the foot appeared old as well-this does not appear to be an acute injury, she had a remote history of a femur fracture (exact date unknown), findings on initial trauma imaging concerning for possible acute worsening of fracture. CT scan of the lower extremity obtained is pending, plan is to obtain CT images and consult orthopedics, she did not have any significant pain in this region or in her foot. -CT scan images were reviewed and orthopedics did not feel the findings represent an acute fracture, no indication for acute intervention though follow-up with her operating surgeon was recommended, no other acute findings at this time and she denied pain, suitable for discharge back to her assisted living facility with instructions to follow up with the facility's PCP as well as her orthopedic surgeon.	D 270		

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D 270	Continued From page 31 Review of Resident #9's facility progress notes dated 12/29/25 revealed: -There was an entry at 11:25am, the resident returned from the ED via EMS transport, her RP was notified about appointments and follow-ups, her PCP was notified and has a follow-up scheduled for 01/31/26 at 1:30pm, she has a follow-up scheduled with her orthopedic provider on 01/08/26 at 10:00am, there were no dietary changes, there were no labs ordered. -There was an entry at 5:10pm, the resident came back from the hospital earlier today and was doing fine, been sleeping most of the day. Review of Resident #9's record revealed there was no Post Fall Care Plan Evaluation for Interventions for the fall on 12/28/25. Review of Resident #9's I/A report dated 12/31/25 revealed: -The I/A report was dated 12/31/25 at 11:00pm. -The description was documented as the resident had an unwitnessed fall with injury in her room on 12/31/25 at 11:00pm. -The location was the resident's room and in notes, resident was found on the floor bedside her bed. -Treatment was documented as 911 called, and in notes, staff called 911, the resident was transported via EMS to the hospital for further evaluation. -Under wound/injury concern, resident complained of pain in hip, she did not specify which side. -There were no witnesses. -A message was left for her RP on 12/31/25 at 11:45pm. -Care outcomes were documented as transported to the ED. -Other suspected injury was documented as pain	D 270		

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D 270	Continued From page 32 In hip. Review of Resident #9's ED discharge plan dated 01/01/26 revealed: -Clinical impression, acute pain of left hip, fall from bed, initial encounter, at high risk for falls, history of falls within the past 90 days, use walker. -Activity restrictions/additional instructions included use your walker to help prevent falls, take Tylenol as needed for pain, you need to discuss with your gerontologist about your falls and a possible referral to a physical medicine doctor to work with you on fall prevention, return to the ED if symptoms change or worsen for recheck or for fever over 101. Review of Resident #9's record revealed there was no Post Fall Care Plan Evaluation for Interventions for the fall on 12/31/25. Observation of Resident #9 on 01/06/26 at 2:43pm revealed: -There was red leaf taped above the resident's name on her name plate on her door. -The resident was lying in a hospital bed. -The half rails to the hospital bed were in the upright position. -There was a wheelchair at the bedside. Interview with Resident #9 on 01/06/26 at 2:43pm revealed: -She fell once when she had to "jump out of bed" and sprained her ankle. -She got up on the opposite side of the bed that she usually got up on and got her foot tangled up in the sheet while she was trying to put on her bathrobe. -She could not remember any other falls. -Staff responded quickly when she pulled her call	D 270		

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D 270	Continued From page 33 bell. Interview with a personal care aide (PCA) on 01/07/26 at 4:29pm revealed: -The residents were checked on every 2 hours. -She tried to check her residents every 1.5 to 2 hours. -Resident #9 had frequent falls, she would pull her call bell but would not wait for the PCA to respond. -She had never been instructed to check on Resident #9 more than every 2 hours, but she tried to since she fell so often. Interview with a medication aide (MA) on 01/07/26 at 10:34am revealed: -The MAs and the PCAs checked on the residents every 2 hours. -The residents were checked to make sure they were clean and dry and to see if they were having any problems. -If a resident was unable to get up or turn from side to side, they needed to be re-positioned every 2 to 4 hours and the PCAs were responsible for this. -Resident #9 was checked on every 2 hours. -Resident #9 fell frequently because she would not use her call bell to call for assistance to get up. -After a resident had a fall, the MAs checked the resident's vital signs and made a note in the facility progress notes every shift for 3 days. -After a resident had a fall, she tried to check the resident more often such as every 30 minutes to an hour or tried to make her rounds more often. -Resident #9 had frequent falls, she had 3 falls in one day on 12/21/25. -Rounds probably should have been increased for Resident #9 to every hour.	D 270		

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D 270	Continued From page 34 Interview with a second MA on 01/07/26 at 12:04pm revealed: -The MAs and PCAs checked the residents every 2 hours. -When a resident had a fall or returned from the ED, the MAs did a progress note on the resident each shift for 3 days. -Resident #9 received physical therapy and had been told by the physical therapist to call for help when she needed to get up. -Resident #9 was "hard-headed" and would not use her call ball to call for help and had frequent falls. -The Resident Care Coordinator (RCC) or Care Managers were responsible for any fall interventions. -She was not aware of increased monitoring ever being put in place for Resident #9. Second interview with the second MA on 01/08/26 at 8:59am revealed: -There were no additional supervision interventions aside from every 2 hours monitoring put in place for Resident #9. -She did not know what the leaf symbol on Resident #9's name plate on her door meant, she thought it was decorative or to help the resident remember which room was her's. Interview with a second PCA on 01/08/26 at 9:11am revealed: -All the residents were checked every 2 hours including Resident #9. -She did not know what the red leaf symbol on Resident #9's door name plate meant, she thought it was decorative. Interview with a third PCA on 01/08/26 at 9:25am revealed: -She checked on her residents constantly	D 270		

