STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH0141	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whitestone a Masonic and Eastern Star Community	700 South Holden Road , Greensboro, North Carolina, 27407

(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
D0000	Initial Comments The survey team entered the facility on 12/15/25 to conduct a complaint investigation survey and exited on 12/16/25. The survey team returned to the facility on 12/30/25 to validate the credible allegation of A1 removal and exited on 12/30/25. Therefore, the exit date was changed to 12/30/25. Event ID# 1DEA1A-H1. The following intakes were investigated 2676569, 2691520, and 2694386. 3 of the 3 complaint allegations resulted in deficiency. Intakes 2684386 and 2691520 resulted in a type A1 violation. A type A1 violation was identified at: 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms at a scope and severity of type A1. The type A1 violation began on 12/11/25 and was removed on 12/24/25.	D0000		01/19/2026
D0259	Resident Care Plan CFR(s): 10A NCAC 13F .0802 (a) (c) 10A NCAC 13F .0802 Resident Care Plan (a) The facility shall develop and implement a care plan for each resident based on the resident's assessment completed in accordance with Rule .0801 of this Section. The care plan shall be resident-centered and include the resident's preferences related to the provision of care and services. A copy of each resident's current care plan shall be maintained in a location in the facility where it can be accessed by facility staff who are responsible for the	D0259	It is the policy of WhiteStone: A Masonic & Eastern Star Community that our community shall develop an individualized, person-centered care plan for each resident. We submit that the facility will continue in this effort as follows. As it relates to correcting the observed deficiency associated with resident 2: On 11/17/2025, the Assisted Living Manager completed a comprehensive reassessment of Resident 2. A new person-centered care plan was developed	12/31/2025

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

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D0259	Continued from page 1 implementation of the care plan. (c) The care plan shall include the following: (1) a description of services, supervision, tasks, and level of assistance to be provided to address the resident's needs identified in the resident's assessment in Rule .0801 of this Section; (2) frequency of the services or tasks to be performed; (3) revisions of tasks and frequency based on reassessments in accordance with Rule .0801 of this Section; (4) licensed health professional tasks required according to Rule .0903 of this Subchapter; (5) a dated signature of the assessor upon completion; and (6) a dated signature of the resident's physician or physician extender as defined in Rule .0102 of this Subchapter within 15 days of completion of the care plan certifying the resident is under this physician's care and has a medical diagnosis with associated physical or mental limitations warranting the provision of the personal care services in the above care plan in accordance with G.S. 131D-2.15. This shall not apply to residents assessed through the Medicaid State Plan Personal Care Services Assessment for the portion of the assessment covering tasks needed for each activity of daily living of this Rule for which care planning and signing are directed by Medicaid. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review, and staff interviews, the facility failed to develop a person-centered individualized care plan for wandering and exit seeking. This deficient practice was identified for 1 of 3 sampled residents reviewed for comprehensive care plans (Resident #2). The findings included: Resident #2 was admitted to the Memory Care Unit on 11/23/2024. Resident #2 had diagnosis that included unspecified dementia, depression, anxiety, and insomnia. Record review of health status notes dated 11/11/2025 at 4:45 AM revealed Resident #2 was yelling up and down the hallway banging on doors and pressing buttons on	D0259	Continued from page 1 addressing wandering and exit-seeking, environmental triggers, supervision needs, and individualized redirection strategies. This new care plan was reviewed with all Memory Care Staff on 11/17/2025. The facility has established the following action steps in attempts to identify residents that might have been affected by similar conditions and to also ensure compliance with the rule, On 11/17/2025, all Memory Care Residents were reviewed by the Assisted Living Manager, Resident Care Coordinator, and Recreational Therapist to identify any residents with history of wandering, exit-seeking behaviors, or cognitive decline impacting safety. All identified residents received updated assessments and new/updated care plans addressing individual risks on 11/17/2025. To prevent future problems associated with this rule the facility submits it will do the following: The Assisted Living Manager and Healthcare Administrator reviewed the policy ‘Admission Assessment and Follow-Up’”, which outlines the steps that are to be completed upon admission, quarterly, and as needed for the Resident assessment. This policy was updated on 12/17/2025 to include the elopement assessment that should be completed for each Resident to identify elopement risk behaviors or factors that could contribute to the Resident’s risk of elopement. All Assisted Living Staff, which covers Certified Nursing Assistants (C.N.A.s), Medication Aides, and Nurses, received education from the Assisted Living Manager on 12/17/2025 regarding the updated policy. This education will be included for all new hires during their orientation by the Staff Development Coordinator. The Assisted Living Manager and Resident Care Coordinator received education by the Healthcare Administrator on 12/18/2025 regarding care plan development and regulatory requirements specific to “10A NCAC 13F .0802 RESIDENT CARE PLAN”.	

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D0259	Continued from page 2 the elevator. Record review of health status note dated 11/13/2025 at 9:27 PM revealed Resident #2 was pacing and agitated wanting to “go somewhere to be seen and taken care of” due to her throat. Resident #2 was attempting to get on the elevator, and the aide was trying to redirect her without success. Resident #2 was documented as continued yelling and making verbalizations of “let me die.” Review of the Memory Care Evaluation dated 11/14/2025, revealed Resident #2 was oriented to person only. The record revealed Resident #2 had impairment in both short- and long-term memory. Resident #2 had mild visual impairment in both eyes but wore eyeglasses. Resident #2 was coded at low risk for wandering with current history of wandering within the residence or facility without exiting, does not jeopardize health or safety (of self or other). Resident #2 was coded with current or history of frequent disruptive, aggressive, or socially inappropriate behavior, either verbally or physically improper. Her cognitive function was coded on the evaluation as moderately severe cognitive decline. Resident #2 mobility was independent and not requiring assistance with ambulation. The evaluation indicated “staff awareness flags” to include “be aware of behaviors.” Review of care plans dated 11/14/2025 revealed Resident #2 had care plans for advanced directives, housekeeping, mood and depression, anxiety, occasional disorientation, behaviors, assistance with medications, and mobility and ambulation. There was no care plan that addressed wandering and exit seeking. Review of the facility reported incident completed by the Administrator revealed Resident #2 had an unsupervised exit from the Memory Care Unit on 11/16/2025 at 2:22 PM. An interview conducted with Assisted Living Manager on 12/16/2025 at 4:00 PM indicated she was a new employee and care plans were just started a few months ago for the residents in the Assisted Living Center because they were not in place prior to her starting. She stated she was responsible for developing the resident care plans for all the residents in the Assisted Living center including the Memory Care Unit. She could not explain why she had not initiated a care plan for wandering and exit seeking behavior for Resident #2. The Assisted Living Manager stated she was aware Resident #2 left the Memory Care unit unsupervised on 11/16/2025 at 2:22 PM and acknowledged Resident #2 was	D0259	Continued from page 2 To ensure the measures taken have been effective and that the deficiency remains corrected, the facility will: The Assisted Living Manager or Resident Care Coordinator will audit new Care Plans five times a week for four weeks, weekly for eight weeks, and then monthly for three months. These audits will verify that elopement assessments have been completed, care plan accuracy, and that interventions are individualized. Findings will be reported to the facility Quality Assurance Performance Improvement (QAPI) Committee for review and to determine if further action is required. The facility submits that it will have achieved substantial compliance with the certification requirements related to the noted citation on 12/19/2025.	

