Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	HAL017054		R-C 10/03/2025

NAME OF PROVIDER OR SUPPLIER
CASWELL HOUSE

STREET ADDRESS, CITY, STATE, ZIP CODE
535 US HIGHWAY 158 WEST
YANCEYVILLE, NC 27379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section completed an annual and follow up survey and complaint investigation from 09/30/25 to 10/03/25.	D 000		
D 068	10A NCAC 13F .0305 (i) Physical Environment 10A NCAC 13F .0305 Physical Environment (i) The requirements for floors are: (1) all floors shall be of smooth, non skid material and so constructed as to be easily cleanable; (2) scatter or throw rugs shall not be used; and (3) all floors shall be kept in good repair. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the floors were kept in good repair related to buckled and torn flooring in the hallway in the assisted living (AL) and missing and chipped flooring in the day room in the special care unit (SCU). The findings are: 1. Observation of the hallway in the AL on 09/30/25 at 8:30am revealed: -There was a main hallway with side-by-side entrances to the main dining room and a private dining room. -There was a buckled section of the sheet vinyl floor approximately 36 inches long leading from the door of the private dining room into the main hallway. -There was a large crack in the vinyl floor directly outside the private dining room. -The crack left an opening in the floor and the	D 068		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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D 068	Continued From page 1 edges of the floor where it was cracked were folding up. -The floor where the crack was located was not flush and created a fall hazard. Attempted telephone interview with the facility's Regional Maintenance Director on 10/02/25 at 2:40pm was unsuccessful. Refer to the interview with the Maintenance Director on 10/01/25 at 11:46am. Refer to the telephone interview with the Administrator on 10/03/25 at 4:10pm. 2. Observation of the day room in the SCU on 09/30/25 at 8:51am revealed: -There was a section of the plank floor approximately 18 inches long where a thick layer of the laminate had peeled off and left an uneven section of flooring near the outside exit door. -There were multiple small chips of plank vinyl flooring missing around the outside door. Interview with a personal care aide (PCA) on 10/01/25 at 11:05am revealed: -The damage to the flooring in the day room in the SCU came from water that leaked under the door from the outside when it rained. -The flooring in the day room had been damaged for months. -The residents in the SCU shuffled their feet and a few of them constantly walked around. -The damaged floor was a trip hazard. -None of the residents had tripped on the floor. Interview with the Special Care Unit Coordinator (SCC) on 10/02/25 at 2:01pm revealed: -If the staff saw something that needed to be repaired they should let her or the Maintenance	D 068		

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D 068	Continued From page 2 Director know. -She told the Maintenance Director when she saw something that he needed to be work on, but she did not document anything, it was always communicated verbally. -The Maintenance Director usually took about a week to repair things. -She saw the flooring in the day room needed to be replaced and told the Maintenance Director about it a week or two ago. -The heat, the rain, and the residents' wheelchair damaged the flooring and wore it out. -She wanted the residents to have something on their feet so they would not get cut on the broken flooring and she did not want anyone to fall. Attempted telephone interview with the facility's Regional Maintenance Director on 10/02/25 at 2:40pm was unsuccessful. Refer to the interview with the Maintenance Director on 10/01/25 at 11:46am. Refer to the telephone interview with the Administrator on 10/03/25 at 4:10pm. _____ Interview with the Maintenance Director on 10/01/25 at 11:46am revealed: -He was aware of the damaged floors in the resident areas. -The facility's Regional Maintenance Director was shown the floors when he was at the facility in June 2025. -The Regional Maintenance Director was responsible for scheduling a company to repair the flooring. -He did not know when a company was going to come repair the floors. -He told the Administrator about the flooring. -Residents could trip on the broken areas but	D 068		