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D 270	Continued From page 35 throughout the day. -Resident #9 fell daily. -She had never been told to increase supervision for Resident #9. -She did not know what the leaf symbol meant on Resident #9's door. Interview with a fourth PCA on 01/08/26 at 10:32am revealed: -The PCAs checked the residents every 2 hours. -Resident #9 fell frequently because she tried to get up by herself without waiting for assistance. -She had never been instructed to check on Resident #9 more than every 2 hours. Interview with the Physical Therapist (PT) on 01/08/26 at 12:07pm revealed: -She had been working with Resident #9 since late November 2025. -Resident #9 had bilateral lower extremity weakness and impaired balance. -Resident #9 had frequent falls related to attempting to transfer without assistance. -Resident #9 was impulsive and required constant cuing and made unsafe decisions without constant cuing. Interview with the Special Care Coordinator (SCC) on 01/08/26 at 10:54am revealed: -She covered the Assisted Living halls currently since there was no longer a Resident Care Coordinator (RCC) at the facility. -All the residents were checked every 2 hours. -The red leaf sticker on Resident #9's door plate was to alert staff that the resident was a fall risk. -She was not aware that staff did not know what the red leaf sticker on a resident's door meant. -When a resident had a fall, they were watched more closely, say every one hour instead of every 2 hours.	D 270		

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D 270	Continued From page 36 -If supervision was increased on a resident, it was communicated verbally to staff. -Resident #9 had frequent falls because she would not use her call bell and tried to transfer herself. -Resident #9's PCP ordered physical therapy, a hi/lo bed and a fall mat on 11/20/25. -Resident #9 received physical therapy and she was in the process of trying to obtain the ordered fall mat for her but had difficulty reaching her PCP for the required paperwork. -After Resident #9's fall on 11/20/25, interventions put in place consisted of making sure her call bell was within reach, reminding her to use her call bell, offering snacks, making sure her wheelchair was by her bed, and she was encouraged to attend activities since all her falls occurred in her room, and every time staff passed her room they were to check on her but there was no specific supervision time frame given outside of the every 2 hour monitoring. -No additional interventions were put in place after Resident #9's 11/26/25 fall. -No additional interventions were put in place after Resident #9's 12/02/25 fall. -No additional interventions were put in place after Resident #9's 12/03/25 fall. -No additional interventions were put in place after Resident #9's 12/06/25 fall. -No additional interventions were put in place after Resident #9's 12/09/25 fall. -No additional interventions were put in place after Resident #9's 12/10/25 fall. -No additional interventions were put in place after Resident #9's 12/15/25 falls. -No additional interventions were put in place after Resident #9's 12/17/25 fall. -No additional interventions were put in place after Resident #9's 12/18/25 fall. -No additional interventions were put in place	D 270		

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D 270	Continued From page 37 after Resident #9's 12/20/25 fall. -No additional interventions were put in place after Resident #9's 12/21/25 falls. -No additional interventions were put in place after Resident #9's 12/26/25 fall. -No additional interventions were put in place after Resident #9's 12/28/28 fall. -No additional interventions were put in place after Resident #9's 12/31/25 fall. -She felt the facility had put every intervention in place that they could to prevent Resident #9's falls. -Resident #9 had an outside provider and contact with their office was very difficult. -They had been trying to get the necessary paperwork completed for Resident #9's fall mat. -Resident #9's PCP was aware of all her falls, the MAs were required to contact his office after each fall and the ED discharge information was faxed to the PCP after each ED visit. -It had not occurred to her to contact the PCP's office to specifically request suggestions for additional fall inventions. Interview with the Administrator on 01/08/26 at 11:27am revealed: -The PCAs and MAs were responsible for checking the residents every 2 hours. -Fall interventions were put in place by the Care Managers (RCC, SCC) for a resident on a case-by-case basis which included increased monitoring and encouraging use of apparatus such as wheelchairs, walkers, and use of call bells. -After Resident #9's 11/20/25 fall, physical therapy, a hospital bed, and fall mats were ordered. -Resident #9 received physical therapy and they were trying to get the necessary paperwork completed for the fall mats from Resident #9's	D 270		