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D0259	Continued from page 3 at risk for wandering/elopement.	D0259		
D0270	Personal Care and Supervision CFR(s): 10A NCAC 13F .0901(b) 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews, and interviews with staff and the physician, the facility failed to provide effective supervision for Resident #1 who had a diagnosis of dementia, was confused, had impaired judgement, exhibited exit-seeking behavior, was identified as being at risk for wandering, and ambulatory. On 12/9/25 Resident #1 was admitted from independent living to the Memory Care Unit due to increased confusion and three episodes of leaving her independent living residence without her family member being aware and was wandering the streets of the campus. On 12/11/25 Resident #1 barricaded her room door, lifted the windows in her room breaking the plastic stoppers, tied a flat bed sheet and a fitted bed sheet together around the middle window frame, and climbed out of a third-story bedroom window without staff awareness. Medication Aide #1 was on break in the facility parking lot and observed Resident #1 with her legs outside the window of her third-story room and alerted Nurse Aide (NA) #1. NA #1 and NA #2 responded and found Resident #1 outside the window, gripping two bed sheets tied together and hanging from the window frame. The resident was leaning on a second-story metal roof with her feet dangling off the edge. NA #1 and NA #2 attempted to pull Resident #1 back inside using the bed sheets but were unsuccessful. Resident #1 released her grip and fell approximately 25 feet, landing feet first in a mulch bed. Emergency Medical Services (EMS) was called and transported Resident #1 to the hospital for evaluation and treatment. Resident #1 sustained multiple fractures including a shattered left heel bone, partial displacement of left foot, a left foot fracture, a right heel fracture, a right open ankle fracture (serious injury where the bone breaks and pierces through the skin) and a right foot fracture. In addition, radiology tests noted a small subdural hematoma (bleeding near the brain). She was admitted to the Trauma Intensive Care Unit (ICU) and underwent surgery on 12/12/25 to repair and stabilize the fractures and remained hospitalized as of 12/16/25 at	D0270	It is the policy of WhiteStone: A Masonic & Eastern Star Community that to protect the safety and well-being of staff and residents, and to promote quality care, this community will provide effective supervision to prevent accident/injuries. We submit that the facility will continue in this effort as follows. As it relates to correcting the observed deficiency associated with resident 1 and resident 2: Resident 1: Resident 1 was transported to the hospital for treatment on 12/11/2025. All windows in Resident #1's room were evaluated by the Director of Plant Operations on 12/11/2025. Director of Plant Operations verified that Resident #1 had broken the stopping mechanisms that prevent the window from opening beyond 6-inches. Director of Plant Operations installed temporary window stoppers that prevent the window from opening beyond 6-inches on 12/11/2025 until the windows were fully repaired on 12/23/2025. Resident 2: Resident 2 was returned safely to the unit on 11/16/2025. The Plant Operations Associate verified the Maglock and Maglock Override worked as intended 11/16/2025. The Plant Operations Director installed "Screamer" alarms on both exit doors and override button covers on 11/17/2025. The facility has established the following action steps in attempts to identify residents that might have been affected by similar conditions and to also ensure compliance with the rule, All other Memory Care Residents were assessed for their elopement risk by the Assisted Living Manager, Resident Care Coordinator, and Memory Care Recreational	12/31/2025

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D0270	Continued from page 4 the time of the survey. In addition, Resident #2 was able to override the magnetic lock mechanism (electromagnet on the door frame and a steel armature plate on the door; when power flows, the electromagnet activates, creating a magnetic field that powerfully pulls the plate, locking the door, and when the power is cut the field disappears releasing the door) on a door and exited the Memory Care Unit down a stairwell unsupervised on 11/16/2025. The deficient practices identified for Resident #1 and Resident #2 resulted in deficiency for 2 of 3 sampled residents reviewed for supervision to prevent accidents. A Type A1 violation (results in death or serious physical harm) was identified on 12/11/2025 when Resident #1 climbed out of the third story bedroom window and fell to the ground. The risk was removed on 12/24/2025 when the facility implemented a credible allegation of removal. The facility remains out of compliance to complete employee education and ensure monitoring systems in place are effective and to correct the deficient practice for Resident #2. The findings included: 1. Record review of the Medicaid Long Term Care FL2 Form (a document used for obtaining prior approval for adult care services which contains details about medical history, conditions and care levels.) dated 12/8/2025 revealed Resident #1 was an 82-year-old ambulatory resident without assistive devices, needed supervision with personal care, had inappropriate behavior with wandering, was intermittently disorientated, communicated her needs verbally, and speech therapy. The document revealed she was on medication for treatment of a urinary tract infection. An interview conducted on 12/16/2025 at 9:39 AM with the Health and Wellness Nurse for the independent living center revealed that she coordinated Resident #1's placement into the Memory Care Unit from the independent living center. The Health and Wellness Nurse stated that Resident #1 had three episodes of leaving her independent living residence during the week prior to admission Memory Care Unit. She reported that Resident #1 was very confused, unable to recognize her family, and unaware of her surroundings. The Health and Wellness Nurse explained that the team met with	D0270	Continued from page 4 Therapist for wandering behaviors or risk behaviors for elopement. These assessments were completed on 12/12/2025, and each Resident's individual service plan was updated to reflect their specific needs and interventions. After these assessments were updated by the Assisted Living Manager, Resident Care Coordinator, and Memory Care Recreational Therapist on 12/12/2025 staff were communicated to in morning meeting and then required to share updates during shift report as part of their standard reporting process moving forward. The information shared during shift report is documented on a report sheet that includes Resident updates to include elopement risk behaviors, updates to service plans, and communication of changes/updates to identified Residents at risk of elopement. This report will cover both current and new admissions to the Memory Care Floor and will include engagement from the Assisted Living Manager and Resident Care Coordinator when applicable. To prevent future problems associated with this rule the facility submits it will do the following: The Assisted Living Manager and Healthcare Administrator reviewed the policy 'Admission Assessment and Follow-Up'", which outlines the steps that are to be completed upon admission, quarterly, and as needed for the Resident assessment. This policy was updated on 12/17/2025 to include the elopement assessment that should be completed for each Resident to identify elopement risk behaviors or factors that could contribute to the Resident's risk of elopement. All Assisted Living Staff, which covers Certified Nursing Assistants (C.N.A.s), Medication Aides, and Nurses, received education from the Assisted Living Manager on 12/17/2025 regarding the updated policy. This education will be included for all new hires during their orientation by the Staff Development Coordinator. On 11/17/2025, The Assisted Living Manager assigned the Memory Care Medication Aide to audit the exit doors on Memory Care each shift to ensure functionality and compliance. This audit is maintained on the Memory Care Medication Cart, and any identified issues are reported immediately to the Assisted Living Manager. The Director of Plant Operations and a Plant Operations Associate completed an audit of all Resident windows in the Assisted Living and Memory Care on 12/12/2025 to ensure that the stopper mechanisms were in good condition. Any findings of this audit were corrected on 12/12/2025 by the Director of Plant Operations and	

