STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD , KING, North Carolina, 27021

(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) COMPLETION DATE
E0006 SS = D	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan.	E0006	"Past Noncompliance - no plan of correction required"	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD , KING, North Carolina, 27021

(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) COMPLETION DATE
E0006 SS = D	Continued from page 1 The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This STANDARD is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to implement the emergency preparedness plan for elopement or unauthorized absence of a resident from the facility for 3 of the 3 staff members interviewed for implementation procedures during an elopement (Nurse Aide #1, Nurse Aide #2, and Nurse #2). The findings included: Documentation on an Elopement/unauthorized absence policy dated as last revised on 8/2/2024 revealed that in the event of a resident elopement the facility would implement its policies and procedures to locate the resident in a timely manner. The first step in the resident elopement/unauthorized absence procedure was to upon determining the resident cannot be located a headcount was to be conducted. If the resident was still missing “Code Green” using the resident name, room number, and unit name was to be announced three times. Resident #1 was admitted to the facility on 5/23/2025 with a diagnosis of dementia and an addiction to nicotine.	E0006		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD , KING, North Carolina, 27021

(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) COMPLETION DATE
E0006 SS = D	Continued from page 2 Receptionist #1 was interviewed on 6/30/2025 at 12:01 PM. Receptionist #1 explained that a part of her front desk responsibilities was to keep a written log of times the residents leave the building and the time they return inside. Receptionist #1 consulted her log and stated that on 6/3/2025, Resident #1 left the building at 8:54 AM and sat in front of the window in her view from her desk and reentered the building at 9:08 AM. Receptionist #1 stated Resident #1 told her she was going to her room to get a sweater. Receptionist #1 revealed she documented on the log that Resident #1 went back outside at 9:37 AM in her wheelchair on the other side of the front of the building so that she was not in the view of her desk. Nurse Aide (NA) #1 was interviewed on 6/30/2025 at 10:53 AM and relayed the following information as occurring on the morning of 6/3/2025 between 9:00 AM and 10:00 AM. NA #1 and NA #2 were giving a shower to a resident who required assistance from two people. NA #1 and NA #2 came out of the shower room, with the other resident, returned him to his room, and noted Resident #1 was standing at the nurses' station next to her wheelchair. NA #1 and NA #2 were in the other resident's room assisting him with care and exited his room together upon completion of care. Then, as NA #1 and NA #2 were walking down the hall, they noted Resident #1 was not in her room. NA #1 and NA #2 went to look in the therapy room to see if she was in there, and they did not find her. NA #1 and NA #2 knew that Resident #1 liked to sit outside, so they went to the front of the building. NA #1 and NA #2 asked Receptionist #1 if she had seen Resident #1. Receptionist #1 told NA #1 and NA #2 that Resident #1 was sitting outside in her wheelchair. NA #1 and NA #2 went outside and saw Resident #1's empty wheelchair in the front of the building. NA #1 and NA #2 went back into the building and ran back to the hall to tell Nurse #2 that Resident #1 was missing. After speaking to Nurse #2, NA #1 and NA #2 ran to the back of the building and out the door to look for Resident #1 in all the doorways and parking lots around the building. NA #1 explained that as a nurse aide if she discovers a resident was missing, she must immediately report this to a nurse who was then supposed to call a code Green over the loudspeaker. NA #2 was interviewed on 6/30/2025 at 11:25 AM. NA #2 explained the same series of events as happened on the morning of 6/3/2025 that NA #1 had relayed in her interview. NA #2 stated that anybody can call a code Green if a resident was missing. NA #2 further stated that the nurse aides are supposed to tell the nurse in the hall if a resident was missing so that the nurse	E0006		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD , KING, North Carolina, 27021

(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) COMPLETION DATE
E0006 SS = D	Continued from page 3 can do what needs to be done. Receptionist #1 was interviewed on 6/30/2025 at 12:01 PM and relayed the following events. NA #1 and NA #2 came to the front of the building and asked Receptionist #1 if she knew where Resident #1 was. Receptionist #1 told them she was sitting outside in the front of the building in her wheelchair. NA #1 and NA #2 hurried back into the building after checking outside, saying Resident #1 was not in front of the building. NA #1 and NA #2 ran to the back of the building. Receptionist #1 then received a phone call from either a family member or a friend of Resident #1 telling her that Resident #1 was at a nearby store getting cigarettes. The caller also told Receptionist #1 they were going to call the police. The Business Office Manager came to Receptionist #1's desk and asked her what was happening. After telling the Business Office Manager about the phone call, the Business Office Manager told the Maintenance Director to come with her in her car and run outside to the parking lot. The Business Office Manager was interviewed on 6/30/2025 at 10:39 AM and provided the following information. The Business Office Manager overheard Receptionist #1 talking with someone with alarm and concern in her voice, so she went to Receptionist #1's desk to find out what was happening. The Business Office Manager asked Receptionist #1 if the facility had a resident at the nearby store. The Receptionist lowered the phone and told her it was Resident #1. The Business Office Manager grabbed her car keys, saw the Maintenance Director, and told him to get in her car. When the Business Office Manager got to her car she saw NA #1 and NA #2 running around the side of the building, and the Maintenance Director was still in front of the building. The Business Office Manager told NA #1 and NA #2 to get in her car, realizing that the only reason they would be outside of the building was to look for Resident #1. The Business Office Manager drove her car up the road and saw Resident #1 standing on the grass on the left-hand side of the road, approximately half a mile from the facility. The Business Office Manager parked her car in a parking lot across the street. NA #1 and NA #2 exited the vehicle, crossing the street to get to Resident #1. Resident #1 was in a good mood and confirmed she was not injured. NA #1 and NA #2 assisted Resident #1 into her vehicle, and they all returned to the facility. As they pulled into the facility, a police car pulled in after them, stopping only momentarily to make sure they had Resident #1. Documentation in a nursing progress note dated 6/3/2025	E0006		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD , KING, North Carolina, 27021

(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) COMPLETION DATE
E0006 SS = D	Continued from page 4 at 10:35 AM written by Nurse #2 revealed the following information. Nurse #2 spoke with Resident #1's daughter advising her that Resident #1 left the front part of the building to walk to the local store to obtain cigarettes. Resident #1 was transported back to the facility by staff with a police escort. Resident #1 was assessed with no acute injuries. Nurse #2 was interviewed on 6/30/2025 at 10:18 AM. Nurse #2 explained that NA #1 and NA #2 ran to her on 6/3/2025 and told her Resident #1 was missing. Nurse #2 stated she locked her medication cart and ran to the front of the building to discover the Business Office Manager was running out the door to retrieve Resident #1 from the nearby store. Nurse #2 revealed she waited outside in front of the building with Resident #1's wheelchair, and when she returned, Nurse #2 did a quick assessment to be sure she was not injured. Nurse #2 then returned Resident #1 to her room to complete a full assessment to include neurological checks, skin assessment, and vital signs. Nurse #2 revealed she had a long talk with Resident #1, who explained to her she just wanted to get some cigarettes and smoke. Nurse #2 discovered from Resident #1 that she had called somebody who was not her daughter and told them she was going to the nearby store for cigarettes despite not having any money. Nurse #2 confirmed she called Resident #1's family members to tell them of the morning events and that Resident #1 was okay. Nurse #2 stated that the events surrounding the elopement of Resident #1 happened so quickly that there was not time to enact a code Green. The facility Administrator was interviewed on 6/30/2025 at 2:06 PM. The Administrator revealed she was notified of Resident #1 leaving the facility on 6/3/2025 while she was in a morning meeting at the facility. The Administrator stated there was only a couple of minutes between the time the facility realized Resident #1 was missing and the Business Office Manager retrieving her. The Administrator confirmed a head count was completed after Resident #1 returned to the facility with no unaccounted-for residents and at that point a code Green was not necessary. The facility provided the following corrective action plan with a completion date of 6/4/2025. 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 6/3/25 Resident #1 had an unsupervised departure	E0006		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD , KING, North Carolina, 27021