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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 270	Continued From page 38 PCP. -Any fall interventions put in place were communicated to staff verbally. -After Resident #9's 11/26/25 fall, staff were encouraged to get Resident #9 out of her room and to join activities or come to the community areas because all her falls occurred in her room. -Staff also were encouraged to lay eyes on Resident #9 more often after her falls. -She was not aware of any additional interventions that were put in place for Resident #9's additional falls aside from notifying the PCP of each additional fall and providing their office with the ED paperwork. Second interview with the Administrator on 01/08/26 at 4:08pm revealed: -Supervision of greater than every 2 hours could have been put in place by the Care Managers for Resident #9's frequent falls. -She felt it would have been impossible to come up with a new and meaningful intervention after each of Resident #9's falls. Telephone with the Registered Nurse (RN) at Resident #9's PCP's office on 01/08/26 at 9:46am revealed: -Resident #9 was a high fall risk. -Resident #9 had a history of either sliding out of her wheelchair on the floor or sliding out of her bed onto the floor. -Resident #9 would not use her walker and this put her as a fall risk as well. -Luckily Resident #9 had not been seriously injured with all her falls, Resident #9 seemed to be able to "stick the landing" each time. -PT, a hi/lo hospital bed and fall mats had been ordered for Resident #9 on 11/20/25. -The facility had notified their office of Resident #9's frequent falls by leaving messages, faxed I/A	D 270		

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D 270	Continued From page 39 reports, and ED discharge summaries. -She did not see documentation of specific contact or requests from the facility for additional fall interventions for Resident #9. Attempted telephone interview with Resident #9's RP on 01/07/26 at 4:14pm was unsuccessful. Attempted telephone interview with Resident #9's PCP on 01/08/26 at 9:32am was unsuccessful. [Refer to Tag 276, 10A NCAC 13F .0902(c)(3-4) Health Care] 2. Review of Resident #1's most recent FL-2 dated 12/04/25 revealed: -Diagnoses included frontotemporal neurocognitive disorder, dementia with behavioral disorder, insomnia, restlessness and agitation, mixed incontinence, and gastrointestinal reflux disorder. -The recommended level of care was special care unit (SCU). -Resident #1 was constantly disoriented. -Resident #1 had wandering behaviors. -Resident #1 needed assistance with bathing and feeding. Review of Resident #1's Resident Register revealed: -Resident #1 was admitted to the facility 08/01/25. -Resident #1 had a guardian. Review of Resident #1's most recent care plan dated 09/03/25 revealed: -Resident #1's bowel function was documented as normal. -Resident #1 was always disoriented. -Resident #1 had significant memory loss and must be directed.	D 270		

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D 270	Continued From page 40 -Resident #1 required increased supervision to prevent ingestion of fluids. -Resident #1 required limited assistance with eating, toileting, bathing, dressing, and grooming. -Resident #1 was independent with ambulation and transferring. Review of primary care provider (PCP) documentation dated 11/20/25 for Resident #1 revealed: -Resident #1 would wander, eat her own feces, toilet paper and other non-food items. -Resident #1 had dementia and was not aware of her behavior. -Resident #1 could not communicate her needs. Review of facility progress notes for Resident #1 revealed: -There was documentation that Resident #1 put non-food items in her mouth on 11/02/25 including a Halloween pendant, small plastic/decorative hat, and a plastic shoe for a baby doll. -There was documentation that Resident #1 put non-food items in her mouth on 11/05/25 including toilet tissue. -There was documentation that Resident #1 put non-food items in her mouth on 11/07/25 including tissue and other paper items. -There was documentation on 11/08/25 that the provider was notified that Resident #1 had been observed eating toilet tissue, feces and other non-food items. -There was documentation that Resident #1 put non-food items in her mouth on 11/12/25. -There was documentation that Resident #1 put non-food items in her mouth on 11/18/25 including napkins and bathroom tissue. -There was documentation on 11/29/25 that Resident #1 was observed eating the feces of	D 270		

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D 270	Continued From page 41 another resident. -There was documentation that Resident #1 put "all kinds of objects and things in her mouth" on 12/12/25. -There was documentation that Resident #1 put "everything including food in her mouth" on 12/18/25. Observation of Resident #1 in the 500 hallway on 01/06/26 from 9:13-9:20am revealed: -Resident #1 was seen leaving room 507, she entered room 509, left room 509, entered room 508, left room 508, entered room 507, left room 507, attempted to enter 506, attempted to enter the soiled linen closet, entered an unmarked room, left the unmarked room, entered room 503, and left room 503. -Resident #1 was redirected by a personal care aide (PCA) in Room 503 at 9:20am. -Resident #1 held a doll as she moved in and out of the rooms. Observation of Resident #1 on 01/06/26 at 9:51am revealed: -Resident #1 was standing in the dining room near a countertop, chewing on a paper napkin product. -Resident #1 was within line of sight of the medication aide (MA) who was at the medication cart in the main living room area. -Resident #1 responded yes when a surveyor asked if she was chewing on a napkin. -Resident #1 followed two surveyors to the MA in the living room who removed the napkin from Resident #1's mouth. -The MA reported to surveyors that she had been trying to get the napkin away from Resident #1. Observation of Resident #1 on 01/07/26 from 9:23am to 9:25am revealed:	D 270		