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D0270	Continued from page 5 Resident #1's family to discuss concerns regarding her safety and the need for protective measures at home or placement in the memory care facility. The Health and Wellness Nurse stated Resident #1 left her independent living residence on 12/9/2025 without her family's knowledge and was found walking on the streets, climbing a hill, and was dressed inappropriately for the weather. She indicated this incident raised significant concern for both the independent living center and the family. A telephone interview was conducted with Family Member #2 on 12/15/2025 at 2:46 PM. Family Member #2 stated that staff from the independent living center informed him that Resident #1 needed to be moved to the Memory Care Unit because she had been wandering from her independent living apartment without her spouse's knowledge. He further indicated that she was unsafe. Family Member #2 explained that Resident #1 was leaving her home because she was confused and no longer recognized her husband. He noted that this represented a sudden and significant decline in her condition. A review of the physician's orders prior to Resident #1's admission to the Memory Care Unit revealed that on 12/8/2025, the attending physician wrote an order for Resident #1 to undergo a psychiatric evaluation. According to the Admission Record, Resident #1 was admitted to the Memory Care Unit of the Assisted Living Center from the independent living portion of the continuing care retirement community on 12/9/2025. Resident #1's diagnoses included pseudobulbar affect (neurological condition characterized by sudden, uncontrollable, and often inappropriate episodes of laughing or crying that do not reflect the person's actual emotions, typically resulting from brain damage caused by conditions such as stroke) dementia without behavioral disturbances, major depression, agitation, and exit-seeking behavior associated with dementia. The December 2025 Medication Administration Record (MAR) indicated that Resident #1 was receiving the following medications: Donepezil for dementia; Lamictal, an anticonvulsant used to treat bipolar disorder and stabilize mood; lorazepam for anxiety; sertraline for depression; quetiapine fumarate, an antipsychotic; and Macrobid, an antibiotic for urinary tract infection.	D0270	Continued from page 5 Plant Operations Associate. On 12/23/2025, the Plant Operations Director and a Plant Operations Associate installed a 3/8" screw into the current custodial tilt window latches used to allow the windows to be opened and cleaned inside. This screw will prevent Residents from being able to utilize the custodial tilt window latches to tilt the windows meaning that the windows will only be accessible with standard opening which is limited to 6-inches by the stopping mechanism adjustment made by the Plant Operations Director and a Plant Operations Associate on 12/12/2025. All Assisted Living staff, which covers Certified Nursing Assistants (C.N.A.s), Medication Aides, and Nurses, received education from the Assisted Living Manager on 12/12/2025 regarding wandering and elopement. This education included caring for Residents who wander, causes of wandering, managing resident's patterns of wandering, elopement prevention, what we can do to prevent elopement, and the missing resident process. This education will be included for all new hires during their orientation by the Staff Development Coordinator. All Assisted Living staff, which covers Certified Nursing Assistants (C.N.A.s), Medication Aides, and Nurses, received education from the Assisted Living Manager starting on 12/12/2025 regarding the placement of an "Elopement Risk List", which is identified by the Resident's elopement assessment, on each Medication Cart to allow staff to identify quickly those Residents who are at risk of elopement. The "Elopement Risk List" includes a photo of the Resident and their room number. The Assisted Living Manager and Resident Care Coordinator are responsible for the updates to the "Elopement Risk List". If staff require additional information about managing elopement risk behaviors, this is available in each Residents individual service plan in the Electronic Medical Record. This education was completed on 12/17/2025. This education will be included for all new hires during their orientation by the Staff Development Coordinator. All Community staff, this includes all departments (Administrative, Plant Operations, Food & Beverage, Environmental Services, Accounting, Nursing, Human Resources), have been assigned as of 12/12/2025 further online in-service training through the Relias Platform, 'Managing Elopement' and 'Dementia Care: Challenging Behaviors and Direct Care Staff'. This education was completed by 12/17/2025. This education will be included for all new hires during their orientation by	

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D0270	Continued from page 6 A functional skills evaluation and cognitive health screening assessment was completed on 12/9/2025. The evaluation utilized a scoring system ranging from 0 to 4 across multiple categories, including communication, maneuvering in the community, safety, and cognition. A score of 0 indicated no concern, while a score of 4 indicated significant concern and/or the need for intervention. Resident #1 received a score of 4 in the safety category, indicating she was considered a danger to herself or others and had a history of elopement. A Speech Therapy evaluation and plan of care dated 12/9/2025 indicated that Resident #1 was assessed for services related to diagnoses of unspecified dementia without behavioral disturbances, psychotic disturbances, severe cognitive impairment, mood disturbances, anxiety, and cognitive communication deficit. The evaluation noted a decline in cognitive function following her transfer from the independent living apartment to the Memory Care Unit after an episode of elopement. Cognitive weaknesses were identified in the areas of orientation, attention, problem-solving, reasoning, safety awareness, and insight. A general progress note dated 12/9/2025 at 3:35 PM, written by the Assisted Living Manager, documented that Resident #1 was very anxious, exhibited exit-seeking behavior, and was argumentative with staff. Attempts at redirection were unsuccessful. Subsequently, activities were provided with two other residents, after which Resident #1 appeared calmer and began painting pictures. A physician progress note dated 12/10/2025 at 12:44 PM, written by the attending physician, documented that Resident #1 exhibited aggression toward staff, claimed she had been kidnapped and poisoned, and used foul language. Despite repeated attempts at redirection, Resident #1 did not calm down, and she was subsequently administered a one-time dose of Haldol (haloperidol), an antipsychotic medication. On 12/10/2025 at 12:45 PM, the attending physician ordered Haloperidol Lactate (antipsychotic medication) injection solution 5mg (milligrams)/ml (milliliter) inject 2.5 mg intramuscular (IM) one time only for anxiety.	D0270	Continued from page 6 the Staff Development Coordinator. To ensure the measures taken have been effective and that the deficiency remains corrected, the facility will: The Plant Operations Director or Plant Operations Associate will audit five windows a day, five times per week for four weeks in the Assisted Living, Memory Care, and Care and Wellness Center beginning the week of 12/15/2025, observing the functionality of the windows to ensure compliance with regulation. Findings will be reported to the facility Quality Assurance Performance Improvement (QAPI) Committee for review and to determine if further action is required. The Plant Operations Director or Plant Operations Associate will audit five exit doors a day, five times per week for four weeks in the Assisted Living, Memory Care, and Care and Wellness Center beginning the week of 12/15/2025, observing the functionality of the doors to ensure compliance with regulation. Findings will be reported to the facility Quality Assurance Performance Improvement (QAPI) Committee for review and to determine if further action is required. The facility submits that it will have achieved substantial compliance with the certification requirements related to the noted citation on 12/24/2025.	