(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) COMPLETION DATE
E0006 SS = D	Continued from page 5 from the facility. She walked down the side of a two-lane road to obtain cigarettes from a local grocery store. Resident #1 was visualized going outside on to the covered porch to drink coffee around 8:54am and was observed around 9:37am going back outside after getting a sweatshirt. The receptionist received a phone call from the resident's family member stating Resident # 1 had called her to report that she was walking to the store to obtain cigarettes. The business office manager and two certified nurse assistants got into a vehicle and observed resident #1 walking on the side of the road. Resident #1 got into the vehicle with staff and returned to the facility at approximately 10:00am. A licensed nurse completed a head-to-toe assessment on resident #1 and no injuries were noted. The provider was notified, and an order was obtained to place a wander guard alarm, and resident #1 was also placed on 1:1 supervision by facility staff as an immediate intervention to keep resident safe. Resident #1 remained on 1:1 staff supervision until she was discharged on 6/5/25 to an Assisted Living Facility that allowed smoking. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 6/3/25 when the facility was made aware that resident #1 had departed the building unsupervised the director of nursing completed an immediate head count of other residents in the facility, all other residents were accounted for. The maintenance director immediately checked door alarms and the wander guard system. Doors and the wander guard system were found to be in working order. The director of nursing and nurse managers reviewed current residents with a wander guard alarm to ensure that their wander guards were in place and functioning correctly. No issues were identified. The director of nursing or designee reviewed all residents in the facility for changes in behaviors and completed another elopement assessment. There were no other residents newly identified at risk for elopement. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Beginning 6/3/25 the director of nursing or designee educated all staff in the facility on the facility elopement policy. 1. Upon discovery that a resident	E0006		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD , KING, North Carolina, 27021

(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) COMPLETION DATE
E0006 SS = D	Continued from page 6 cannot be located a head count will be conducted. If the resident is still missing a “code green” is to be announced on the facility paging system to alert all staff to assist in locating the missing resident. 2. The clinical supervisor will notify the Administrator, the Director of nursing and the attending physician. 3. The highest-ranking staff member will become the team leader and coordinate the search. 4. The team leader will maintain documentation during the search process. 5. The floor plan will be used to ensure a thorough search of the interior. 6. If the resident is not located on the premises the team lead will direct staff to conduct an external search. The team leader will notify the family/legal representative and inquire as the potential whereabouts of the resident. 7. If the resident is not located on the premises the Administrator will notify the local emergency response agencies. The elopement policy also states that an elopement assessment is to be completed on admission, quarterly and as needed. Staff were also educated to report new or increased behaviors to nurse management. If a resident is designated as at risk for elopement that should be added to the elopement books at the receptionist desk and at each nurses’ station. On 6/3/25 nurse management was educated by the regional director of clinical services to review new and increased behaviors for the need to complete a new elopement assessment during clinical morning meeting. Nurse management was also educated to review the resident diagnosis for dementia and other cognitive impairment and review with the interdisciplinary team to include the administrator, director of nursing, medical records, nurse managers, social workers, therapy director, environmental services director admission coordinator, minimum data set coordinator, and medical director, to discuss other assessments to determine cognition and the need for elopement interventions. No staff will work until they have received this education. On 6/3/25 the administrator informed the scheduler to ensure all agency staff receive the education prior to working. The administrator informed the payroll coordinator they are to ensure all new hired staff receive the education during new hire orientation 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Include dates when corrective action will be completed. On 6/3/25 a Quality Assurance and Performance Improvement (QAPI) meeting was held by the interdisciplinary team, and the decision was made to	E0006		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD , KING, North Carolina, 27021

(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) COMPLETION DATE
E0006 SS = D	Continued from page 7 initiate audits for 12 weeks. On 6/3/25 the Administrator informed the maintenance director the week of 6/4/25 he will conduct a weekly elopement drill to ensure the facility responds to an elopement per company policy. Elopement drills will be conducted on first, second, and third shift and include the weekends. Beginning the week of 6/8/25 the administrator or designee will audit 3 newly admitted resident records to ensure the elopement assessment was completed, if there were behaviors noted in the resident records they were addressed by nursing and elopement interventions were discussed by the interdisciplinary team. Audits will be reviewed weekly in the QAPI meeting and changes to the plan of correction will be made as needed. Compliance date of 6/4/2025 Validation of the corrective action plan was completed on 7/1/2025. The facility assessed all residents for risk for elopement and put interventions in place to ensure the safety of Resident #1 and all at risk residents. The facility staff were educated on the facility elopement policy and the steps to perform when a resident was thought to be missing. The facility initiated audits and elopement drills to confirm the education was retained by the staff for implementation of the elopement policy. The compliance date of 6/4/2024 was validated.	E0006		
F0000	INITIAL COMMENTS The survey team entered the facility on 6/30/2025 to conduct a complaint investigation and exited on 7/1/2025. Additional information was obtained on 7/2/2025. The survey team returned to the facility on 7/7/2025 and 7/8/2025 to investigate an additional intake and to conduct a partial extended survey. Additional information was obtained on 7/9/2025 and 7/11/2025. Therefore, the exit date was changed to 7/11/2025. Event ID # HLJ011. The following intakes were investigated 870137 and 870059. Intake 870137 resulted in immediate jeopardy. Past Non-compliance was identified at: CFR 483.25 at tag F689 at a scope and severity J The tag F689 constituted Substandard Quality of Care. A partial extended survey was conducted. Two of the two complaint allegations resulted in a	F0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD , KING, North Carolina, 27021

(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) COMPLETION DATE
F0000	Continued from page 8 deficiency.	F0000		
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to protect a severely cognitively impaired resident's right to be free from physical and verbal abuse. During care on 6/26/2025 Nursing Assistant (NA) #5 held the resident's arms down on the bed, told him to "shut up", and put her gloved hand over Resident #4's mouth while assisting with incontinence care. This deficient practice occurred for 1 of 2 residents reviewed for abuse (Resident #4). The findings included: Resident #4 was admitted on 8/5/202 with the diagnosis of non-Alzheimer's dementia. The quarterly Minimum Data Set dated 5/6/2025 revealed Resident #4 was severely cognitively impaired and was dependent on staff to turn in bed, with activities of daily living and incontinence care. Resident #4 did not refuse care and had no behavior towards staff. The most recent care plan, revised 3/7/2025, revealed Resident #4 had cognitive loss related to dementia. The goal was to provide positive experiences in his daily routine without overly demanding tasks and to avoid	F0600	"Past Noncompliance - no plan of correction required"	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD , KING, North Carolina, 27021

(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) COMPLETION DATE
F0600 SS = D	Continued from page 9 causing stress by anticipating and meeting Resident #4's needs. He was incontinent of bowel and bladder. The goal was that Resident #4 would not experience complications related to his incontinence. The interventions were for the nursing staff to assist with toileting, hygiene, and transfers as needed. A telephone interview was completed on 7/8/2025 at 3:37 PM with NA #7. NA #7 explained on the night of 6/26/2025 she arrived at work at 11:00 PM and took over NA #5's resident assignments. NA #5 voiced to NA 7 that she had done her incontinent care at 8:00 PM. During the rounds, NA #7 stated residents assigned to NA #5 were either wet or soiled. NA #7 further explained that she instructed NA #5 to provide incontinence care for Resident #4 before clocking out. NA #5 was agitated and instructed NA #6 to assist her in providing care to Resident #4. NA #7 observed that NA #6 was tearful at the nursing station, but she did not know the reason. NA #5 did not mention any abuse. During a telephone interview on 7/9/2025 at 8:31 AM, NA #8 stated that NA #5 left residents wet or soiled at the change of shift at 11:00PM. NA #7 went to check the residents assigned to NA #5 and found them to be soiled or wet. NA #7 instructed NA #5 to provide incontinent care for Resident #4 before she clocked out. NA #5 was talking under her breath and rolling her eyes. She took NA #6 and completed the incontinent care for Resident #4. After the care was completed, NA #5 was at the nursing station, and she was angry and speaking loudly. NA #6 was crying and did not say that NA #5 had abused Resident #4. A telephone interview on 7/8/2025 at 1:05 PM with NA # 6 revealed that she was working with NA #5 on 6/26/2025 during second shift (3:00 PM -11:00 PM). NA #7 and NA #8 arrived at work for the third shift (11:00 PM - 7:00 AM), and during the rounds, NA #7 stated that there were residents who were not dry. NA #7 instructed NA #5 to provide incontinence care for Resident #4. NA #6 stated that she and NA #5 and went to Resident #4's room to provide incontinent care. NA #6 indicated NA# 5 held Resident #4's arms down because he flailed his arms during care. NA #6 recalled NA #5 voiced, "Sometimes you have to be aggressive with them." Resident #4 "growled", and NA #5 told him to "Shut up." NA #6 stated that Resident #4 was lying on his side, and she had turned her back to retrieve a washcloth from the nightstand. When she turned around, NA #5 quickly removed her gloved hand from over Resident #4's mouth, and they finished his care and covered him with	F0600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD , KING, North Carolina, 27021