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D 270	Continued From page 42 -Resident #1 was sitting in the main living room and put a piece of paper in her mouth. -A PCA was in the room with Resident #1 and other residents, but did not see Resident #1 put the paper in her mouth. -When the surveyor notified the PCA that Resident #1 had non-food item in her mouth the PCA removed the paper. -Resident #1 walked to the dining room unattended and drank liquid from a cup that was sitting on a table. -The same PCA was notified by the surveyor and she removed the cup, which was then empty. Observation of Resident #1 on 01/07/26 at 9:57am revealed Resident #1 had paper in her mouth and agreed to remove the paper from her mouth when staff prompted her. Observation on 01/08/26 at 9:04am revealed: -Resident #1 approached the surveyor and a PCA at the intersection of the 400 and 500 hallways. -Resident #1 was not wearing pants, but was wearing an incontinence brief. -Resident #1 was chewing on a button. -Resident #1's care needs were addressed by the PCA. Observation of Resident #1 on 01/08/26 at 11:18am revealed: -Resident #1 wandered into room 401, left room 401 chewing on something. -Resident #1 walked to the MA, and the MA removed paper from Resident #1's mouth. Interview with a PCA on 01/06/26 at 9:21am revealed: -Staff kept personal care products away from Resident #1 and kept doors locked. -Resident #1 was allowed to roam but was	D 270		

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D 270	Continued From page 43 monitored. -Resident #1 had gotten stuff and drank it. -Somebody was on hospice and Resident #1 got a product for hospice care and drank it. -She tried to drink a cleaning solution in the dining room; there was a bucket and a rag and she tried to drink the solution. -Resident #1 would chew on things like paper, plastic, a rag, or a sock. Second interview with the same PCA on 01/06/26 at 1:00pm revealed: -Resident #1 got paper or things from the floor or other residents' rooms, it was random. -Staff tried to get it out of Resident #1's mouth, but she could be resistant. -Staff had to be urgent, but not forceful with Resident #1. -Resident #1 would eat other residents' food. -Resident #1 was a "24-hour person"; when she was awake she needed someone watching her. -Staff did not have time to follow her around with other residents. Interview with a third PCA on 01/08/25 at 8:55am revealed: -There was a previous occasion where Resident #1 chewed on a pinecone, she would eat it, but staff got it and took it away. -Resident #1 never needed medical care that she knew of. -When she reported something, nothing was done. -She could not take care of Resident #1 all day because there were other residents. -Staff could not babysit Resident #1 every second. Interview with a second PCA on 01/08/25 at 9:54am revealed:	D 270		

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D 270	Continued From page 44 -Resident #1 would eat food packaging, stuff out of the trash, feces and toilet tissue. -She had not observed Resident #1 eat feces, but when she came back to work she heard about it. -She observed that when Resident #1 was receiving incontinence care she tried to touch the feces. Interview with a MA on 01/06/26 at 1:23pm revealed: -Earlier today she thought Resident #1 was eating toilet paper. -Staff tried to keep toilet paper from her all the time. -Resident #1 had the paper in her mouth no more than 5 minutes or so. -Resident #1 spit some out and walked away, she could not leave because she was at the medication cart, observing a situation with more than 6 residents; staff was not to leave groups 6 or more residents unattended. -Normally she would call the PCAs with the walkie talkie and then attempt to get the tissue. -The PCAs this morning were tending to residents who needed incontinence care. -Sometimes Resident #1 would resist care. -When Resident #1 walked away staff had to stop because Resident #1 would get agitated and would try to hurt staff. -Resident #1 did not have teeth but may try to bite or hit and could be very violent, but she was not like that all the time. Interview with a second MA on 01/07/26 at 10:53am revealed: -Resident #1 attempted to eat or chew on products every day. -Resident #1 may chew on a sock. -One day a hospice worker left iodine and Resident #1 drank some and was sent to the	D 270		

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D 270	Continued From page 45 hospital. -She had never completed other incident reports for Resident #1. Interview with the Special Care Coordinator (SCC) on 01/07/26 at 3:58 revealed: -Resident #1 put a lot of things that she shouldn't put in her mouth such as paper, toilet paper. -Resident #1 never ingested any cleaning products or sanitizers. -They tried to keep Resident #1 in the activity room, but every 30 minutes or so staff would try to get up and find Resident #1. -Resident #1 could get something in 10-15 minutes. -Checking every 30 minutes might not be enough to stop her. -Staff could not neglect all the residents for one resident. -There could be one-to-one monitoring overnight when everyone else was in bed. -The facility could not provide one on one monitoring during the daytime. -Staffing was according to the policy. -For the amount of residents in the SCU they could staff 2 PCAs plus an MA. -Resident #1 was assessed by another facility, but they could not take the resident. -Psychiatry declined to see Resident #1. -Resident #1's medications were adjusted. -Resident #1 would pack her mouth with whatever she could obtain and eating food did not stop the behavior. Interview with the Administrator on 01/07/25 at 5:02pm revealed: -Staff should check on Resident #1 every two hours. -Resident #1 was very mobile so she was sure they had eyes on her every two hours or more.	D 270		