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D0270	Continued from page 7 Review of Resident #1's Medication Administration Record (MAR) indicated Haldol 2.5 mg was administered IM to Resident #1 at 1:22 PM for anxiety. A behavior note dated 12/10/2025 at 1:50 PM, written by the Licensed Recreational Therapist, documented that Resident #1 exhibited increased agitation and anger toward staff who prevented her from boarding the elevator. Multiple attempts at redirection were unsuccessful. The note indicated that the Administrator also attempted to de-escalate Resident #1's behavior without success. Later, friends arrived at the facility to visit with Resident #1, and this interaction was documented as successful in calming her. A physician progress note dated 12/11/2025 at 10:00 AM reported that Resident #1's mental status was disorganized and repetitive, and she confabulated statements regarding her family and dog. Resident #1 was observed pacing in the hallway, holding her coat, and appearing visibly anxious. Staff reported continued difficulty redirecting her. The physician's plan included maintaining safety measures in the Memory Care Unit to prevent elopement and instructing staff to notify the physician of recurrent agitation, worsening behaviors, or medication side effects. An interview conducted with the Licensed Recreational Therapist on 12/15/2025 at 10:13 AM revealed that she was assigned to the Memory Care Unit to work with residents on that unit and was familiar with Resident #1 and her recent admission. She stated that Resident #1 displayed confusion and anxiety related to her husband and family dog, making redirection difficult during her placement in the Memory Care Unit. The therapist reported providing one-to-one (1:1) care to Resident #1 on 12/11/2025 until approximately 5:08 PM. She noted that Resident #1 had a "calmer day" and responded well to activities. However, near the end of the day, Resident #1 began exit-seeking behavior as commotion increased with dinner preparations. The therapist stated that when she left for the day, she notified Medication Aide #1 that she would no longer be working with Resident #1. An alert charting note dated 12/11/2025 at 8:02 PM, written by the Assisted Living Manager, documented that Resident #1 attempted elopement at 5:51 PM. Resident #1 had broken the window jams, kicked out the screen, and	D0270		

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D0270	Continued from page 8 was attempting to exit through the window. She subsequently fell, resulting in injury. Resident #1 was transported to the hospital for treatment. The family and Administrator were notified of the attempted elopement and subsequent fall. An interview conducted with the Assisted Living Manager on 12/15/2025 at 9:31 AM revealed that she was aware Resident #1 was at risk for wandering and elopement. She stated that Resident #1 was placed in the Memory Care Unit because she had been leaving her residence in the independent living area, where she lived with her husband. The Assisted Living Manager reported that Resident #1 frequently paced the hallways, made statements about needing to leave, called 911, and believed she had been kidnapped. She further stated that she had emailed a consent form to Resident #1's family for a psychiatric evaluation but had not received a response before Resident #1 was discharged from the facility. Additionally, she noted that on 12/11/2025, the Recreational Therapist spent most of the day with Resident #1, during which time the resident appeared calmer. The Assisted Living Manager stated Resident #1 had a "better day" on 12/11/2025 while she received 1:1 (one to one) support from staff. She indicated she was not at the facility when Resident #1 had an unsupervised exit on 12/11/2025 as she had already left for the day. An interview conducted with Medication Aide #1 on 12/15/2025 at 11:06 AM revealed that she was assigned to Resident #1 on 12/11/2025. Medication Aide #1 confirmed she was told by the Recreational therapist she was no longer going to sit with Resident #1. The Medication Aide stated since her placement in the Memory Care Unit Resident #1 was confused, and trying to get on the elevator to see her husband and find her "dog." The Medication Aide stated she went to have a dinner break leaving Resident #1 on the unit with 2 other staff members (NA #1 and NA #2). She stated while taking a break in her car in the facility parking lot, she observed Resident #1 placing her legs outside the third-floor window at approximately 5:51 PM. Medication Aide #1 reported she immediately exited her car, ran into the facility, and notified NA #3 on the 1st floor of the facility and by calling NA #1 on her cell phone. NA #1 instructed her to call 911, and she placed the call at 5:52 PM. Medication Aide #1 further stated she then proceeded to the third floor to assist the other nursing staff with Resident #1.	D0270		

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D0270	Continued from page 9	D0270		

An interview conducted with NA #3 on 12/15/2025 at 2:01 PM revealed that she was working on the first floor of the facility on 12/11/2025, the day of the incident involving Resident #1. NA #3 stated that at approximately 5:51 PM, Medication Aide #1 informed her that Resident #1 was trying to climb out of her window. Medication Aide #1 told NA #3 Resident #1 legs were outside of her window on the 3rd floor. NA #3 immediately notified Nurse #1 and then proceeded to the third floor to assist the other nursing staff with Resident #1.

A joint interview conducted with NA #1 and NA #2 on 12/15/2025 at 3:01 PM revealed that they were the nurse aides assigned to the Memory Care Unit and to Resident #1 on 12/11/2025. NA #2 stated Resident #1 had been confused and wanting to see her family since she had been on the Memory Care unit. She stated Resident #1 was wanting to call her family or try to go down the elevator to see her family. NA #2 stated that Resident #1 refused dinner and continued pacing up and down the hallway during the evening on 12/11/2025. Resident #1 reportedly said she needed to go to the hospital for her head. NA #2 stated after dinner they assisted other residents back to their rooms, and NA # 2 observed Resident #1 going to her room and closing the door. NA #2 stated while she was cleaning the dining room, she received a call from Medication Aide #1 at approximately 5:51 PM, notifying her that Resident #1 was climbing out of her window. NA #2 reported she and NA #1 immediately went to Resident #1's room, but the door was barricaded. She stated she had to force the door open, finding a table and chair placed against it. Upon entering, they discovered that Resident #1 was no longer in the room and the 3 windows were fully open with a sheet tied around the metal window frame. NA #1 recalled she and NA #2 looked out and saw Resident #1 gripping the sheet, with her legs dangling off the second-story roof. NA #1 stated both she and NA #2 attempted pull Resident #1 up with the bed sheets back into the window asking Resident #1 to hold on. NA #2 stated Resident #1 was unable to hold on, released her grip, and fell to the ground. Following the fall, staff ran outside to help Resident #1. NA #1 stated she called 911.