(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) COMPLETION DATE
F0600 SS = D	Continued from page 10 a blanket. NA #5 did not know if Resident #4's mouth was touched. NA #6 stated she was shocked by NA #5's behavior. Review of a facility submitted investigation report 6/27/2025 specified an allegation of abuse for Resident #4 that occurred on 6/26/2025. The allegation was reported by NA #6 to the facility Administrator on 6/27/25. Nurse Aide #5's handwritten note dated 6/30/2025 indicated that she held Resident #4's arms down due to the resident being combative and trying to hit. NA #5 denied that she put her hand over his mouth. During a telephone interview on 7/11/2025 at 9:13 AM, NA #5 stated that on 6/26/2025, she was behind on her incontinent rounds and had not completed Resident #4's incontinent care. She worked on the same hall as NA #6, and they provided care for Resident #4. NA #5 stated that Resident #4 didn't like to have incontinent care, and he hit and scratched during care. NA #5 stated she tried to explain to Resident #4 that she was going to change him. NA #5 stated she "gently" held his arms to the bed while he was lying on his back. NA #6 pulled the incontinent product from under him and Resident #4 had completely saturated the bed. NA #5 stated that he was soaked because she couldn't get to him earlier in the shift because she helped NA #6 with her assignment. She denied that she told Resident #4 to shut up or that she put her hand over his face. NA #5 indicated she usually did rounds after dinner and at 10:30 PM. During a telephone interview on 7/8/2025 at 2:29 PM Nurse #7 stated he was the nurse during the evening shift on 6/26/2025 and was not told about the abuse by NA #6. He did not observe any behavior from NA #6 that gave him an indication that she had observed abuse. Nurse #7 indicated he did not observe behavior from NA #5 that was out of the ordinary, it was a normal evening shift. He had not heard any residents cry out while NA #5 was providing care. An interview with the Director of Nursing (DON) on 7/8/2025 at 12:23 PM stated that nursing assistants from the third shift (11:00 PM to 7:00 AM) had complained that NA #5 did not like to do rounds and that she had left residents soiled who needed incontinence care at the beginning of the shift. The DON recalled that she had provided NA #5 with	F0600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD , KING, North Carolina, 27021

(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) COMPLETION DATE
F0600 SS = D	Continued from page 11 reeducation for not providing care but was not sure. NA #6 reported to the DON on 6/27/2025 around 3:40 PM that she had observed NA #5 physically and verbally abusing Resident #4 on 6/26/25 and that NA #5 held her hand over Resident #4's mouth. NA #6 also reported NA #5 told Resident #4 to shut up during care. NA #5 was immediately suspended and never returned to work at the facility. Resident #4 was not interviewable and had a head-to-toe body assessment, and there were no injuries. There was no change in Resident #4's behavior. The facility started an investigation 6/27/2025. A skin assessment was conducted by Nurse #4 on 6/27/2025 at 3:27 PM with Resident #4 after an allegation of abuse. No injury was noted. An interview on 7/8/2025 at 11:10 AM with Nurse #4 was completed. Nurse #4 stated on 6/27/2025 that she assessed Resident #4 head to toe for new injuries. Resident #4 was at his baseline and had no injuries. During an interview on 7/8/2025 at 11:15 AM, NA #8 revealed that Resident #4 did not hit staff during incontinence care; he verbally objected. On 7/8/2025 at 4:21 PM, the Administrator stated that the investigation they conducted was unsubstantiated for abuse because they did not find any proof of abuse. The facility provided the following corrective action plan with a compliance date 6/28/25. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? On 6/27/2025 Certified Nursing Assistant (CNA) #6 reported allegation of abuse to the Director of Nursing (DON). The Director of Nursing notified the Administrator. The Director of Nursing called CNA # 5 (the accused staff member), suspended her, and took her statement regarding incident. The Nursing Home Administrator (NHA) notified the Police Department, Adult Protective Services and submitted an initial allegation to the Department of Health Services Regulation. The DON started abuse education for staff who were present in the facility to include dealing with behaviors exhibited by the resident in question.	F0600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD , KING, North Carolina, 27021

(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) COMPLETION DATE
F0600 SS = D	Continued from page 12 Nurse #4 performed head- to-toe assessment of Resident #4 with no negative findings noted. Nurse #4 notified the Provider with no new orders and notified Resident #4's responsible party. The Administrator interviewed CNA #5 and obtained her statement. CNA #6 was educated on the Abuse Policy and reporting by the DON on 6/27/2025. NHA provided emotional support for Resident #4 who was calm and had no recollection of any incident How will the facility identify other residents having the potential to be affected by the same deficient practice? To identify like residents that have the potential to be affected the Director of Nursing/Designee completed skin checks on residents with BIMS less than 12 for any signs and symptoms of abuse. No negative findings noted. The NHA/Designee interviewed residents with BIMS of 12 or above if they are aware of or have experienced any abuse. No negative findings noted. These interviews and observations were completed by 6/27/2025. On 6/27/25 the Interdisciplinary Team (IDT), which consists of the Director of Nursing, Administrator, Nurse Managers, Social Worker (SW), Dietary Manager, and Minimum Data Set Coordinator, reviewed residents with behaviors during their resident review meeting. Any resident identified with behaviors making them more at risk for abuse were reviewed by the interdisciplinary team and interventions were updated on the resident care plan and staff are informed of new interventions during pre-shift huddles. What measures will be put into place or systemic changes be made to ensure that the deficient practice will not occur? To prevent this from happening again on 6/27/25 the DON/Designee was notified by the Administrator to educate all current staff on the abuse policy and reporting. Education included recognizing signs of burn-out, frustration, stress and appropriate interventions to deal with aggressive residents. If staff recognized burn out, they are to report to their supervisor. Staff will be educated annually to prevent abuse and also periodically throughout their employment. Any staff not working received the education prior to working their first shift. Agency staff will be educated upon first shift working. Newly hired staff will be educated with the onboarding procedure. The Director of Nursing is responsible for ensuring all current staff are educated on the abuse and neglect policy and the Social Worker is responsible for ensuring new hired staff are educated during the	F0600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD , KING, North Carolina, 27021

(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) COMPLETION DATE
F0600 SS = D	Continued from page 13 onboarding process, the Scheduler is responsible for ensuring all agency staff receive the education. Previous to 6/27/25, the Payroll Coordinator was only verifying dates of employment with previous employers. On 6/27/25 the Administrator educated the Payroll Coordinator to obtain reference checks and request additional performance information. How will the facility monitor its corrective actions to ensure the deficient practice will not recur? The Administrator and Director of Nursing discussed Resident #4 and the allegation of abuse on 6/27/2025 and determined to have ADHOC Quality Assurance Process Improvement (QAPI) meeting. ADHOC QAPI was held on 6/27/2025 with the Interdisciplinary team to discuss the incident with Resident #4 and educate the team on the interventions that were put into place to prevent further incidents. The Medical Director was notified by the Director of Nursing via phone on 6/27/2025 regarding the abuse allegation and what interventions that were put in place for Resident #4 and the plan of correction to prevent abuse. The Director of Nursing implemented the plan of correction to prevent abuse on 6/27/2025. To monitor and maintain ongoing compliance the SW/Designee will interview 2 residents with BIMS of 12 weekly, if they are aware of any concerning behavior of staff that may lead to abuse. DON/Designee will observe 2 staff on rotating shifts performing care for any signs of abuse weekly. Audits will continue for 12 weeks. Any negative findings will be followed by the Administrator. The Interdisciplinary team will review and provide recommendations on the audit results provided by the Director of Nursing and or Designee during the QAPI meeting for the next 3 months to ensure sustained compliance. If noncompliance is identified during these three months, immediate correction, re-education to staff members and an ADHOC QAPI meeting will be held to address the noncompliance and make recommendations for adjustments to the plan. The Administrator and Director of Nursing will ensure the corrective action plan is implemented. Alleged Date of Compliance 6/28/2025 The facility's corrective action plan was validated on 7/7/2025 by validating the following:	F0600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD , KING, North Carolina, 27021

(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) COMPLETION DATE
F0600 SS = D	Continued from page 14 - NA#5 was suspended pending investigation and never returned to work. - Interviews with staff in all departments verified they were educated and were able to articulate abuse policy, abuse prevention, and recognizing signs of burn-out, frustration, stress and appropriate interventions to deal with aggressive residents. In addition, staff stated if they recognized burn-out in themselves or another staff member they would report it to their supervisor. - Facility provided records of residents who were interviewed to determine if they were aware of or had experienced any abuse. - Review of facility records revealed all residents with a BIMS score of 12 or less had a head-to-toe assessment for injury by the DON with the nursing staff. - The facility provided evidence they had conducted audits of staff providing care and the SW/Designee completed interviews with residents with a BIMS score of 12 or greater as specified in the corrective action plan. - Inclusion in QAPI was verified. The corrective action plan compliance date of 6/28/25 was validated.	F0600		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services	F0609	"Past Noncompliance - no plan of correction required"	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD , KING, North Carolina, 27021