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D 270	Continued From page 46 -If there was something going on that supervision would alleviate then more frequent checks would be provided. -Staff removed trashcans, décor including pinecones. -Resident #1 did not eat the pinecones but had them in her mouth. -Resident #1 would have had to get feces from the trash or from reaching into someone's brief, but she doubted that occurred. -The provider was consulted after that episode. -After the provider could not offer other interventions, further placement was sought. Telephone interview with the PCP for Resident #1 on 01/07/26 at 3:02pm revealed: -Resident #1 came from another facility and her medications were adjusted 5 or 6 times. -Resident #1 tried to eat everything. -Psychiatry refused to see Resident #1. -Resident #1 had taken feces from other residents and smeared it on the walls. -The interventions in place were care plans, one-hour checks, psychiatry evaluations. -One-hour checks meant that someone usually has eyes on her every hour or every two hours. -The facility met her expectations for supervision. -There was one mostly empty bottle of wound cleanser and Resident #1 was found with the bottle in August. -She had not received any other significant reports of ingestion. Interview with the Guardian for Resident #1 on 01/07/26 at 10:22am revealed -Resident #1's behavior was causing problems, touching other patients, taking their food. -The facility tried different care plans, and they had done what they could do to help her. -Instead of discharging Resident #1 immediately	D 270		

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D 270	Continued From page 47 they were willing to work with him on moving her. The facility failed to provide supervision and interventions for a resident, who was assessed as a fall risk upon admission, which resulted in the resident sustaining 17 falls from 11/20/25 to 12/31/25, with 3 falls occuring in a single day, resulting in six visits to the emergency department (#9), and supervision for one resident in the Special Care Unit who ingested non-food substances (#1). This failure of the facility to provide supervision of the residents resulted in substantial risk of physical harm and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/08/26 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 7, 2026.	D 270		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure physician	D 276	ED and SCC will discuss all orders received during the daily managers meeting to ensure timely follow up. Care Managers will utilize the order processing system to ensure orders have been completed prior to uploading into the EHR. Care managers will document in the EHR communication DME company and PCP all attempts to obtain equipment. PCP will be notified of any delays with an order and communication will be documented in the EHR.	2/27/26 2/27/26 2/27/26

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D 276	Continued From page 48 orders for fall mats were implemented for 1 of 7 sampled residents (#9) with a history of numerous falls. The findings are: Review of Resident #9's current FL-2 dated 11/17/25 revealed: -Diagnoses included muscle weakness, unsteadiness on feet, displaced fracture of right femur, cognitive communication deficit, and fibromyalgia. -The resident was semi-ambulatory. Review of Resident #9's Resident Register revealed: -She was admitted to the facility on 11/19/25. -She required assistance with dressing, bathing, ambulation, getting in and out of bed, and toileting. Review of Resident #9's care plan dated 12/17/25 revealed: -She was ambulatory with the aid of a wheelchair. -She had limited strength in the upper extremities. -She weakness in the lower extremities with limited range of motion. -She was occasionally incontinent of bowel and bladder. -She required assistance with all toileting needs. -She required limited assistance with ambulation/locomotion. -She required assistance with all bathing needs. -She required assistance with all dressing needs. -She required assistance with all grooming/personal/hygiene needs. -She required extensive assistance with transferring. Review of Resident #9's Fall Risk Admission	D 276		

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D 276	Continued From page 49 Evaluation dated 11/20/25 revealed: -The description was documented as admission evaluation. -Yes was documented as the answer for the question" have you fallen in the last year". -Yes was documented as the answer for the question "are you unsteady when walking or standing". -Yes was documented as the answer for the question "do you worry or have a fear of falling". -If yes was answered to any of the questions, a Fall Risk Banner is placed in Matrix Care, print and give to Therapy for Therapy Screening, a safety emblem is placed on name plate, and complete a Fall Intervention Care Plan. Review of an FL2 Medication Clarification form for Resident #9 dated 11/19/25 revealed: -There was a handwritten order for a hi-lo hospital bed, pads on the floor for safety X 2, and physical therapy for strengthening and balance. -The FL2 Medication Clarification form was signed by Resident #9's primary care provider (PCP) on 11/20/25. Review of Resident #9's facility progress notes revealed: -There was an entry on 11/24/25 at 6:37pm, new orders were received for a hi/lo bed, floor mat and physical therapy were received, the orders did not need clarification, the orders were sent to the third-party vendor, the resident's RP was notified. -There was an entry on 12/12/25 at 9:55am, faxed PCP to sign orders for resident to get equipment, on 12/17/25 paperwork was faxed again and on 12/22/25 paperwork was faxed again. -There was an entry on 12/24/25 at 10:12am, paperwork was given to her Responsible Party (RP) on 12/15/25 to take to PCP to sign, RP has	D 276		