An interview conducted with the Resident Care Coordinator, Nurse #1, on 12/15/2025 at 9:49 AM addressed the incident on 12/11/2025 when Resident #1 fell from her window. Nurse #1 stated Resident #1 had been on one-to-one (1:1) supervision for most of the day due to increased agitation and was engaged in

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D0270	Continued from page 10 various activities. She noted Resident #1 was ambulatory without assistive devices and able to move independently throughout the Memory Care Unit. Resident Care Coordinator, Nurse #1 reported leaving the facility at 5:30 PM but returned shortly thereafter when NA #3 notified her Resident #1 was climbing out of her window and assistance was needed on the third floor. Upon arrival, Resident Care Coordinator, Nurse #1 found the windows in Resident #1's room open and observed Resident #1 outside the window, gripping bed sheets. NA #1 and NA #2 were attempting to pull Resident #1 back inside using the sheets. Nurse #1 indicated she took NA #1's cellphone and communicated with emergency medical services (EMS). She stated that Resident #1 fell to the ground level, landing in mulch, and staff immediately responded. Resident #1 was alert and responsive after the fall and did not initially report pain. Nurse #1 noted an open wound on Resident #1's leg and blood on her right foot. EMS arrived at 6:05 PM and while EMS provided care, Resident #1 continued to state she had been kidnapped. Review of the Guilford County Emergency Medical Service (EMS) report revealed the facility contacted EMS on 12/11/2025 at 5:55 PM. EMS arrived at the facility with lights and sirens at 6:03 PM and reached Resident #1 at 6:05 PM to provide immediate emergency care. The report documented Resident #1 had fallen approximately 25 to 30 feet from a third-story window. EMS departed the facility at 6:16 PM and transported Resident #1 to the hospital, arriving at 6:26 PM. The responding EMS unit was from Base #3, located approximately 0.7 miles from the facility. The hospital record dated 12/11/2025 revealed Resident #1 sustained multiple fractures including a shattered left heel bone, partial displacement of left foot, a left foot fracture, a right heel fracture, a right open ankle fracture, and a right foot fracture. Additionally, the hospital record dated 12/11/2025 documented a possible femoral deep vein thrombosis (DVT-a serious condition in which a blood clot forms in a deep vein, typically in the leg, causing pain, swelling, warmth, and redness) in the left leg and pulmonary embolism (PE-blockage of an artery in the lungs) but due to a small subdural hematoma treatment with Heparin (blood thinner) could not be initiated. Follow up imaging on 12/13/2025 were negative for DVT and PE. The hospital record indicated Resident #1's condition required "critical care to prevent imminent or life-threatening deterioration." Resident #1 was admitted to the Trauma Intensive Care Unit (ICU) of the	D0270		

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D0270	Continued from page 11 hospital. On 12/12/2025 hospital records revealed Resident #1 had surgery on the sustained injuries. The surgery report revealed realignment to fix Resident #1's severely broken right heel bone using plates, screws, or rods, placed the severe right injured dislocated bones back in their natural position in the hindfoot, crucial cleaning procedure to prevent infection and help the bones heal properly, left heel bone broken requiring a cast or boot, break in the right outer ankle bone required a cast or boot, used tiny screws to fix a partial dislocated left mid foot, and surgery to fix a broken bone in the left foot using pins or screws to hold stable while it heals. Resident #1 was started on an anticoagulant on 12/14/2025 to reduce the risk of DVT or PE. An observation and interview with the Director of Plant of Operations of Resident #1's 3 windows on 12/15/2025 at 11:48 AM revealed that the original window stoppers were broken, allowing the windows to open above 6 inches. The window latches on both sides were not locked, allowing windows to open inward. The Director of Plant Operations stated he installed window stopping brackets inside the window frame of Resident #1's room after the incident on 12/11/2025 to prevent the windows from opening any further than 6 inches. An interview conducted with the Director of Plant Operations on 12/15/2025 at 12:00 PM revealed that he was notified of Resident #1's fall from her window by Security Guard #1 at approximately 6:00 PM on 12/11/2025. He stated that prior to this incident, there was no evidence of preventative maintenance on the window stoppers in resident rooms. He confirmed that the window stoppers in Resident #1's room were broken and noted that, because they were made of plastic, they were easily broken. Following Resident #1's unsupervised exit on 12/11/2025, maintenance staff adjusted the brackets inside all facility window frames to prevent the windows from opening more than six inches. He further explained that the windows were designed to tilt forward and open, and he planned to order "key latches" to eliminate this functionality. A purchase record provided to the surveyor on 12/16/2025 confirmed an order for 500 "custodial tilt latches" and/or "key latches," scheduled for delivery on 12/17/2025. The Director of Plant Operations reviewed the area where Resident #1 fell and estimated the drop to be approximately 25 feet. A telephone interview conducted on 12/16/2025 at 8:34	D0270		

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D0270	Continued from page 12 AM with the attending Physician confirmed that he was aware of the incident involving Resident #1 on 12/11/2025. The Physician stated that he had been Resident #1's attending physician for the past three years. He reported that Resident #1 experienced a recent cognitive decline while living in the independent living center and prior to placement in the Memory Care Unit, characterized by increased confusion and impaired judgment. He explained that assessing her confusion was challenging because Resident #1's depression was overwhelming. The physician described her depression as "overwhelming," noting frequent episodes of crying and tearfulness, and stated that he was actively treating her depression. He added that Resident #1's husband was very concerned about her safety and requested placement in the Memory Care Unit because she continued to leave their home without his knowledge. The Physician indicated that Resident #1 required both neurology and psychiatry consultations to address her mood and sudden cognitive changes. He also noted that he was treating Resident #1 for a urinary tract infection at the time of her admission to the Memory Care Unit on 12/9/2025. The Physician expressed surprise that Resident #1 was able to climb out of her window. An interview conducted with the Administrator on 12/15/2025 at 4:58 PM revealed that he was aware of Resident #1's risk for wandering and exit seeking. He stated that Resident #1 had been on the facility's "agenda" for some time and had been discussed for potential admission to the Memory Care Unit prior to her admission. The Administrator explained that the facility holds weekly team meetings to review potential admissions and Resident #1 had been considered and discussed several times. He confirmed that he was aware of the incident in which Resident #1 fell from her window. The Administrator stated following the event the facility implemented widespread interventions, including inspecting all windows, ensuring proper functionality of locking devices, checking window tracks, updating assessments and care plans for residents at risk, and providing staff education. He further expressed that he believed staff responded appropriately during the incident in their efforts to ensure Resident #1's safety. The Administrator was notified of the Type A1 Violation on 12/16/2025 at 1:10 PM. The facility provided the following Type A1 violation removal plan. Identify those recipients who have suffered, or are	D0270		