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D 068	Continued From page 3 none of the residents had yet. Telephone interview with the Administrator on 10/03/25 at 4:10pm revealed: -She had seen the damaged floors in the facility. -The Regional Maintenance Director saw the damaged floors in June 2025 and took pictures. -She was waiting for a company to repair the flooring; no one had come to repair the flooring yet. -Staff and residents were aware of the damaged flooring. -Her concern with the damage to the flooring was a resident could trip and fall. -She expected the staff to let the Maintenance Director know when there was something that needed to be repaired. -She expected the Maintenance Director to let her know what needed to be repaired and to do repairs as needed.	D 068		
D 074	10A NCAC 13F .0306 (a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings that are clean, safe, and functional; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities.	D 074		

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D 074	Continued From page 4	D 074		

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure the walls were clean, safe, and functional, related to the walls in a resident room in the SCU that was in disrepair.

The findings are:

Observation of resident room #307 on 09/30/25 at 9:30am revealed:
-There was a small common area with a bathroom and two resident rooms adjacent to the common area.
-Only one resident resided in the room.
-There were black marks on the walls, doors, and corners of resident room #307 at the level of wheels on a wheelchair.
-There was a large area of missing paint and a layer of broken drywall on the inside corner of the room.
-There were two 6-inch areas of missing paint and a layer of drywall along the two walls in the room.

Review of the environmental inspection report from the local county health department dated 05/22/25 revealed the facility received 0.5 demerits for scuffs on the walls and wall damage in resident rooms in the SCU.

Interview with the resident who resided in room #307 on 09/30/25 at 9:30am revealed:
-The walls had been "like that" for as long as he

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D 074	Continued From page 5 could remember. -He did not complain about the walls because the staff knew what they looked like. -The staff knew what the walls looked like because they came in his room all the time. Interview with a personal care aide (PCA) on 10/01/25 at 11:08am revealed: -She noticed the black marks and the chips in the paint and drywall on the wall in resident room #307. -The resident who resided in room #307 was rough on the walls and banged into them with his wheelchair. -The facility painted the walls in the SCU at the first of the year. Interview with the Maintenance Director on 10/01/25 at 10:25am revealed: -He did random walk throughs of he SCU to inspect furniture weekly and monthly. -He checked resident rooms weekly. -He had noticed some of the walls in the residents' rooms in the SCU were scuffed and had chips in the paint from wheelchairs. -He was waiting for paint to repair and paint the walls. -He requested more paint to do repair around the first of the year. -The Regional Maintenance Director had completed an inspection of the SCU a few weeks ago and had seen the walls needed to be repaired and painted. -He did not know when the supplies to repair and paint the walls would be delivered. Interview with the Special Care Unit Coordinator (SCC) on 10/02/25 at 2:01pm revealed: -She went into the residents' rooms and bathrooms every day and looked for anything that	D 074		

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D 074	Continued From page 6 was broken or needed to be repaired. -If the staff saw something that needed to be repaired they should let her or the Maintenance Director know. -She would tell the Maintenance Director when she saw something that he needed to work on, but she did not document anything it was always communicated verbally. -The Maintenance Director usually took about a week to repair things. -The resident who resided in room #307 was always sitting against the wall in his wheelchair so she could not see the damage to the wall. -She knew he was always hitting the walls with his wheelchair. -Staff had not reported the damaged walls to her. -The walls could be repaired and repainted. Telephone interview with the Administrator on 10/03/25 at 4:10pm revealed: -She did not do inspections of resident rooms because the Maintenance Director did inspections. -The facility received a delivery of paint and supplies today, 10/03/25. -She knew there were some areas in the SCU that needed to be painted but they were waiting on the paint to be delivered. -She expected the staff in the SCU to let the Maintenance Director know when there was something that needed to be repaired. -She expected the Maintenance Director to let her know what needed to be repaired and to do repairs as needed. Attempted telephone interview with the facility's Regional Maintenance Director on 10/02/25 at 2:40pm was unsuccessful.	D 074		