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D 276	Continued From page 50 not returned paperwork yet. -There was an entry on 12/31/25 at 12:45pm, the PCP faxed over signed paperwork to get equipment from medical supply, paperwork was faxed to the durable medical equipment provider (DME) provider. Observations of Resident #9's room on 01/06/26 at 2:43pm revealed: -The resident was lying in a hospital bed on her right side with the half bedrails in the up position. -There was a wheelchair at the bedside. -There was no fall mat observed under or by her bed. Interview with Resident #9's on 01/06/26 at 2:43pm revealed: -She had not seen a fall mat in her room by her bed. -She was not sure what a fall mat was. Observation of Resident #9's room on 01/07/26 at 4:04pm revealed: -Resident #9 was sitting in her recliner beside her bed. -There was no fall mat visible by her bed or under her bed. Observation of Resident #9's room on 01/08/26 at 8:53am revealed: -The resident was in bed with half bed rails in the up position. -There was a seat lift recliner positioned in up position at the head of her bed. -There was no fall mat visible by her bed or under her bed. Interview with a medication aide (MA) on 01/07/26 at 10:57am revealed: -Resident #9 fell frequently because she would	D 276		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 51 not use to use call bell to call for assistance to get up. -Resident #9 had frequent falls, she had 3 falls in one day on 12/21/25. -She had never seen a fall mat in Resident #9's room. Interview with a second MA on 01/08/26 at 8:59am revealed she had never seen a fall mat in Resident #9's room. Interview with a personal care aide (PCA) on 01/07/26 at 4:29pm revealed: -Resident #9 had frequent falls, she would pull her call bell but would not wait for the PCA to respond. -She had never been instructed to check on Resident #9 more than every 2 hours, but she tried to since she fell so often. -She had never seen a fall mat in Resident #9's room but thought she needed one. Interview with a second PCA on 01/08/26 at 9:11am revealed: -Resident #9 did not have a fall mat. -She had never seen a fall mat in Reside t#9's room. Interview with a third PCA on 01/08/26 at 9:25am revealed: -Resident #9 fell daily. -She had never seen a fall mat in Resident #9's room. Interview with a fourth PCA on 01/08/26 at 10:32am revealed: -Resident #9 fell frequently because she tried to get up by herself without waiting for assistance. -She had never seen a fall mat in Resident #9's room but thought she could use one.	D 276		

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D 276	Continued From page 52 Interview with the Special Care Coordinator (SCC) on 01/08/26 at 10:54am revealed: -She covered the Assisted Living halls currently since there was no longer a Resident Care Coordinator (RCC) at the facility. -Resident #9 had frequent falls because she would not use her call bell and tried to transfer herself. -Resident #9's PCP ordered physical therapy, a hi/lo bed, and a fall mat on 11/20/25. -Resident #9 received physical therapy and she was in the process of trying to obtain the ordered fall mat for her but had difficulty reaching her PCP for the required paperwork. -Resident #9 had an outside provider and contact with their office was very difficult. -She had been trying to get the necessary paperwork for completed for Resident #9's fall mat. -She sent the signed 11/20/25 order for the fall mat to the local durable medical equipment provider (DME) provider and the DME provider sent paperwork back that had to be completed by Resident #9's PCP. -She faxed the paperwork for the fall mat to Resident #9's PCP for signature several times and had not received the singed paperwork back. -She also gave the fall mat paperwork to Resident #9's Responsible Party (RP) to physically take to her PCP for signature. -She was sure she had made phone calls to Resident #9's PCP's office about the fall mat paperwork but did not document the attempts. -The signed paperwork for Resident #9's fall mat had been received a few days ago and was sent to the DME provider and they were awaiting delivery. -It was frustrating to her that it took over a month to get the necessary paperwork back for Resident	D 276		

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D 276	Continued From page 53 #9's fall mat. Interview with the Administrator on 01/08/26 at 11:32am revealed: -Resident #9 used an outside provider and communication with their office was difficult. -She knew the SCC had faxed Resident #9's paperwork numerous times to the PCP and had given Resident #9's RP paperwork to take to her PCP for signature. -She was certain phone calls had been made to Resident 9's PCP in addition to the faxes to obtain the safety equipment for Resident # 9 but were not documented. Telephone interview with the Registered Nurse (RN) at Resident #9's PCP's office on 01/08/26 at 9:46am revealed: -Resident #9 was a high fall risk. -Resident #9 had a history of either sliding out of her wheelchair on the floor or sliding out of her bed onto the floor. -PT, a hi/lo hospital bed, and fall mats had been ordered for Resident #9 on 11/20/25. -There was no discontinue order issued for the fall mats for Resident #9. -Resident #9 should have fall mats in place. -She could not tell if paperwork had been received for Resident #9's fall mat, that would have been received by the PCP's medical assistant, and she would have the medical assistant return the call. Attempted telephone interview with the Medical Assistant at Resident #9's PCP's office on 01/08/26 at 9:46am was unsuccessful. Attempted telephone interview with Resident #9's PCP on 01/08/26 at 9:32am was unsuccessful.	D 276		