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D0270	Continued from page 13 likely to suffer, a serious adverse outcome as a result of the noncompliance. On 12/11/2025, Resident #1 was not displaying behaviors related to exit seeking and/or elopement. She spent most of the day engaged with the Recreational Therapist in both group and individual activities. Prior to the event, Resident #1 was in the dining room with other Residents, she did not display behaviors, but Resident #1 did not consume much of her meal despite encouragement. On 12/11/2025 at 5:51 PM, while Medication Aide #1 was outside on her break, she observed Resident #1 outside of the bedroom window in her resident room, located on the 3rd floor, lowering herself down the side of the building holding on to a bed sheet to the 2nd floor roof. Medication Aide #1 called Medication Aide #2, who was on the Memory Care Floor, where Resident #1 resided, and Medication Aide #1 called 911. Medication Aide #2, Certified Nursing Assistant #1, and the Resident Care Coordinator arrived and attempted to assist Resident #1 back into the building by pulling up the bed sheet. The Resident Care Coordinator went to the ground floor to assist. While Medication Aide #2 and Certified Nursing Assistant #1 were pulling Resident #1 back up, Resident #1 let go of the bed sheet and fell to the ground. Staff immediately met Resident #1 on the ground and provided immediate first aid. 911 was called for a 2nd time at 5:52 PM by Medication Aide #2 and arrived at 6:05 PM. Resident #1 was sent to the local Hospital immediately following the event on 12/11/2025. As a result of the event, Resident #1 sustained multiple fractures to both legs. The fractures included a left heel fracture, multiple fractures and dislocations of bones/joints in the left foot, a right heel open fracture in which the bone had broken through the skin, multiple fractures and dislocations of bones/joints in the right foot, a right distal fibula fracture, and deep vein thrombosis. She was admitted with a diagnosis of bilateral calcaneus fractures which she received surgery on 12/12/2025 for. Resident #1 remains at the Hospital at this time in stable condition. All windows in Resident #1's room were evaluated by the Director of Plant Operations on 12/11/2025. Director of Plant Operations verified that Resident #1 had broken the stopping mechanisms that prevent the window from opening beyond 6-inches. Director of Plant Operations installed temporary window stoppers that prevent the window from opening beyond 6-inches on 12/11/2025 until the windows could be fully repaired.	D0270		

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D0270	Continued from page 14 Resident #1 was in a private apartment, and she did not have a roommate. All other Memory Care Residents were assessed for their elopement risk by the Assisted Living Manager, Resident Care Coordinator, and Memory Care Recreational Therapist for wandering behaviors or risk behaviors for elopement. These assessments were completed on 12/12/2025, and each Resident's individual service plan was updated to reflect their specific needs and interventions. After these assessments were updated by the Assisted Living Manager, Resident Care Coordinator, and Memory Care Recreational Therapist on 12/12/2025 staff were communicated to in morning meeting and then required to share updates during shift report as part of their standard reporting process moving forward. The information shared during shift report is documented on a report sheet that includes Resident updates to include elopement risk behaviors, updates to service plans, and communication of changes/updates to identified Residents at risk of elopement. This report will cover both current and new admissions to the Memory Care Floor and will include engagement from the Assisted Living Manager and Resident Care Coordinator when applicable. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. The Director of Plant Operations and a Plant Operations Associate completed an audit of all Resident windows in Memory Care on 12/11/2025 to ensure that they operate as intended preventing them from opening no more than 6-inches. This audit did not reveal any windows not operating as designed. The Plant Operations Director and a Plant Operations Associate, per manufacturer's recommendation, adjusted on 12/12/2025 the internal mechanisms of all the windows on Memory Care to only open 6-inches. This measure has been implemented as an addition to the current stopping mechanisms. This adjustment would prevent Residents from pushing the windows past the stoppers which could result in them breaking. The Director of Plant Operations and a Plant Operations Associate completed an audit of all Resident windows in the Assisted Living and Memory Care on 12/12/2025 to ensure that the stopper mechanisms were in good condition. This audit identified 12 stopper mechanisms in poor condition in Assisted Living and 6 in Memory	D0270		

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D0270	Continued from page 15 Care that were in need of repair. All windows identified to have physical failures of the stopper mechanism were secured by the Plant Operations Director and a Plant Operations Associate by drilling a metal bracket drilled into the window frame on 12/12/2025 to restrict the window from opening beyond 6-inches as outlined in regulation. All stopper mechanisms found not in good condition were replaced on 12/23/2025 by the Director of Plant Operations or a Plant Operations Associate. On 12/23/2025, the Plant Operations Director and a Plant Operations Associate installed a 3/8 inch screw into the current custodial tilt window latches used to allow the windows to be opened and cleaned inside. This screw will prevent Residents from being able to utilize the custodial tilt window latches to tilt the windows meaning that the windows will only be accessible with standard opening which is limited to 6-inches by the internal mechanism adjustment made by the Plant Operations Director and a Plant Operations Associate on 12/12/2025. All Assisted Living staff, which covers Certified Nursing Assistants (C.N.A.s), Medication Aides, and Nurses, received education from the Assisted Living Manager starting on 12/12/2025 regarding wandering and elopement. This education included caring for Residents who wander, causes of wandering, managing resident's patterns of wandering, elopement prevention, what we can do to prevent elopement, and the missing resident process. This education was completed on 12/12/2025. This education will be included for all new hires during their orientation. The Assisted Living Manager and Healthcare Administrator reviewed the policy 'Admission Assessment and Follow-Up'", which outlines the steps that are to be completed upon admission, quarterly, and as needed for the Resident assessment. This policy was updated on 12/17/2025 to include the elopement assessment that should be completed for each Resident to identify elopement risk behaviors or factors that could contribute to the Resident's risk of elopement. All Assisted Living Staff, which covers Certified Nursing Assistants (C.N.A.s), Medication Aides, and Nurses, received education from the Assisted Living Manager on 12/17/2025 regarding the updated policy. This education will be included for all new hires during their orientation. All Assisted Living staff, which covers Certified Nursing Assistants (C.N.A.s), Medication Aides, and Nurses, received education from the Assisted Living	D0270		

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D0270	Continued from page 16 Manager starting on 12/12/2025 regarding the placement of an “Elopement Risk List”, which is identified by the Resident’s elopement assessment, on each Medication Cart to allow staff to identify quickly those Residents who are at risk of elopement. The “Elopement Risk List” includes a photo of the Resident and their room number. The Assisted Living Manager and Resident Care Coordinator are responsible for the updates to the “Elopement Risk List”. If staff require additional information about managing elopement risk behaviors, this is available in each Residents individual service plan. This education was completed on 12/17/2025. This education will be included for all new hires during their orientation. All Community staff, this includes all departments (Administrative, Plant Operations, Food & Beverage, Environmental Services, Accounting, Nursing, Human Resources), have been assigned as of 12/12/2025 further online in-service training through the Relias Platform, ‘Managing Elopement’ and ‘Dementia Care: Challenging Behaviors and Direct Care Staff’. This education will be completed by 12/17/2025. The Staff Development Coordinator is responsible for the tracking and monitoring of this education’s completion for all staff. This education will be included for all new hires during their orientation. The facility alleges removal of the A1 type violation on 12/24/2025. On 12/30/25, the facility’s corrective action plan was validated on-site by record reviews, observations, and staff interviews. The Director of Plant Operations and an associate completed an audit of every window in the memory care section and found 12 windows needed repair. Observation of Resident #1’s room showed all windows have had metal brackets installed to prevent the rise past 6 inches. Observations of random rooms showed all windows have had metal brackets installed to maintain the 6-inch opening. No windows can be tilted for cleaning. Review of audits showed the facility completed new wandering/elopement assessments on all residents. Record review of the in-service documents dated 12/12/25 showed the DON, the ADON and the Staff Development Coordinator completed the in-person training. Signed staff rosters were reviewed with no issues or concerns. Interviews conducted with multiple staff members revealed they had received training about dementia, behaviors, and the elopement process and were able to identify what processes to put into place in the event a resident begins showing increased agitation and wandering. Ongoing weekly audits of the windows in the memory care unit will continue to ensure there are	D0270		