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D 076	Continued From page 7	D 076		
D 076	10A NCAC 13F .0306 (a)(3) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (3) have furniture that is clean, safe, and functional; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a dresser was in good repair in the special care unit (SCU). The findings are: Observation of resident room #307 on 09/30/25 at 9:30am revealed: -There was a tall five drawer dresser in the room. -The second drawer from the top was missing and there was an opening where the drawer would have been. -The resident's clothes in the third drawer were visible from the opening. -The bottom drawer was askew and not on the glide track; the left bottom corner was resting on the floor. Interview with the resident who resided in resident room #307 on 09/30/25 at 9:30am revealed: -The dresser drawer had been missing for over a month.	D 076		

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D 076	Continued From page 8 -He thought the bottom drawer was broken but he did not use it. -He did not complain to anyone about the dresser drawer. -The staff knew it was missing because they put his clothes away. -He had plenty of room for his clothes. Interview with a personal care aide (PCA) on 10/01/25 at 11:08am revealed: -The drawer had been missing from the dresser in resident room #307 for quite a while. -There was enough room in the dresser for the resident to put his clothes. -She reported the broken dresser to the Maintenance Director about a month ago. -She had just noticed the bottom dresser drawer was off the track; she did not know if it would open. Interview with the Maintenance Director on 10/01/25 at 10:25am revealed: -He did random walk throughs the of SCU to inspect furniture weekly and monthly. -He checked resident rooms weekly. -He checked dressers to see if the drawers were missing, broken or off the track. -About two weeks ago he saw the drawers in the dresser in resident room #307 were off the track. -He was going to trade the dresser out with a new one but had not gotten a chance. -He did not know the drawer was now missing; one of the staff must have pulled it out. Interview with the Special Care Unit Coordinator (SCC) on 10/02/25 at 2:01pm revealed: -She went into the residents' rooms and bathrooms every day and looked for anything that was broken or needed to be repaired. -If the staff saw something that needed to be	D 076		

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D 076	Continued From page 9 repaired they should let her or the Maintenance Director know. -She would tell the Maintenance Director when she saw something that he needed to work on but, she did not document anything it was always communicated verbally. -The Maintenance Director usually took about a week to repair things. -She had not seen the missing dresser drawer in resident room #307, it must have been recent. -The resident who resided in resident room #307 had been in the room for some time. -He liked to mess with and tried to fix things. Telephone interview with the Administrator on 10/03/25 at 4:10pm revealed: -She did not do inspections of resident rooms because the Maintenance Director did inspections. -She was not aware there was a broken dresser in resident room #307 in the SCU. -She expected the staff in the SCU to let the Maintenance Director know when there was something that needed to be repaired. -She expected the Maintenance Director to let her know what needed to be repaired and to do repairs as needed.	D 076		
D 079	10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; Notwithstanding the requirements of Rule .0301	D 079		

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D 079	Continued From page 10 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure residents were free from hazards including a closet door that was leaning against the wall in a resident room in the special care unit (SCU), and a broken paper towel dispenser in a resident bathroom in the SCU. The findings are: 1. Observation of Resident room #307 in the SCU on 09/30/25 at 9:30am revealed: -The closet in the room had two bi-folding doors. -One of the bi-folding doors was removed from the closet and was leaning against the wall next to the closet. Interview with the resident who resided in resident room #307 on 09/30/25 at 9:30am revealed: -The closet door had been leaning against the wall next to the closet for about one month. -He did not complain to anyone about the closet door. -The staff knew it was not on the closet because they leaned it against the wall when it came off the hinge. Interview with a personal care aide (PCA) on 10/01/25 at 11:08am revealed: -She had seen the closet door leaning against the wall in resident room #307.	D 079		