(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) COMPLETION DATE
F0609 SS = D	Continued from page 15 where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to implement their abuse policy and procedure in the area of reporting when Nursing Assistant (NA) #6 failed to immediately report she had observed NA #5 physically and verbally abuse Resident #4 when NA #5 held the resident's arms down on the bed, told him to "shut up" and put her gloved hand over Resident #4's mouth while providing incontinence care for 1 of 2 residents reviewed for abuse (Resident #4). The findings included: The facility policy for Abuse, Neglect and Exploitation, last reviewed on 7/11/2024, revealed the following statement: All allegations of abuse, neglect, involuntary seclusion, injuries of unknown source, and misappropriation of resident property must be reported immediately to the Administrator and Director of Nursing (DON). Review of the investigation report specified an allegation of abuse for Resident #4 that occurred on 6/26/2025 at about 11:00 PM. This allegation was reported by NA #6 to the facility Administrator on 6/27/25 at 3:40 PM. NA# 6 observed NA #5 put her hand over Resident #4 mouth without "any type of force" and told him to "shut up." NA #5 was immediately suspended and skin checks completed on Resident #4. Interviews with alert and oriented residents were conducted by the facility. NA #6 was reeducated on timely reporting. A telephone interview on 7/8/2025 at 1:05 PM with NA # 6 revealed that she was working with NA #5 on 6/26/2025 during second shift (3:00 PM -11:00 PM). NA #7 and NA #8 arrived at work for the third shift (11:00 PM - 7:00 AM), and during the rounds, NA #7 stated that there	F0609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD , KING, North Carolina, 27021

(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) COMPLETION DATE
F0609 SS = D	Continued from page 16 were residents who were not dry. NA #7 instructed NA #5 to provide incontinence care for Resident #4. NA #6 stated that she and NA #5 and went to Resident #4's room to provide incontinent care. NA #6 indicated NA# 5 held Resident #4's arms down because he flailed his arms during care. NA #6 recalled NA #5 voiced, "Sometimes you have to be aggressive with them." Resident #4 "growled", and NA #5 told him to "Shut up." NA #6 stated that Resident #4 was lying on his side, and she had turned her back to retrieve a washcloth from the nightstand. When she turned around, NA #5 quickly removed her gloved hand from over Resident #4's mouth, and they finished his care and covered him with a blanket. NA #6 stated she was shocked by NA #5's behavior and went home and told her family member what had happened. The family member told NA #6 to tell the facility. She indicated that she was a new nursing assistant graduate, and she hated confrontation, and she was afraid that NA #5 might say something to her if she said anything about what she saw. The next day, she reported what she saw to Scheduler. NA #6 further stated she was educated during orientation on abuse, and she couldn't remember who to tell. NA#6 explained that she felt very comfortable who to report abuse and when to report abuse. Now that she had gone through this situation and had been reeducated. She was shocked by NA#5 behavior towards the resident and told the Scheduler because she was comfortable with her. During a telephone interview on 7/11/2025 at 9:13 AM, NA #5 stated that on 6/26/2025, she was behind on her incontinent rounds and had not completed Resident #4's incontinent care. She worked in the same hall as NA #6, and they provided care for Resident #4. NA #5 stated that Resident #4 didn't like to have incontinence care, and he hit and scratched during care. NA #5 stated she tried to explain to Resident #4 that she was going to change him. NA #5 said she "gently" held his arms to the bed while he was lying on his back. NA #6 pulled the incontinent product from under him and Resident #4 had completely saturated the bed. NA #5 stated that he was soaked because she couldn't get to him earlier in the shift because she helped NA #6 with her assignment. She denied that she told Resident #4 to "shut up" or that she put her hand over his face. NA #5 indicated she usually did rounds after dinner and at 10:30 PM. During a telephone interview on 7/8/2025 at 2:29 PM Nurse #7 stated he was the nurse during the evening shift on 6/26/2025 and was not told about the abuse by NA #6. He did not observe any behavior from NA #6 that gave him an indication that she had observed abuse. Nurse #7 indicated he did not observe behavior from NA #5 that was out of the ordinary, it was a normal	F0609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD , KING, North Carolina, 27021

(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) COMPLETION DATE
F0609 SS = D	Continued from page 17 evening shift. He had not heard any residents cry out while NA #5 was providing care. An interview was conducted on 7/27/2026 at 2:58 PM with the Scheduler, who stated that NA #6 came into her office on 6/27/2025 around 3:45 PM and expressed she needed to talk. The Scheduler stated NA #6 shut the door and proceeded to explain the incident involving Resident #4 that had occurred on the night of 6/26/2025. NA #6 explained she had helped NA #5 with care the previous and NA #5 told Resident #4 to shut up. The Scheduler had NA #6 stop explaining, and both (Scheduler and NA #6) went directly to speak with the Director of Nursing (DON). During an interview with DON on 7/8/2025 at 12:23 PM, she stated that Nursing Assistants from the 3rd shift had complained that NA #5 did not like to do rounds and that she had residents who required incontinence care at the beginning of the shift change. The DON stated she thought that she had provided NA #5 with reeducation for not providing care but was not sure. NA #6 reported to the DON on 6/27/2025 around 3:40 PM that she had observed NA #5 physically and verbally abusing Resident #4 on 6/26/25 and that NA #5 held her hand over Resident #4's mouth. NA #6 also reported to the DON that NA #5 told Resident #4 to shut up during care. The DON explained that NA #6 was immediately reeducated to report any abuse immediately to the supervisor. The DON stated Resident #4 was not interviewable and underwent a head-to-toe body assessment; there were no injuries observed or noted Resident #4 did not exhibit any changes in behavior. The facility started an abuse investigation on 6/27/2025. On 7/8/2025 at 4:21 PM, the Administrator was interviewed and stated that all abuse should be reported to her immediately. The Administrator further expressed that she was informed by the Director of Nursing of the abuse allegation on 6/27/2025. The facility provided the following corrective action plan with a compliance date of 6/28/25. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? On 6/27/2025, Certified Nursing Assistant #6 reported an allegation of abuse that happened the night before to the Director of Nursing. The Director of Nursing	F0609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD , KING, North Carolina, 27021

(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) COMPLETION DATE
F0609 SS = D	Continued from page 18 notified the Administrator. The Director of Nursing called CNA #5 (the accused staff member), suspended her, and took her statement regarding the incident. The NHA notified the Police Department, Adult Protective Services, and submitted an initial allegation to the Department of Health Services Regulation. The DON started abuse education for staff who were present in the facility. Nurse #1 performed a head-to-toe assessment of Resident #4 with no negative findings noted. Nurse # 1 notified the Provider with no new orders given and notified Resident #4's responsible party. The Administrator interviewed CNA #6 and obtained her statement. CNA #6 was educated on the Abuse Policy to include immediate reporting of suspected abuse by the DON on 6/27/2025. NHA provided emotional support for Resident #4, who was calm and had no recollection of any incident. NA #5 informed the Director of Nursing that she resigned from her position on 7/2/25. How will the facility identify other residents having the potential to be affected by the same deficient practice? On 6/27/25, the social worker or designee interviewed all alert and oriented residents to determine if they were aware of any abuse. The Director of Nursing or designee performed a skin check on all non-alert residents. The Director of Nursing/Designee interviewed all staff to determine if they were aware of any abuse that had not been reported. These interviews and observations were completed by 6/27/2025. No other maltreatment was identified as not reported. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur? To prevent this from happening again, the DON/Designee educated current staff on the abuse policy, including immediately reporting abuse to the administrator. This education was completed on 6/27/2025. Any staff member not working received the education before working their first shift. Agency staff were educated on first shift working. Newly hired staff to the facility will be educated on the onboarding procedure. The scheduler is responsible for ensuring all agency staff are educated, and Human Resources is responsible for ensuring that all newly hired staff are educated. How will the facility monitor its corrective actions to ensure the deficient practice will not recur?	F0609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD , KING, North Carolina, 27021