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D 276	Continued From page 54 Attempted telephone interview with Resident #9's RP on 01/07/26 at 4:14pm was unsuccessful.	D 276		
D 315	10A NCAC 13F .0905 (a & b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his or her will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to develop a program of activities to promote active involvement of the residents. The findings are: Observation of the facility on 01/06/26 at 8:30am revealed: -The was no activities calendar posted on the assisted living (AL) side of the facility. -There was no activities calendar posted in the special care unit (SCU). Observation of the activity room on the AL on 01/06/26 from 8:00am to 4:00pm revealed there were no activities done. Observation of the facility on 01/07/26 at 9:00am revealed:	D 315	ED will monitor the activities program during daily rounds to ensure activities are occurring as scheduled on the calendar. LEC will ensure the activity calendars is available and posted on the wall in both the AL and SCC units. LEC will communicate with the residents and update the posted calendar when an activity has been cancelled or changed. LEC will create a calendar that promotes the residents active involvement with each other, their families and the community.	2/27/26 2/27/26 2/27/26 2/27/26

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D 315	Continued From page 55 -The was no activities calendar posted on the AL side of the facility. -There was no activities calendar posted in the SCU. Interview with a resident on 01/06/26 at 9:15am revealed: -She lived in AL. -There were not many activities being offered in the facility. -There facility offered bingo to residents. -There was a volunteer that came to the facility that spent time and did activities with residents a couple times a week. -She would like to be offered more activities. Interview with the Maintenance Director on 01/07/26 at 2:30pm revealed he took the activities calendar down in order to paint the wall that the calendar was posted on. Interview with a second resident on 01/07/24 at 3:15pm revealed: -She lived on the AL. -The facility offered bingo to residents, but not much else. -They did not have multiple activities daily. -The facility did not have group outings for residents. -She would like the facility to offer more outings. Interview with a personal care aide (PCA) on 01/07/26 at 3:25pm revealed: -The December activities calendar was posted on the wall until the morning of 01/06/26. -The PCAs were supposed to do activities with residents when the activities director was not there. -There were not many activities being offered to residents.	D 315		

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D 315	Continued From page 56 Interview with the Special Care Coordinator (SCC) on 01/07/25 at 3:30pm revealed: -The Activities Director had been on leave for a week. -The medication aides (MA) usually did activities with residents on the SCU. -There were not enough activities being offered to residents on the AL. -AL residents complained about not having activities to do. Interview with the Executive Director (ED) on 01/07/26 at 3:40pm revealed: -The Activities Director was on leave. -She expected a minimum of 14 hours of activities to be offered to residents each week. -The facility scheduled 14 hours of activities, but 14 hours of activities were not being completed. -The Activities Director and other staff members had attendance problems making it difficult to offer activities to residents.	D 315		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications	D 358	ED and Care managers will review hospital discharge summaries and clarify an new orders, order changes or discontinued order with the PCP upon return to the community. Order changes will be sent to the pharmacy to ensure medications are being administered as ordered. ED and care managers will complete random chart audits weekly to ensure medications are being administered as ordered.	2/27/26 2/27/26 2/27/26

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D 358	Continued From page 57 were administered as ordered to 1 of 5 sampled residents (#4) including a medication used to treat insomnia, a medication used to thin the blood and prevent clotting, and a medication patch used to treat pain. The findings are: Review of Resident #4's current FL-2 dated 10/17/25 revealed diagnoses included hypertension, depression, general anxiety disorder, chronic embolism and thrombosis, and vascular dementia. a. Review of Resident #4's Physician Order Report dated 10/17/25 revealed an order for Eliquis 2.5mg 1 tablet daily (Eliquis is used to prevent blood clots, embolism, and thrombosis). Review of Resident #4's Discharge Summary from a local hospital dated 12/05/25 revealed an order to discontinue Eliquis 2.5mg. Review of Resident #4's December 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Eliquis 2.5mg give 1 tablet twice daily at 9:00am and 9:00pm. -Eliquis 2.5mg was administered at 9:00am and 9:00pm on 45 of 55 opportunities in December 2025. Review of Resident #4's January 2026 eMAR revealed: -There was an entry for Eliquis 2.5mg give 1 tablet twice daily at 9:00am and 9:00pm. -Eliquis 2.5mg was administered at 9:00am and 9:00pm on 10 of 12 opportunities in January 2026.	D 358		

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D 358	Continued From page 58 Observation of Resident #4's medications on hand on 01/07/25 at 11:15am revealed there was a bubble pack of Eliquis 2.5mg dispensed for a quantity of 28 on 1/1/26. Telephone interview with a pharmacist at the facility's contracted pharmacy on 01/07/25 at 3:07pm revealed the pharmacy was still dispensing Resident #4's Eliquis 2.5mg tablets because they had received no discontinue order from the facility. Telephone interview with Resident #4's primary care provider (PCP) on 01/07/25 at 4:47pm revealed: -She was not aware that Resident #4 was still receiving Eliquis 2.5mg twice daily. -Resident #4's Eliquis 2.5mg should have been discontinued when the order was received from the hospital. -Resident #4's Eliquis was discontinued because it increased her risk for bleeding and injury if she fell. b. Review of Resident #4's Physician Order Report dated 10/17/25 revealed an order for Diphenhydramine 25mg 1 tablet every night at bedtime (Diphenhydramine is an antihistamine medication that also treats insomnia). Review of Resident #4's Discharge Summary from a local hospital dated 12/05/25 revealed an order to discontinue Diphenhydramine 25mg. Review of Resident #4's December 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Diphenhydramine 25mg give 1 tablet at bedtime every night at 8:00pm. -Diphenhydramine 25mg was administered at	D 358		