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D 079	Continued From page 11 -The closet door had been leaning against the wall for about a month. -She reported it to the Maintenance Director about a month ago. Interview with the Maintenance Director on 10/01/25 at 10:25am revealed: -He did random walk throughs the of SCU to inspect furniture weekly and monthly. -He checked resident rooms weekly. -The bi-folding closet doors easily came off the pivot point when they were pulled down on. -Staff had reported the closet door in resident room #307 kept coming off the closet about two weeks ago. -He saw the door was off the hinge but not off the closet. -Staff would put the door back in place when it came out. -Someone must have put the door against the wall. -He was concerned it was a safety issue because the door could fall on a resident if it was bumped. Interview with the Special Care Unit Coordinator (SCC) on 10/02/25 at 2:01pm revealed: -She went into the residents' rooms and bathrooms every day and looked for anything that was broken or needed to be repaired. -If the staff saw something that needed to be repaired they should let her or the Maintenance Director know. -She would tell the Maintenance Director when she saw something that he needed to work on but, she did not document anything it was always communicated verbally. -She had not seen the closet door in resident room #307, it must have happened on the previous Friday or on 09/29/25. -The resident would not be able to move the	D 079		

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D 079	Continued From page 12 closet door and lean it against the wall so one of the staff must have. -The staff had not told her about the broken closet door. -Her concern was the door could fall if it was just leaning on the wall. Telephone interview with the Administrator on 10/03/25 at 4:10pm revealed: -She did not do inspections of resident rooms because the Maintenance Director did inspections. -She was not aware there was a closet door leaning against the wall in resident room #307 in the SCU. -The closet door needed to be put back in place because it could fall and hurt a resident. -She expected the staff in the SCU to let the Maintenance Director know when there was something that needed to be repaired. -She expected the Maintenance Director to let her know what needed to be repaired and to do repairs as needed. Attempted telephone interview with the facility's Regional Maintenance Director on 10/02/25 at 2:40pm was unsuccessful. 2. Observation of resident room #206 in the SCU on 09/30/25 at 9:11am revealed: -There was one resident residing in the room. -There was a bathroom adjacent to the room. -There was a paper towel dispenser resting between the edge of the sink and the wall, leaning against the wall, unsecured. -There were holes in the wall where the screws had held the paper towel dispenser to the wall next to the door. Interview with a personal care aide (PCA) on	D 079		

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D 079	Continued From page 13 10/01/25 at 11:05am revealed: -The paper towel dispenser had been off the wall and sitting on the sink for about a month. -The Maintenance Director knew about it because she wrote it down for him when she saw it was broken. -It had not been replaced or re-hung that she was aware of. Interview with the Maintenance Director on 10/01/25 at 10:25am revealed: -He was in the process of replacing paper towel dispensers in the residents' bathrooms. -He had seen the paper towel dispenser in resident room #206 when he did room inspections last week. -He had not had a chance to re-hang the paper towel dispenser. -He knew he needed to re-hang it soon because a resident could pull it off the sink while pulling a paper towel out, and pull the whole dispenser onto themselves. Interview with the Special Care Unit Coordinator (SCC) on 10/02/25 at 2:01pm revealed: -She went into the residents' rooms and bathrooms every day and looked for anything that was broken or needed to be repaired. -If the staff saw something that needed to be repaired they should let her or the Maintenance Director know. -She would tell the Maintenance Director when she saw something that he needed to work on but, she did not document anything it was always communicated verbally. -She had not seen any paper towel holders off the walls. -She had not seen the paper towel holder in resident room #206. -She had not had the chance to go into every	D 079		

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535 US HIGHWAY 158 WEST
YANCEYVILLE, NC 27379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 079	Continued From page 14 resident room this week. -Her concern would be the paper towel dispenser could fall on the resident if they went to pull a paper towel out and it was not secured. -The Maintenance Director would replace the paper towel holder the same day it was reported. Telephone interview with the Administrator on 10/03/25 at 4:10pm revealed: -She did not do inspections of resident rooms because the Maintenance Director did inspections. -She expected the staff in the SCU to let the Maintenance Director know when there was something that needed to be repaired. -She expected the Maintenance Director to let her know what needed to be repaired and to do repairs as needed. Attempted telephone interview with the facility's Regional Maintenance Director on 10/02/25 at 2:40pm was unsuccessful. Based on observations and interviews it was determined the resident who resided in resident room #206 was not interviewable.	D 079		
D 105	10A NCAC 13F .0311 (a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition.	D 105		