(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) COMPLETION DATE
F0609 SS = D	Continued from page 19 To monitor and maintain ongoing compliance, the DON/Designee will interview two staff members if they have any knowledge of abuse that has not been reported, and if they know when abuse should be reported, weekly for 12 weeks. Any negative findings will be followed immediately by the Administrator. The Administrator and Director of Nursing discussed Resident #4's allegation of abuse on 6/27/2025 and determined to have an ADHOC Quality Assurance Process Improvement (QAPI) meeting. ADHOC QAPI was held on 6/27/2025 with the Interdisciplinary team to discuss the incident with Resident #4 and educate the team on the interventions that were put into place to prevent further incidents. The Medical Director was notified by the Director of Nursing via phone on 6/27/2025 regarding the abuse allegation and the interventions that were put in place for Resident #4 and the plan of correction for late abuse reporting. The Director of Nursing implemented the plan of correction for late abuse reporting on 6/27/2025. The Interdisciplinary team will review and provide recommendations on the audit results provided by the Director of Nursing and or Designee during the QAPI meeting for the next 3 months to ensure sustained compliance if supposed noncompliance was identified during these three months. In that case, immediate correction, re-education to staff members, and an ADHOC QAPI meeting will be held to address the noncompliance and make recommendations for adjustments to the plan. The Administrator and Director of Nursing will ensure the corrective action plan is implemented. Alleged Date of Compliance: 6/28/2025 The facility's corrective action plan was validated on 7/7/2025 by validating the following: - NA#5 was suspended pending investigation and never returned to work. - Interviews with staff verified that staff were educated and were able to articulate who to report abuse to and when to report abuse. - Facility-provided records of residents who were interviewable and were interviewed about abuse that they did not report to the social worker. - Facility records revealed that non-interviewable residents had head-to-toe assessments for injury by the	F0609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD , KING, North Carolina, 27021

(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) COMPLETION DATE
F0609 SS = D	Continued from page 20 DON with the nursing staff. - Facility records revealed nursing, dietary, housekeeping, activity and maintenance departments were reeducated by the DON on the abuse policy, with an emphasis on reporting. - The facility provided evidence they had conducted audits with two random staff members to verify who to report abuse to and when to report abuse by the DON or designee. - Documents were prepared to continue with future audits of residents for unreported abuse. - The QAPI IDT team was to discuss compliance with reporting abuse by the DON, verified with documents. The corrective action plan compliance date of 6/28/25 was validated.	F0609		
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and staff, family member, Resident, Physician Assistant, and Medical Director interviews, the facility failed to provide supervision for Resident #1 who had a diagnosis of dementia, an addiction to cigarettes, and required supervision/touching assistance for walking 10 feet. Resident #1 left the facility unnoticed and unattended, walking along the side of a 35 mile an hour two-lane road to obtain cigarettes at a nearby store. Resident #1 was located approximately 1/2 mile away from the facility standing in a grassy field near the side of the road. The walking route to where the resident was located included an upward sloping sidewalk, a downward sloping sidewalk with a pond to the left, and then a dirt path that ended at the edge of the grassy field.	F0689	"Past Noncompliance - no plan of correction required"	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD , KING, North Carolina, 27021

(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) COMPLETION DATE
F0689 SS = SQC-J	Continued from page 21 Resident #1 did not have a phone, money or means to pay for cigarettes and stated she had hoped someone at the store would be kind enough to give her a cigarette and a lighter. There was a high likelihood of a serious adverse outcome for Resident #1 who had a diagnosis of dementia when she left the facility unsupervised to obtain cigarettes and was walking along the side of a 35 mile an hour two-lane road. The deficient practice occurred for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #1). Findings included: Documentation on a hospital discharge summary for the hospitalization of Resident #1 from 5/15/2025 to 5/23/2025 provided the following information. Resident #1 had the life limiting illness of progressive dementia. Resident #1 resided with Family Member #2 before her hospitalization. Resident #1 had required more help with activities of daily living over the last few months and had declining memory. Resident #1 had a fall at home resulting in fractured multiple ribs on the left side and occipital hematoma. Resident #1 was to start taking five 0.5 milligrams (mg) tablets of haloperidol (an antipsychotic medication) orally at bedtime for the treatment of agitation. Resident #1 was to stop taking 21 mg of nicotine every 24 hours, in the form of a transdermal patch. Resident #1 was admitted to the facility on 5/23/2025 from the hospital with diagnoses of closed fracture of multiple ribs on the left side, dementia, chronic obstructive pulmonary disease, and chronic kidney disease. Resident #1 was not admitted to the facility with an initial diagnosis of agitation. Resident #1's Family Member #1 was interviewed on 6/30/2025 at 4:43 PM. Family Member #1 revealed Resident #1 had dementia and was a strong-willed person. Family Member #1 further revealed Resident #1 could not read and ambulated with a shuffling gait. An interview was conducted with the Director of Admissions on 7/1/2025 at 8:46 AM and she provided the following information. Resident #1 had previously been admitted to the facility in September 2024 for 14 days. Resident #1 did not have any issues with the non-smoking policy of the facility during her previous admission in 2024. The hospital liaison, who requested a bed offer on behalf of Resident #1 to the facility for the most recent admission, was aware the facility was a smoke free facility. The Director of Admissions reiterated and explained to Resident #1 upon admission that the facility was a smoke free facility. Resident	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD , KING, North Carolina, 27021

(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) COMPLETION DATE
F0689 SS = SQC-J	Continued from page 22 #1 completed her own admission paperwork. In addition, the family members of Resident #1 agreed Resident #1 was cognizant enough to complete her own admission paperwork. The Director of Admissions explained all the paperwork to Resident #1, and she seemed to understand. The Director of Admissions went over the non-smoking policy of the facility with Resident #1 who responded with acknowledgment that she already knew that. The Director of Admissions revealed Resident #1 was discussed during the morning meeting when she was first admitted because she was trying to get out of the building to go outside to smoke. The Director of Admissions was not aware Resident #1 did not know how to read and felt Resident #1 had answered questions appropriately. Documentation on admission observations completed on 5/23/2025 at 1:35 PM by Nurse #2 revealed Resident #1 had no identified risks for elopement. The admission observations indicated Resident #1 did not have any diagnoses indicating cognitive impairment. In addition, admission observations noted Resident #1 was a current smoker but intended to remain non-smoking. Documentation on the baseline care plan initiated 5/23/2025 listed a care plan problem for admission of Resident #1 to the facility for skilled care. One of the approaches under this care plan problem was for wandering, stating Resident #1 would be monitored to minimize the risk of wandering or eloping. Resident #1 had a physician's order initiated on 5/23/2025 for 0.5 milligrams of haloperidol to be administered orally in the amount of 5 tablets for a total of 2.5 mg at bedtime for the diagnosis of dementia, unspecified severity, with other behavioral disturbance. An interview was conducted with the weekend Receptionist #2 on 7/1/2025 at 9:17 AM, and the following information was revealed. The first weekend Resident #1 was at the facility (5/24/2025-5/25/2025), she came to the front of the building wanting to go out the front door. Receptionist #2 did not allow Resident #1 to go outside and told her she would have to contact her nurse to make sure it was okay. Resident #1 became very argumentative and took a swing at Receptionist #1. Resident #1 left very angry to return to her room because she was not allowed outside by Receptionist #2. An interview was conducted with the Activity Director on 7/1/2025 at 11:07 AM and the following information was obtained. The only activity Resident #1 participated in while she was at the facility was the	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD , KING, North Carolina, 27021

(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) COMPLETION DATE
F0689 SS = SQC-J	Continued from page 23 coffee and snack cart every Tuesday. The only thing Resident #1 was interested in doing was smoking. The Activity Director brought the coffee and snack cart to the room of Resident #1 on the first Tuesday (5/27/2025) she was at the facility. Resident #1 told the Activity Director that she drank a pot of coffee every morning and smoked while she drank coffee. The Activity Director stated that she saw Resident #1 in the parking lot smoking in a car with her family members the first week Resident #1 was at the facility, noting this was against the rules of the facility. An interview was conducted with the facility's Social Worker on 7/1/2025 at 10:17 AM, and the following information was revealed. The facility had an interdisciplinary meeting/care plan meeting on 5/27/2025, during which input from Resident #1 and Resident #1's family members was considered as a part of the process for new admissions. Resident #1 was reminded that she was not allowed to smoke on the facility property, but family members could come and take her off the facility property if she wanted to smoke. Resident #1 was not happy about the facility's non-smoking policy and refused the offer for nicotine patches or nicotine gum. Resident #1's family members relayed to the Social Worker that Resident #1 was a smoker, and they could not come to the facility all the time to take Resident #1 off the property to smoke. Resident #1's family members requested that an alternate placement be found for Resident #1. The Unit Manager for the hall in which Resident #1 resided, Nurse #5, was interviewed on 7/1/2025 at 3:07 PM. Nurse # 5 stated that when Resident #1 was initially admitted to the facility, it was suspected she was smoking in the bathroom because staff reported they smelled smoke in her bathroom. Nurse #5 revealed that Resident #1 told him she had been smoking since she was 13 years old, and she was going to die smoking because she was addicted, and it was hard to stop. Nurse #5 indicated Resident #1 was discussed in the morning clinical meetings because everyone was not sure she should be allowed outside on her own due to her cognition. Nurse #5 stated Resident #1 was usually alert and oriented to herself but had some confusion. An interview was conducted with Nurse Aide (NA #3) on 6/30/2025 at 4:11 PM. NA #3 revealed he worked the 3:00 PM to 11:00 PM shift on the hallway where Resident #1 resided. NA # 3 revealed the first week Resident #1 was in the facility, a nurse found Resident #1 with a lighter and took it away from her. NA #1 could not remember which nurse it was. NA #3 stated he recalled getting a report from a nurse aide who worked the 7:00	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD , KING, North Carolina, 27021