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D0270	Continued from page 17 no issues. The date of the removal of the Type A1 violation removal plan was validated as 12/24/25. #2 The findings included: Review of the Medicaid Long Term Care FL2 record dated 11/15/2024, Resident #2 was admitted to the Memory Care Unit on 11/23/2024. Resident #2 had diagnosis that included unspecified dementia (clinical term for when cognitive decline is evident, but it doesn't fit a specific know type like Alzheimer's), diabetes, depression, anxiety, and insomnia. Resident #2 information on the FL2 included intermittently disorientated, ambulatory, inappropriate behavior of wandering, and communicated verbally. Record review of health status notes dated 11/11/2025 at 4:45 AM revealed Resident #2 was yelling up and down the hallway banging on doors and pressing buttons on the elevator. Record review of health status note dated 11/13/2025 at 9:27 PM revealed Resident #2 was pacing and agitated wanting to "go somewhere to be seen and taken care of" due to her throat. Resident #2 was attempting to get on the elevator, and the aide was trying to redirect her without success. Resident #2 was documented as continued yelling and making verbalizations of "let me die." Review of the Memory Care Evaluation dated 11/14/2025, revealed Resident #2 was oriented to person only. The record revealed Resident #2 had impairment in both short- and long-term memory. Resident #2 had mild visual impairment in both eyes but wore eyeglasses. Resident #2 was coded at low risk for wandering with current history of wandering within the residence or facility without exiting, does not jeopardize health or safety (of self or other). Resident #2 was coded with current or history of frequent disruptive, aggressive, or socially inappropriate behavior, either verbally or physically improper. Her cognitive function was coded on the evaluation as moderately severe cognitive decline. Resident #2 mobility was independent and not requiring assistance with ambulation. The evaluation indicated "staff awareness flags" to include "be aware of behaviors." Review of care plan dated 11/14/2025 revealed Resident #2 had moderate impairment with orientation and needed supervision and oversight for safety. The goal for the care plan was to maintain and/or maximize current level	D0270		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
D0270	Continued from page 18 of functioning with orientation. Intervention, included Resident # 2, require supervision and oversight for safety. Review of the facility reported incident completed by the Administrator revealed Resident #2 had an unsupervised exit from the Memory Care Unit on 11/16/2025 at 2:22 PM. The report indicated the next staff member who saw Resident #2 was at 2:24 PM who then assisted Resident #2 back to the Memory Care Unit. There was an inspection of the maglock, and it was noted the override button was pushed in to deactivate the use of them. Education was provided to staff members regarding the unsupervised exit of Resident #2 and the monitoring of the override button for the maglocks. A health status note dated 11/16/2025 at 5:06 PM written revealed Resident #2 was found alone near the therapy gym when a staff member was coming into the facility. Upon assessment both exit doors' maglock function failed. Notified security then facility Administration. Maintenance immediately came to check on both doors. Memory care and Assisted living staff were alerted to check on exit doors while maintenance worked on doors. Staff called family members to let them know of incident and that both doors were being checked and repaired. Review of preventative maintenance documentation of the testing of maglock doors for the Memory Care unit on 11/16/2025 revealed there were no issues with the maglocks prior to 11/16/2025. Reviewed the prior 3 months and preventative maintenance revealed inspection of the maglock door functioning properly. A telephone interview conducted with Medication Aide #2 on 12/16/2025 at 2:11 PM revealed she was the staff member that found Resident #2 by the therapy gym on 11/16/2025. She observed Resident #2 sitting in a chair by the therapy gym on the 1st floor at approximately 2:28 PM. The Medication Aide #2 stated this was not out of the norm for Resident #2 to be downstairs because she would normally go for walks with staff and be on different floors. She stated she waited to see if any staff members were coming to retrieve Resident #2. When no one came, Medication Aide #2 called the Assisted Living Manager to notify her of Resident #2 on the 1st floor unsupervised. The Medication Aide #2 stated she did not get a response from the Assisted Living Manager so she escorted Resident #2 back to the Memory Care unit on the third floor without incident in a wheelchair. The Medication Aide #2 stated when Resident #2 was brought back to the Memory care unit the staff	D0270		

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D0270	Continued from page 19 revealed she was just on the Memory Care unit minutes ago. An interview conducted on 12/16/2025 at 3:02 PM with Nurse Aide (NA) #4 revealed she had been with Resident #2 prior to her leaving the Memory Care unit unsupervised on 11/16/2025. NA #4 revealed she was walking with Resident #2 on another floor and brought Resident #2 back to the Memory Care unit through the elevator. The NA was unable to recall the exact time but stated it was after lunch. NA #4 stated once on the Memory Care unit Resident #2 stated she was tired and with the assistance of another staff member she was advised to lie down. NA #4 stated it was about 3 to 4 minutes later she was told Resident #2 was off the Memory Care unit. The NA stated Resident #2 was very smart and able to read signs and do as the signs tell her. NA #4 revealed she thought Resident #2 read the signs to push the button for the stair well and got out the exit door on the Memory Care unit. NA #4 stated she did not go down the elevator because she just went down the elevator and was right by the elevator on the 1st floor. NA #4 stated it was normal for staff to take Resident #2 for walks off her unit supervised for activities on other floors. A telephone interview conducted with Family Member #3 on 12/16/2025 at 2:58 PM revealed he was aware of Resident #2 exiting the Memory Care unit unsupervised on 11/16/2025. He stated it was hard to control someone who can read signs and do as they say and then get off the memory care unit. The Family Member #3 further revealed he was pleased with the care the facility is providing and had no concerns. Review of work order on 11/16/2025 revealed the work order was completed on 11/17/2025 at 2:35 PM for the installation of “screamers” on both exit doors on the Memory care unit. An interview conducted with Director of Plant Operation on 12/16/2025 at 3:30PM revealed he was aware of Resident #2 exiting the Memory Care Unit unsupervised on 11/16/2025. He indicated Resident #2 pushed the button to the maglocks for the stairwell door deactivating the maglock allowing her to enter the stairwell and go down the stairs. The Director of Plant Operations stated when he checked the maglocks on 11/16/2025 after the incident the maglocks were deactivated and the button was pushed in. The Director of Plant Operations stated the facility have placed “screamers” on the 2 exit doors on the Memory Care unit. The covers for the override button for the maglocks have “screamers” and the exit doors have	D0270		