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D 105	Continued From page 15 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the sprinkler system, which was connected to the fire alarm system, the heating, ventilation, and air conditioning (HVAC) system, which had not worked since June 2025 and caused the dining room and activity room to be excessively warm and uncomfortable to residents, and the plumbing system as evidenced by cracked, jagged shower floors, and smoke detectors were maintained in a safe and operating condition. The findings are: 1. Review of a fire inspection report dated 03/28/25 revealed: -Next to the entry "fire resistant construction not compromised" was marked "fail". -There was an additional note on the report dated 04/01/25 that read "sprinkler system is still not functioning properly causing alarms". Telephone interview with a representative from the company that completed the fire inspection on 10/03/25 at 8:12am revealed: -The facility failed the inspection on 03/28/25 because the sprinkler system was malfunctioning. -The facility was due to have another inspection completed. -If the sprinkler system was not functioning properly, it would not pass the inspection. -The facility had not passed a fire inspection in years. -The facility refused to get licensed individuals to look at and fix the issues. -They currently had mixed metals in the system	D 105		

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D 105	Continued From page 16 and whatever repairs that had been done, had been done wrong. Telephone interview with the county fire marshal on 10/03/25 at 8:22am revealed: -The fire department had been told the sprinkler system at the facility was being replaced multiple times for the last 3 years. -When the sprinkler system did not function properly, the fire alarm system could not function properly and that put the residents and staff at risk of not knowing if a fire broke out. Interview with the facility's Maintenance Director on 10/02/25 at 5:16pm revealed: -There were a lot of issues in the facility. -The sprinkler system was currently being replaced. -The sprinkler system worked on and off; someone would come out and fix something, it would work for awhile, and then break again. -Right now, he thought there was only one section of the facility (100 hall) where the sprinkler system still needed to be replaced. -The company would be back next week to finish the work on the sprinkler system. -If the sprinkler system was not functioning properly, that meant the alarms would not sound and the fire department might not be aware if there was an emergency. Interview with the Administrator on 10/02/25 at 5:31pm revealed: -The sprinkler system had been malfunctioning since she began working at the facility. -The sprinkler system was not functioning properly right now. -The sprinkler system was being replaced and should be completed next week.	D 105		

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D 105	Continued From page 17 2. Review of the temperature records from the National Weather Service (NWS) for the county the facility was in from July 2025 to September 2025 revealed: -The highest temperature for July 2025 was 95 degrees Fahrenheit (°F), and the lowest temperature was 75.2°F. -The temperature was 89.6°F to 91°F on 17 days, 93°F on 2 days and 95°F on one day in July 2025. -The highest humidity level (the measure of water vapor in the air; humidity would not change the air temperature but influenced how hot the air would feel to the human body) for July 2025 was 91 percent and the lowest was 63 percent. -The highest temperature for August 2025 was 91.4°F and the lowest temperature was 68°F. -The temperature was 86°F to 88°F on six days and 91.4°F on one day in August 2025. -The highest humidity level for August 2025 was 96 percent and the lowest was 59 percent. -The highest temperature for September 2025 was 90°F and the lowest temperature was 71.6°F. -The temperature was 86°F to 89°F on four days and 90°F on three days in September 2025. -The highest humidity level for September 2025 was 93 percent and the lowest was 63 percent. Observation of the main hallway of the facility on 09/30/25 at 8:50am revealed: -There was a noticeable temperature change from the main hallway to just outside the entrance of the dining room. -Warm air was felt in the hall just outside the entrance of the dining room and inside the dining room. Observation of the thermostat in the dining room on 09/30/25 at 10:45am revealed the temperature reading on the thermostat was 79°F.	D 105		