(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) COMPLETION DATE
F0689 SS = SQC-J	Continued from page 24 AM to 3:00 PM shift that Resident #1 was suspected of smoking in her bathroom because they smelled smoke in her bathroom. NA #3 reported that Resident #1 would get very frustrated at times because she wanted to try to get out the front door, but the doors lock after 5:00 PM and would not open without a code. NA #3 revealed that Resident #1 would tell him she wanted to go outside to go home to smoke. Documentation in a Situation, Background, Appearance, and Review (SBAR) dated 5/28/2025 at 3:15 PM for Resident #1, written by Nurse #4, revealed the situation or change in condition was “increased agitation.” The SBAR further revealed in the nursing notes portion of the document, “Resident (#1) had increased agitation on wanting to smoke a cigarette. The floor nurse offered to get Resident (#1) a nicotine patch. Resident (#1) kept stating she would just leave and walk home and started to pack her belongings. Family notified and stated they would come in and talk with Resident (#1).” Nurse #4 was interviewed on 7/1/2025 at 10:39 AM, and she revealed the following information. On 5/28/2025 Resident #1 was trying to get outside to smoke. Resident #1 had previously been suspected of lighting a cigarette in her bathroom on the 7:00 AM to 3:00 PM shift on that day. Staff said they smelled cigarette smoke in her bathroom, and Resident #1 was quickly flushing something down the toilet when she was confronted. A search in her belongings for cigarettes or a lighter was not conducted because Resident #1 was an alert and oriented resident. Nurse #4 explained that the Physician Assistant (PA) #1 was made aware and an order for the antipsychotic Haloperidol administered intramuscularly for Resident #1 was obtained. Resident #1 was irate and wanted to go outside to smoke. A Family Member #2 was called by Nurse #4, and she could not come to the building, so another Family Member #3 was sent to try to calm Resident #1 down. Nurse #4 had already stayed past the end of the shift, ending at 3:00 PM, to try to calm Resident #1 down, so she left before the arrival of Family Member #3. The Director of Nursing (DON) and Nurse #3 were assisting to try to calm Resident #1 down. Nurse #4 spoke with Resident #1 the following day, 5/29/2025. Resident #1 told Nurse #4 that she was so mad she was not allowed to go out and smoke the previous day, she threw her cell phone at Family Member #3 and broke it. Resident #1 told Nurse #4 she was sorry because she no longer had a functional phone. The DON was interviewed on 6/30/2025 at 12:15 PM. The DON revealed she witnessed part of a confrontation	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD , KING, North Carolina, 27021

(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) COMPLETION DATE
F0689 SS = SQC-J	Continued from page 25 Resident #1 had with Family Member #3 next to the front office. The DON stated the argument was about cigarettes, and Resident #1 was being very physical. The DON indicated Resident #1 put her hands around the neck of Family Member #3, and Family Member #3 threw her hands down fast from her neck. The DON did not recall what day it was that she witnessed the confrontation. Nurse #3 was interviewed on 6/30/2025 at 12:18 PM. Nurse #3 revealed PA #1 was contacted on 5/28/2025 because Resident #1 was getting very agitated. Nurse #3 revealed the provider gave an order for 5 milligrams (mg) of haloperidol lactate to be administered intramuscularly (IM) via syringe every two hours as needed. Nurse #3 revealed Resident #1 did not receive the IM haloperidol on that day because it was decided she would be given her scheduled 2.5 mg tablets of haloperidol by mouth earlier, instead of at bedtime. Nurse #3 added that if Resident #1 had been allowed to smoke, she would have been fine. PA #1 was interviewed on 6/30/2025 at 2:04 PM. PA #1 explained that Resident #1 was having early symptoms of dementia such as sundowning while she was at the facility. PA #1 revealed she was notified by the Unit Manager, Nurse #5, that Resident #1 was showing physical aggression, agitation, and combativeness. PA #1 further explained Resident #1 did not have a formal diagnosis of dementia, but it was suspected she had underlying dementia. PA #1 stated Resident #1 was very agitated because she was not allowed to smoke so the order for haloperidol was for her suspected dementia and her agitation. Documentation on a care plan problem area initiated on 5/29/2025 revealed that Resident #1 had impaired cognitive function, impaired thought process relative to a diagnosis of dementia. The interventions were: use of simple, direct statements during communication to ensure resident understood; provision of cueing and prompting to ensure resident made attempts about own care before offering assistance; provision of a calm and relaxing environment; monitoring/observation and reporting changes in cognitive status; medication per physician orders; laboratory tests per physician orders; explanation of each activity/care procedure prior to beginning it and throughout procedure; establishment of daily routine; ensure resident's physiological needs were met; completion of BIMS (Basic Interview Mental Status) with MDS (Minimum Data Set) schedule and as needed; and anticipation of needs and observe for non-verbal cues.	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD , KING, North Carolina, 27021

(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) COMPLETION DATE
F0689 SS = SQC-J	Continued from page 26 Documentation on a care plan problem area initiated on 5/29/2025 revealed Resident #1 had a health and safety risk relative to smoking. The interventions under this problem were to ensure Resident #1 was aware of the no smoking policy in the community, consultation with a medical professional for the possible use of transdermal nicotine patches to facilitate quitting, encouragement to express feelings/frustrations, and offering of a smoking cessation program. Documentation on the admission Minimum Data Set (MDS) assessment dated 5/30/2025 revealed Resident #1 was coded as cognitively intact. Resident #1 was coded as having non-Alzheimer's dementia, depression, and nicotine dependence on the assessment. The same assessment coded Resident #1 as having physical behaviors one to three days, verbal behaviors one to three days, rejection of care one to three days, and wandering behavior one to three days of the assessment period. Resident #1 was coded as using a walker and a wheelchair requiring supervision/touching assistance for walking 10 feet. The assessment coded Resident #1 as currently using tobacco. The Verification of Receipt of the Resident Handbook for the facility was signed by Resident #1 on 5/30/2025. The signature of Resident #1 verified she received a copy of the resident handbook that gave information pertaining to the rules of the facility, to include the no smoking policy on the facility property. Documentation on a care plan problem area initiated on 6/1/2025 revealed that Resident #1 required a supervised leave of absence related to dementia and impaired mobility. The interventions under this care plan problem were the education of the resident and/or family members on leave of absence policy/procedure, obtaining an order for leave of absence indicating either supervised or unsupervised leave of absence, and Resident #1's family/friend/responsible party to sign resident in or out and notify the nurse when leaving and returning with resident. An interview was conducted with the Speech Therapist #1 on 6/30/2025 at 4:35 PM. Speech Therapist #1 stated she knew Resident #1 had a diagnosis of dementia. Speech Therapist #1 relayed that on 6/2/2025, Resident #1 asked her to take her to the nearby store to get cigarettes. Speech Therapist #1 explained she told Resident #1 she was not allowed to take her from the building and reminded her of the facility no-smoking policy. Speech Therapist #1 stated she did not call a family member to tell her of the plan Resident #1 had to go to the nearby store to get cigarettes.	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD , KING, North Carolina, 27021