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D 358	Continued From page 59 8:00pm on 23 of 26 opportunities in December 2025. Review of Resident #4's January 2026 eMAR revealed: - There was an entry for Diphenhydramine 25mg give 1 tablet at bedtime every night at 8:00pm. -Diphenhydramine 25mg was administered at 8:00pm on 5 of 6 opportunities in January 2026. Observation of Resident #4's medications on hand on 01/07/25 at 11:15am revealed Diphenhydramine 25mg was included in each 8:00pm multi-dose packet of medication. Telephone interview with a pharmacist at the facility's contracted pharmacy on 01/07/25 at 3:07pm revealed the pharmacy was still dispensing Resident #4's Diphenhydramine 25mg tablets because they had received no discontinue order from the facility. Interview with a medication aide (MA) on 01/08/25 at 8:45am revealed: -MAs did not send orders to the pharmacy. -The Special Care Coordinator (SCC) or Administrator sent new orders to the pharmacy including orders to discontinue medication. -She did not know that Resident #4's Eliquis and Diphenhydramine were supposed to be discontinued. Interview with the SCC on 01/08/25 at 9:20am revealed: -The orders to discontinue Eliquis and Diphenhydramine were missed by her and the Administrator when Resident #4 returned to the facility from the hospital. -The medications should have been discontinued as ordered.	D 358		

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D 358	Continued From page 60 Interview with the Administrator on 01/08/25 at 10:15am revealed: -She or the SCC reviewed any hospital discharge records for new orders and ensured orders reached the pharmacy. -They did not catch the discontinue orders for Eliquis or Diphenhydramine on 12/05/25 and she did not know why the orders were missed. Telephone interview with Resident #4's primary care provider (PCP) on 01/07/25 at 4:47pm revealed: -She was not aware that Resident #4 was still receiving Diphenhydramine 25mg at bedtime. -Resident #4's Diphenhydramine 25mg should have been discontinued due to the order received from the hospital. -She did not like using Diphenhydramine in the elderly population due to side effects and wanted the medication discontinued. c. Review of Resident #4's Physician Order Report dated 10/17/25 revealed an order for Lidocaine 4% patch apply 1 patch to lower back every day and remove after 12 hours (Lidocaine patch is used to treat pain). Review of Resident #4's December 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Lidocaine 4% patch apply to lower back at 9:00am and remove at 9:00pm every day. -Lidocaine 4% patch was applied at 9:00am and then removed at 9:00pm on 25 of 31 opportunities in December 2025. Review of Resident #4's January 2026 eMAR revealed:	D 358		

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D 358	Continued From page 61 - There was an entry for Lidocaine 4% patch apply to lower back at 9:00am and remove at 9:00pm every day. -Lidocaine 4% patch was applied at 9:00am and removed at 9:00pm on 5 of 6 opportunities in January 2026. Observation of Resident #4's medications on hand on 01/07/25 at 11:15am revealed there were 12 Lidocaine patches on the medication cart and Lidocaine 4% patches were dispensed for a quantity of 15 patches on 10/03/25. Telephone interview with a pharmacist at the facility's contracted pharmacy on 01/07/25 at 3:07pm revealed the pharmacy last dispensed Lidocaine 4% patches for a quantity of 15 patches on 10/03/25. Interview with Resident #4 on 01/08/25 at 10:30am revealed: -She denied having pain at present but said her back hurts sometimes. -She could not remember having a Lidocaine patch applied to her back for pain. Interview with a medication aide (MA) on 01/08/25 at 8:45am revealed: -MAs did not handle or process new orders. -New orders were processed by the Special Care Coordinator (SCC) or Administrator. -Resident #4's Lidocaine 4% patches were provided by the facility's contracted pharmacy and not by the family or another pharmacy. -She did not know why Resident #4's Lidocaine 4% patches were being documented as applied if they were not being utilized. Interview with the MCM on 01/08/25 at 9:20am revealed:	D 358		

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D 358	Continued From page 62 -Lidocaine 4% patch and all other medications should have been administered as ordered. -She did not know that staff were documenting the medication as administered but not actually applying the Lidocaine 4% patch to Resident #4's back. -Staff should never document administration of a medication if they did not administer it. Interview with the Administrator on 01/08/25 at 10:15am revealed: -She did not know staff were documenting administration of Resident #4's Lidocaine 4% patch but not applying the patch. -If Resident #4 was refusing application of the patch, the MAs should have notified her or the SCC so they could get an order to discontinue the patch. -Resident #4 had not complained of any pain, including back pain, to her knowledge. -All ordered medication should be administered per the orders and not documented unless administered. Telephone interview with Resident #4's primary care provider (PCP) on 01/07/25 at 4:47pm revealed: -She was not aware that Resident #4 was not receiving Lidocaine 4% patch to her lower back each day. -Lidocaine 4% patch was ordered for Resident #4's back pain caused by an old sacral fracture and kyphosis. -Facility staff should have been administering the Lidocaine 4% patch as ordered.	D 358		