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D 105	Continued From page 18 Observation of the thermostat in the dining room on 10/01/25 at 12:12pm revealed the temperature reading on the thermostat was 71°F. Observation of the thermostat in the activity room on 10/02/25 at 3:00pm revealed the temperature reading on the thermostat was 72°F. Requests for invoices and communication with the facility's contracted HVAC repair and installation company were made to the Administrator and the Maintenance Director on 09/30/25 at 4:50pm, 10/01/25 at 10:10am, and 10/02/25 at 9:30am but were not provided by survey exit. Interview with a resident on 09/30/25 at 9:31am revealed: -Something was wrong with the air conditioning and the dining room was always too warm. -The facility had a problem with the air conditioning in the facility for a few months now. -He did not know what the issue was or when it would be repaired. Interview with another resident on 10/02/25 at 3:04pm revealed: -It was really hot in the dining room. -Staff did not put a fan in the dining room to help with the heat. -Staff would open doors that led to the outside to help reduce heat inside the dining room. Interview with a third resident on 10/02/25 at 3:59pm revealed: -The heat in the dining room was "awful" from June 2025 until the week of 09/29/25. -When eating meals in the dining room, he would sweat due to how hot it was.	D 105		

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D 105	Continued From page 19 -He informed the Administrator, on multiple occasions, of his discomfort while in the dining room and was told the air conditioning system would be fixed soon. -The activities room was also extremely hot. -The Activity Director was sent home due to passing out from heat exhaustion. Confidential interview with a staff revealed: -The staff had called the facility's corporate hot line and complained about the temperature of the dining room in July 2025 and August 2025. -Residents had complained about the temperature in the dining room all summer. -The Administrator told the residents and the staff that corporate was aware of the broken air conditioner, and the repair company was backed up and would get to the facility as soon as they caught up. -The Administrator and the Maintenance Director put fans in the dining room, but it did not help. -The thermostat in the dining room had temperatures in the 80s and 90s. -One day last week the thermostat in the dining room was 85°F. -The more residents and staff there were in the dining room, the hotter the room would become. -The air conditioner in the kitchen did not work either and the hot air in the kitchen would come into the dining room during meals and make it hotter in the dining room. -The Administrator did not go into the dining room during meals because it was so hot; the staff had not seen the Administrator in the dining room during meals in a while. -The facility's corporate office did not get the air conditioner fixed because they owed the repair company money and the company refused to fix the equipment.	D 105		

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D 105	Continued From page 20 Interview with the Kitchen Manager on 09/30/25 at 10:55am revealed: -The air conditioner for the dining room had not worked for almost a year. -It was replaced in June 2025 but stopped working soon after it was replaced. -She did not know what the temperatures in the dining room were while the air conditioner was broken. -The temperatures in the kitchen had been as high as 99°F. -The air conditioner in the kitchen did not work either and the staff had no choice but to open the door to the dining room to get some relief in the kitchen. -There were fans everywhere, but the dining room was still hot, and the residents complained about the heat. -The residents complained about having to eat in the hot dining room. -The Administrator and the Maintenance Director knew the air conditioner was broken because they put the fans in the dining room. Interview with the Activity Director on 10/02/25 at 3:04pm revealed: -Her office was in the corner of the activity room in AL. -The facility began having problems with the air conditioner not cooling the dining room and the activities room on 06/23/25. -Last Wednesday, 09/24/25, the thermostat in the activity room read 89°F. -The temperatures in the activity room had reached the 90s in the afternoon because the sun came through the windows; it was 91°F one afternoon. -She complained to the Maintenance Director and the Administrator; she was told the Regional Maintenance Director had been informed.	D 105		