(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) COMPLETION DATE
F0689 SS = SQC-J	Continued from page 27 Documentation in an MDS progress note dated 6/3/2025 at 9:01 AM, written by Nurse #1, revealed the following information. Resident #1 had wheeled herself independently outside to the front of the building with a cup of coffee. Nurse #1 informed Resident #1 that she would have to sign out if she was leaving the building, and she verbalized her understanding. Nurse #1 visualized Resident #1 park her wheelchair and lock the wheels. Nurse #1 made the staff aware that Resident #1 was outside. Nurse #1 was interviewed on 6/30/2025 at 9:57 AM. Nurse #1 confirmed she saw Resident #1 outside in front of the building on 6/3/2025. Nurse #1 revealed she informed the Director of Nursing and the Administrator at the morning stand-up meeting that Resident #1 was outside, sitting in the front of the building. Nurse #1 said she also sent an electronic message at 8:57 AM to alert the leadership that Resident #1 was outside, for which Nurse #5, the unit manager, reacted to the alert with a thumbs up. Nurse #2 was interviewed on 6/30/2025 at 10:18 AM and revealed the following information. Nurse #2 recalled she saw Resident #1 on the morning of 6/3/2025 with her coffee cup in her room during her morning medication administration pass. As the nurse aides were picking up the breakfast trays from the resident rooms, a therapist (Occupational Therapist (OT) #1) asked Nurse #2 where Resident #1 was. Nurse #2 told OT #1 that she did not know where Resident #1 was. OT #1 was interviewed on 6/30/2025 at 11:19 AM. OT #1 stated she was looking for Resident #1 on the morning of 6/3/2025, but she was not in her room. OT #1 stated she went on to provide therapy services to another resident and did not look for Resident #1. OT #1 revealed that later that day when she saw Resident #1, she told her she had left the building to obtain cigarettes at a nearby store. OT #1 indicated she had no knowledge of Resident #1's absence from the facility prior to that. OT #1 also indicated Resident #1 was a very independent person who was able to do all her activities of daily living but required supervision. OT #1 explained that Resident #1 was very motivated to do therapy, progressed quickly, and was cooperative. Receptionist #1 was interviewed on 6/30/2025 at 12:01 PM. Receptionist #1 explained that a part of her front desk responsibilities was to keep a written log of times the residents leave the building and the time they return inside. Receptionist #1 consulted her log and stated that on 6/3/2025, Resident #1 left the	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD , KING, North Carolina, 27021

(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) COMPLETION DATE
F0689 SS = SQC-J	Continued from page 28 building at 8:54 AM and sat in front of the window in her view from her desk and reentered the building at 9:08 AM. Receptionist #1 stated Resident #1 told her she was going to her room to get a sweater. Receptionist #1 revealed she documented on the log that Resident #1 went back outside at 9:37 AM in her wheelchair on the other side of the front of the building so that she was not in the view of her desk. Nurse Aide (NA) #1 was interviewed on 6/30/2025 at 10:53 AM and relayed the following information as occurring on the morning of 6/3/2025 between 9:00 AM and 10:00 AM. NA #1 and NA #2 were giving a shower to a resident who required assistance from two people. NA #1 and NA #2 came out of the shower room, with the other resident, returned him to his room, and noted Resident #1 was standing at the nurses' station next to her wheelchair. NA #1 and NA #2 were in the other resident's room assisting him with care and exited his room together upon completion of care. Then, as NA #1 and NA #2 were walking down the hall, they noted Resident #1 was not in her room. NA #1 and NA #2 went to look in the therapy room to see if she was in there, and they did not find her. NA #1 and NA #2 knew that Resident #1 liked to sit outside, so they went to the front of the building. NA #1 and NA #2 asked Receptionist #1 if she had seen Resident #1. Receptionist #1 told NA #1 and NA #2 that Resident #1 was sitting outside in her wheelchair. NA #1 and NA #2 went outside and saw Resident #1's empty wheelchair in the front of the building. NA #1 and NA #2 went back into the building and ran back to the hall to tell Nurse #2 that Resident #1 was missing. After speaking to Nurse #2, NA #1 and NA #2 ran to the back of the building and out the door to look for Resident #1 in all the doorways and parking lots around the building. NA #1 stated that Resident #1 was dressed in a purple sweatsuit and shoes on the morning of 6/3/2025. NA #2 was interviewed on 6/30/2025 at 11:25 AM. NA #2 explained the same series of events as happened on the morning of 6/3/2025 that NA #1 had relayed in her interview regarding Resident #1 leaving the facility. Receptionist #1 was interviewed on 6/30/2025 at 12:01 PM and relayed the following events. NA #1 and NA #2 came to the front of the building and asked Receptionist #1 if she knew where Resident #1 was. Receptionist #1 told them she was sitting outside in the front of the building in her wheelchair. NA #1 and NA #2 hurried back into the building after checking outside, saying Resident #1 was not in front of the building. NA #1 and NA #2 ran to the back of the building. Receptionist #1 then received a phone call	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD , KING, North Carolina, 27021

(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) COMPLETION DATE
F0689 SS = SQC-J	Continued from page 29 from either a family member or a friend of Resident #1 telling her that Resident #1 was at a nearby store getting cigarettes. The caller also told Receptionist #1 they were going to call the police. The Business Office Manager came to Receptionist #1's desk and asked her what was happening. After telling the Business Office Manager about the phone call, the Business Office Manager told the Maintenance Director to come with her in her car and run outside to the parking lot. The Business Office Manager was interviewed on 6/30/2025 at 10:39 AM and provided the following information. The Business Office Manager overheard Receptionist #1 talking with someone with alarm and concern in her voice, so she went to Receptionist #1's desk to find out what was happening. The Business Office Manager asked Receptionist #1 if the facility had a resident at the nearby store. The Receptionist lowered the phone and told her it was Resident #1. The Business Office Manager grabbed her car keys, saw the Maintenance Director, and told him to get in her car. When the Business Office Manager got to her car she saw NA #1 and NA #2 running around the side of the building, and the Maintenance Director was still in front of the building. The Business Office Manager told NA #1 and NA #2 to get in her car, realizing that the only reason they would be outside of the building was to look for Resident #1. The Business Office Manager drove her car up the road and saw Resident #1 standing on the grass on the left-hand side of the road, approximately half a mile from the facility. The Business Office Manager parked her car in a parking lot across the street. NA #1 and NA #2 exited the vehicle, crossing the street to get to Resident #1. Resident #1 was in a good mood and confirmed she was not injured. NA #1 and NA #2 assisted Resident #1 into her vehicle, and they all returned to the facility. As they pulled into the facility, a police car pulled in after them, stopping only momentarily to make sure they had Resident #1. The following observations were made outside on 7/1/2025 at 8:25 AM of the route, walking environment, and road speed limit taken by Resident #1 to the nearby store based on the information provided by the Business Office Manager on 6/30/2025 at 10:39 AM. Resident #1 would have had to start on an upward sloping sidewalk after exiting the facility. The sidewalk passed by a downward sloped area with a pond off to the left. Directly after the pond, the sidewalk ended, and a dirt path continued next to a forest of trees close to the road. The dirt path was uneven and continued to gradually slope uphill. After approximately a 15 to 20 minute walk, the dirt path ended at the edge of a	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD , KING, North Carolina, 27021

(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) COMPLETION DATE
F0689 SS = SQC-J	Continued from page 30 grassy field, where Resident #1 was located on the morning of 6/3/2025. Beyond the grassy field, another 10-minute walk, was a shopping center with parking lots and intersecting roads. The posted speed limit on the road next to the facility was 35 miles per hour. Documentation on a historical weather data website revealed on 6/3/2025 there was no precipitation and temperatures at 9:00 AM were 69 degrees Fahrenheit in the location of the facility. Documentation in a nursing progress note dated 6/3/2025 at 10:35 AM written by Nurse #2 revealed the following information. Nurse #2 spoke with Resident #1's daughter advising her that Resident #1 left the front part of the building to walk to the local store to obtain cigarettes. Resident #1 was transported back to the facility by staff with a police escort. Resident #1 was assessed with no acute injuries. Nurse #2 was interviewed on 6/30/2025 at 10:18 AM. Nurse #2 explained that NA #1 and NA #2 ran to her on 6/3/2025 and told her Resident #1 was missing. Nurse #2 stated she locked her medication cart and ran to the front of the building to discover the Business Office Manager was running out the door to retrieve Resident #1 from the nearby store. Nurse #2 revealed she waited outside in front of the building with Resident #1's wheelchair, and when she returned, Nurse #2 did a quick assessment to be sure she was not injured. Nurse #2 then returned Resident #1 to her room to complete a full assessment to include neurological checks, skin assessment, and vital signs. Nurse #2 revealed she had a long talk with Resident #1, who explained to her she just wanted to get some cigarettes and smoke. Nurse #2 discovered from Resident #1 that she had called somebody who was not her daughter and told them she was going to the nearby store for cigarettes despite not having any money. Nurse #2 confirmed she called Resident #1's family members to tell them of the morning events and that Resident #1 was okay. Resident #1 was interviewed on 7/1/2025 at 1:37 PM. Resident #1 confirmed she recalled the events of 6/3/2025 when she tried to walk to a nearby store from the facility. Resident #1 stated, "I've lost some of my [curse word] mind, but not all of it." Resident #1 confirmed she did not have a phone, and she was not injured on that day. Resident #1 denied she called her family on 6/3/2025 and would have "cussed out" who notified the facility she left the facility on that day. Resident #1 explained she was good at walking and all she wanted was a cigarette. Resident #1 acknowledged she did not have any money or means of	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD , KING, North Carolina, 27021