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D0270	Continued from page 20 “screamers.” A telephone interview conducted on 12/16/2025 at 3:33 PM with the Psychiatrist Nurse Practitioner (NP) revealed she was aware of the unsupervised exit Resident #2 had on 11/16/2025 from the Memory Care Unit. She stated Resident #2 was severely cognitively impaired and had exit seeking behavior. The NP stated Resident #2 liked to walk and many times was off the floor with staff walking and participating in activities on other floors. She further revealed that it was good for Resident #2 to be involved and active as possible with walking. The NP stated Resident #2 was able to read signs and do what the signs tell her to do but if you ask Resident #2 questions she does not respond appropriately due to impaired cognition. The NP stated Resident #2 probably read the sign to press the door in following directions and went out the stairwell door. She stated Resident #2 was doing well currently and medication regime was appropriate. The NP further indicated placement on the Memory Care unit for Resident #2 was appropriate. Observation of the stairwell was conducted with the Director of Plant Operations of the stairwell on 12/16/2025 at 3:45 PM. At the bottom of the stairwell on the 1st floor there were two doors unlocked. One door led to back into the facility common area and the other door led to the facility outside parking lot. The Director of Plant Operation acknowledged this was the stairwell Resident #2 exited the Memory Care Unit unsupervised and that both doors observed were unlocked. An interview conducted with Assisted Living Manager on 12/16/2025 at 4:00 PM indicated she was aware Resident #2 left the Memory Care unit unsupervised on 11/16/2025 at 2:22 PM. She stated Resident #2 left through the stairwell deactivating the maglock door to the stairwell. She stated Resident #2 was doing well currently and no longer exit seeking. The Assisted Living Manager stated there was additional staff assigned to the Memory Care unit now which helps with diversional activities and with behaviors. She further revealed the extra staff help with residents who need 1:1. An interview conducted with the Administrator on 12/16/2025 at 4:15 PM revealed he was aware of Resident #2’s risk for wandering and exit seeking behavior. He stated he was aware the maglock exit doors were not activated and this was the causative factor for Resident #2 leaving the Memory Care Unit unsupervised. The Administrator revealed the maglock exit doors have	D0270		

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D0270	Continued from page 21 been fixed with "screamers." The Administrator acknowledged the two doors in the stairwell were unlocked during the surveyor observation on 12/16/2025 and with Resident#2 unsupervised exit on 11/16/2025 at 2:22 PM. The Administrator revealed one door leads to the common area of the facility and the 2nd door is the emergency exit to the parking lot.	D0270		
D0451	Reporting of Accidents and Incidents CFR(s): 10A NCAC 13F .1212(a) 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to notify Adult Protective Services (APS) of Resident #1 having an unsupervised exit from her window on the 3rd floor resulting in her emergency hospitalization on 12/11/2025. This deficient practice was identified for 1 of 3 sampled residents reviewed for supervision to prevent accidents (Resident #1). The findings included: According to the Admission Record, Resident #1 was admitted from the independent living portion of the continuing care retirement community to the Memory Care Unit of the Assisted Living Center on 12/9/2025. Resident #1 had diagnoses that included pseudobulbar affect (a neurological condition causing sudden, uncontrollable and often inappropriate outbursts of laughing or crying that doesn't match the person's actual feelings, resulting from brain damage due to conditions like stroke), dementia without behavioral disturbances (marked by cognitive decline without significant emotional/behavioral issues like aggression, wandering, hallucinations or severe mood swings), agitation, and exit seeking behavior associated with dementia. Review of the initial allegation report completed by the Administrator dated 12/11/2025 revealed Resident #1 exited the facility unsupervised on 12/11/2025 at 5:51	D0451	It is the policy of WhiteStone: A Masonic & Eastern Star Community that in the event of a reportable event, the community will notify all required parties/entities of the event. We submit that the facility will continue in this effort as follows. As it relates to correcting the observed deficiency associated with resident 1: Adult Protective Services (APS) was notified on 12/16/2025 by the Administrator of the event. The facility has established the following action steps in attempts to identify residents that might have been affected by similar conditions and to also ensure compliance with the rule, An audit was completed by the Administrator on 12/16/2025 to identify any other incidents that lacked notification of regulated parties/entities. Results of this audit showed no other incidents lacking notification. To prevent future problems associated with this rule the facility submits it will do the following: The Administrator, Director of Nursing, and Assisted Living Manager received training on 12/17/2025 from the community's Regional Nurse Consultant on reporting requirements and notifications. The Incident Reporting Policy was revised on 12/17/2026 to reflect notification of regulated parties/entities within required timeframes of any reportable event. To ensure the measures taken have been effective and that the deficiency remains corrected, the facility will:	12/31/2025

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D0451	Continued from page 22 PM through her bedroom window on the 3rd floor using bed sheets she had tied together. Resident #1 tied two bed sheets together from her bed and wrapped them around the middle frame of her window in her room. She broke the window stoppers, or tabs, to 2 of the windows in her room, which allowed the windows to open further than six inches. Resident #1 lowered herself down using the tied sheets out of the window. Resident #1 let go of the bed sheets falling approximately 25 feet to the ground outside. Resident #1 was transferred to local hospital and was admitted to intensive care unit (ICU) for her injuries including but not limited to; left side subdural hematoma (a serious collection of blood between the brain's surface and its tough outer covering), open right ankle fracture (the broken bone broke through the skin creating a serious wound at high risk for infection), B type calcaneus (heel) fracture (meaning the fracture line extends into the critical subtalar joint making it more serious injury), and left 2nd metatarsal fracture (a break in one of the long bones in your midfoot, often causing pain, swelling, bruising, and difficulty walking). Record review of facility reported incident dated 12/11/2025 revealed Greensboro police was notified. There was no documentation in the report of notification to Adult Protective Services about Resident #1's unsupervised exit from her window and subsequent emergency treatment at the hospital. The hospital record dated 12/11/25 indicated that Resident #1 sustained multiple fractures in both legs, including a shattered left heel bone, partial displacement of the left foot, a left foot fracture, a right heel fracture, a fracture of the right outer ankle bone, and a right foot fracture. Additionally, the hospital record dated 12/11/2025 at 7:30 PM documented evidence of deep vein thrombosis (DVT) in the left leg (a serious condition in which a blood clot forms in a deep vein, typically in the leg, causing pain, swelling, warmth, and redness). On 12/14/2025, Resident #1 was started on Heparin, an anticoagulant medication, for prophylaxis. An interview conducted with the Administrator on 12/16/2025 at 10:16 AM revealed he was aware of Resident #1 unsupervised exit from her window on 12/11/2025 at 5:51 PM. He stated he completed the initial facility reported incident and sent in the form to the State of North Carolina. He confirmed to the surveyor he did not notify Adult Protective Services of Resident #1 unsupervised exit and emergency transfer to the hospital. The Administrator confirmed to the surveyor he should have notified Adult Protective Services of Resident #1 unsupervised exit. The	D0451	Continued from page 22 For three months, the Administrator will audit 100% of incidents to ensure notification is present when required. Findings will be reported to the facility Quality Assurance Performance Improvement (QAPI) Committee for review and to determine if further action is required. The facility submits that it will have achieved substantial compliance with the certification requirements related to the noted citation on 12/18/2025.	

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D0451	Continued from page 23 Administrator stated they would notify Adult Protective Services today.	D0451		