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D 105	Continued From page 21 -The residents had complained to her about the heat in the dining room and the activity room. -She had one fan for the activity room. -She had activities in the hallway because the hallway was cooler than the dining room and the activity room. -She had larger activities like bingo, in the dining room. -During one of the bingo games, it got so hot some of the residents began to complain about the heat and left the activity. -Three of the residents got up and said they felt nauseous from the heat, and they did not want to stay. -She conducted the Resident Council meetings, and the residents complained during the Resident Council meeting about the temperature in the dining room and the activity room. -The Administrator and the other managers were given a copy of the minutes from the Resident Council meeting to review. Interview with the Resident Care Coordinator (RCC) on 10/02/25 at 5:05pm revealed: -The air conditioner had been down almost all summer. -The kitchen, the activity room and the dining room had been "pretty hot". -The facility had put fans in the dining room and left the doors to the hallway open. -Once the residents all got into the dining room or activity room, it would get comfortable and was okay. -She never thought the dining room was too hot. -The residents did not complain and were not unhappy until they had to do an activity in the dining room. -The residents said it was a "little too hot" in the dining room to do any activities so they did them elsewhere.	D 105		

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D 105	Continued From page 22 -The first time the air conditioner stopped working was mid-spring 2025 and they got a new one. -The air conditioner was fixed and about a month later it broke and it got hot again. -The facility put a portable air conditioner in the dining room and the activity room, and it was not bad. -She thought the air conditioner was fixed at one time because they removed the portable air conditioner, but it got hot again. -She had not looked at the thermostats in the dining room or the activity room. -She only noticed the thermostat once when the temperature went from 77°F to 75°F because they opened the doors in the dining room to the hallway; that was about three weeks ago. Interview with the Maintenance Director on 10/01/25 at 10:10am -The broken air conditioner supplied the kitchen, the activity room and the dining room in the AL. -The air conditioner stopped working sometime in March 2025 and was replaced in June 2025. -The new air conditioner stopped working before the end of June 2025. -The repair company came out and said there were blown fuses; they replaced the fuses, and it worked again. -It worked for about three weeks and then it stopped working around the beginning or middle of July 2025. -The repair company was contacted but the facility was told the company was too busy to come and fix the air conditioner. -He placed box fans in the kitchen and dining room and opened the doors from the hallway into the dining room to draw air from the hallways where the air conditioner was working. -The facility also borrowed a portable air conditioner from another facility, but he had to	D 105		

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D 105	Continued From page 23 give it back after a couple of weeks. -The dining room stayed cool during July 2025 and August 2025 because the hallway was cool. -He looked at the thermostat on the wall in the dining room every day; the temperatures averaged from 76°F to 83°F; the highest temperature he saw was 85°F in the dining room. -He did not document the temperatures in the dining room or the activity room. -The temperature in the dining room depended on the outside temperatures and the humidity. -On 08/11/25, he notified the Corporate Maintenance Director about the issue with the air conditioner to let him know it still needed to have a repair company look at it. -The repair technician came to the facility yesterday, 09/30/25; it was the first time he had been at the facility since June 2025. -Freon was added to the air conditioner when it was installed; he was not aware of any other time freon was added. -There had not been any storms or power loss at the facility since the air conditioner was installed. -He was not told what the repair technician did to the air conditioner the day before, but it was working today, 10/01/25. -The residents asked about the air conditioner and complained about the heat in the dining room; they had complained at Resident Council meetings and to the Activity Director. -The Activity Director's office was hot; her office was in the activity room. -The dining room was also used for activities when there was a larger group of residents. Interview with the Administrator on 09/30/25 at 4:50pm revealed: -The air conditioner repair company was at the facility today, 09/30/25, to repair the equipment. -The facility had a new air condition unit installed	D 105		