(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) COMPLETION DATE
F0689 SS = SQC-J	Continued from page 31 paying for cigarettes that day, and she did not know how she was going to obtain cigarettes on that day. Resident #1 indicated she had hoped someone at the store would have been kind enough to give her a cigarette and a lighter. Family Member #1 was interviewed on 7/1/2025 at 8:28 AM. Family Member #1 revealed Resident #1 had been smoking since she was 13 years old, and prior to her hospitalization, she smoked a pack of cigarettes a day or every two days. Family Member #1 also revealed that Resident #1 was not allowed to smoke when she was in the hospital, but it was not a problem. Family Member #1 confirmed Resident #1 had no means of paying for cigarettes and did not have a personal phone on 6/3/2025. Family Member #2 was interviewed on 7/1/2025 at 2:43 PM. Family Member #2 revealed she was out of town when she was called by the facility on 6/3/2025, notifying her that Resident #1 had left the facility on her own to try to obtain cigarettes. Family Member #2 said the facility asked her to come to the facility because Resident #1 was very upset that she could not go to the nearby store. Family Member #2 said Resident #1 had only one thought, and that was how she was going to get a cigarette that day. The DON was interviewed on 6/30/2025 at 8:15 AM. The DON explained that the facility was a smoke-free facility, and the family of Resident #1 was aware of this before she was admitted. The DON stated that Resident #1's family and Resident #1 both said she would not smoke while she was at the facility, or they would take her off the property to smoke. The DON further explained that staff members who smoke or residents who were smokers at the time of the transition to a non-smoking facility, had to go to the edge of the facility property and stand in a field to smoke. The DON confirmed there was no smoking on the facility property to include the parking lot. The DON acknowledged that Resident #1 was adamant about smoking cigarettes and refused any nicotine gum or patches after she was admitted. The DON also acknowledged that Resident #1 was not safe to walk by herself outside. The DON explained that Resident #1 was alert and oriented and had a strong personality, so multiple conversations were had with the family to try to resolve the issue of the facility being smoke-free. The facility Administrator was interviewed on 7/1/2025 at 1:17 PM. The Administrator stated Resident #1 had a plan and she was aware she did not have any money on 6/3/2025. The Administrator stated that Resident #1	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD , KING, North Carolina, 27021

(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) COMPLETION DATE
F0689 SS = SQC-J	Continued from page 32 told her she was going to have someone give her a cigarette at the local store. The facility Medical Director was interviewed on 7/7/2025 at 11:16 AM. The Medical Director stated that he saw Resident #1 one time upon admission. The Medical Director relayed that he knew cognition was an issue for Resident #1, as she had sufficient cognitive skills to leave the building undetected with a purposefully executed plan, but lacked the cognitive skills to realize it was a poor decision. The facility was notified of the immediate jeopardy on 7/1/2025 at 4:00 PM. The facility provided the following corrective action plan: 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 6/3/25 Resident #1 had an unsupervised departure from the facility. She walked down the side of a two-lane road to obtain cigarettes from a local grocery store. Resident #1 was visualized going outside on to the covered porch to drink coffee around 8:54am and was observed around 9:37am going back outside after getting a sweatshirt. The receptionist received a phone call from the resident's family member stating Resident # 1 had called her to report that she was walking to the store to obtain cigarettes. The business office manager and two certified nurse assistants got into a vehicle and observed resident #1 walking on the side of the road. Resident #1 got into the vehicle with staff and returned to the facility at approximately 10:00am. A licensed nurse completed a head-to-toe assessment on resident #1 and no injuries were noted. The provider was notified, and an order was obtained to place a wander guard alarm, and resident #1 was also placed on 1:1 supervision by facility staff as an immediate intervention to keep Resident #1 safe. Resident #1 remained on 1:1 staff supervision until she was discharged on 6/5/25 to an Assisted Living Facility that allowed smoking. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 6/3/25 when the facility was made aware that	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD , KING, North Carolina, 27021

(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) COMPLETION DATE
F0689 SS = SQC-J	Continued from page 33 resident #1 had departed the building unsupervised the director of nursing completed an immediate head count of other residents in the facility, all other residents were accounted for. The maintenance director immediately checked door alarms and the wander guard system. Doors and the wander guard system were found to be in working order. The director of nursing and nurse managers reviewed current residents with a wander guard alarm to ensure that their wander guards were in place and functioning correctly. No issues were identified. The director of nursing or designee reviewed all residents in the facility for changes in behaviors and completed another elopement assessment. There were no other residents newly identified at risk for elopement. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Beginning 6/3/25 the director of nursing or designee educated all staff in the facility on the facility elopement policy. 1. Upon discovery that a resident cannot be located a head count will be conducted. If the resident is still missing a “code green” is to be announced on the facility paging system to alert all staff to assist in locating the missing resident. 2. The clinical supervisor will notify the Administrator, the Director of nursing and the attending physician. 3. The highest-ranking staff member will become the team leader and coordinate the search. 4. The team leader will maintain documentation during the search process. 5. The floor plan will be used to ensure a thorough search of the interior. 6. If the resident is not located on the premises the team lead will direct staff to conduct an external search. The team leader will notify the family/legal representative and inquire as the potential whereabouts of the resident. 7. If the resident is not located on the premises the Administrator will notify the local emergency response agencies. The elopement policy also states that an elopement assessment is to be completed on admission, quarterly and as needed. Staff were also educated to report new or increased behaviors to nurse management. If a resident is designated as at risk for elopement that should be added to the elopement books at the receptionist desk and at each nurses’ station. On 6/3/25 nurse management was educated by the regional director of clinical services to review new and increased behaviors for the need to complete a new elopement assessment during clinical morning meeting. Nurse management was also educated to review the resident diagnosis for dementia and other cognitive	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD , KING, North Carolina, 27021

(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) COMPLETION DATE
F0689 SS = SQC-J	Continued from page 34 impairment and review with the interdisciplinary team to include the administrator, director of nursing, medical records, nurse managers, social workers, therapy director, environmental services director admission coordinator, minimum data set coordinator, and medical director, to discuss other assessments to determine cognition and the need for elopement interventions. No staff will work until they have received this education. On 6/3/25 the administrator informed the scheduler to ensure all agency staff receive the education prior to working. The administrator informed the payroll coordinator they are to ensure all new hired staff receive the education during new hire orientation 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Include dates when corrective action will be completed. On 6/3/25 a Quality Assurance and Performance Improvement (QAPI) meeting was held by the interdisciplinary team, and the decision was made to initiate audits for 12 weeks. On 6/3/25 the Administrator informed the maintenance director the week of 6/4/25 he will conduct a weekly elopement drill to ensure the facility responds to an elopement per company policy. Elopement drills will be conducted on first, second, and third shift and include the weekends. Beginning the week of 6/8/25 the administrator or designee will audit 3 newly admitted resident records to ensure the elopement assessment was completed, if there were behaviors noted in the resident records they were addressed by nursing and elopement interventions were discussed by the interdisciplinary team. Audits will be reviewed weekly in the QAPI meeting and changes to the plan of correction will be made as needed. The alleged date of immediate jeopardy removal and compliance was 6/4/2025. Validation of the corrective action plan was completed on 7/7/2025. The immediate jeopardy removal plan was validated by onsite verification through facility staff interviews and observations. The interviews revealed all facility staff to include agency staff had received training of elopement policy and the announcement of a “code green”. Nursing staff were educated to report any new behaviors or increased behaviors to the nurse management. Nurse management were educated to review	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD , KING, North Carolina, 27021

(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) COMPLETION DATE
F0689 SS = SQC-J	Continued from page 35 resident diagnosis for dementia and cognitive impairment. All doors were checked for the function of magnetic locks and or wander guard locks and were found in working order. Fourteen residents were wearing a wander guard bracelet and those were also in working order. The facility provided binders at each nursing station with a picture and information about each resident and where the resident was wearing the bracelet. The battery life and serial number of the bracelet was also recorded. The facility conducted audits of new residents to ensure, and elopement assessment was completed. Any resident who scored over a 4 was provided with a wander guard. Elopement drills were reviewed that began the week of 6/8/25 and occurred various shifts and times. The audit was to continue for twelve weeks and reviewed by the QAPI team. Three new admitted resident's records were audited for behaviors and elopement risk beginning 6/8/25. The facility's immediate jeopardy removal date and corrective action plan of 6/4/2025 was validated.	F0689		