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D 105	Continued From page 24 in June 2025. -The new air conditioner worked for about two weeks and then stopped working. -An air conditioner repair company came back and added freon gas to the system and it worked off and on for a while. -She was told by the Corporate Maintenance Director that the air conditioning repair company was backed up and the facility was on a list for repairs, and they would get to the facility as soon as they could. -Today, 09/30/25, was the first day the air conditioning repair company had come out since June 2025. -She was told the air conditioner was repaired and was now working; a breaker had been tripped and reset. -The breaker had been the reason the air conditioner had stopped working in June or July 2025. -She was told the breaker most likely tripped because of a storm or a power outage in the area. -The air conditioner supplied air to the dining room and the activity room in the AL. -The Maintenance Director checked temperatures in the dining room and used fans to pull the cooler air from the hallway into the dining room. Attempted telephone interview with a representative from the facility's contracted HVAC company on 10/03/25 at 2:51pm was unsuccessful. Attempted telephone interview with the facility's Regional Maintenance Director on 10/02/25 at 2:40pm was unsuccessful. 3a. Observation of resident room #206 in the SCU on 09/30/25 at 9:11am revealed:	D 105		

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D 105	Continued From page 25 -There was one resident residing in the room. -There was a bathroom with a shower adjacent to the room. -The shower floor was a fiberglass material. -There was a patched area approximately 12 inches long and 10 inches wide on the floor to the shower; the patch extended from the front lip of the shower to the drain. -There was a crack in the patch that extended 10 inches from the drain; the crack was black. -There was a second crack in the floor of the shower that extended eight inches from the opposite side of the drain and branched out to the left and the right. -The second crack curved to the left six inches and was the shape of a ball and toes of a foot. -The second crack curved 12 inches to the right and was the shape of the side of a foot with the crack continuing to curve in the shape of the heel of a foot. -The second crack was depressed exposing the jagged edges of the fiberglass. -There were patched areas on the second crack. -There were large black and brown spots along the cracks and on the floor of the shower. Interview with a personal care aide (PCA) on 10/01/25 at 11:05am revealed: -There were a few showers in the SCU with damaged floors. -The Maintenance Director had repaired the shower floor in room #206 but a couple of months later it broke again; sometime around the first of the year. -The PCAs took the residents to the spa to bathe them. -The resident who resided in room #206 could bathe herself and used the shower in her room until it broke. -She did not want the resident who resided in	D 105		

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D 105	Continued From page 26 room #206 to put her foot through the shower floor or get cut on the crack. Interview with the Special Care Unit Coordinator (SCC) on 10/02/25 at 2:01pm revealed: -She went into the residents' rooms and bathrooms every day and looked for anything that was broken or needed to be repaired. -If the staff saw something that needed to be repaired they should let her or the Maintenance Director know. -She would tell the Maintenance Director when she saw something that he needed to work on but, she did not document anything it was always communicated verbally. -The Maintenance Director usually took about a week to repair things. -She told the Maintenance Director about the shower floors, and he said he was aware of it and was working on them. -The Maintenance Director usually sealed the cracks up himself. -The staff were giving the residents their showers in empty rooms or in the spa if the flooring in the shower was cracked. -Her concern was the flooring could crack more, and a resident could get cut. Based on observations and interviews it was determined the resident who resided in resident room #206 was not interviewable. b. Observation of a resident room on the AL hall on 09/30/25 at 8:56am revealed: -There was a bathroom with a shower in the room. -There was a large crack in the fiberglass on the floor of the shower from the drain of the shower to the corner of the shower. -There was another smaller crack in the	D 105		

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D 105	Continued From page 27 fiberglass on the floor of the shower. -The cracks left exposed areas of the flooring and caused jagged, sharp pieces of the shower floor. c. Observation of resident rooms #507/509 on the AL hall on 10/02/25 at 1:33pm revealed: -There was a small common area with a bathroom and two resident rooms adjacent to the common area. -There was a long crack in the fiberglass on the shower floor that extended from the shower drain to the back right corner of the shower floor. -There was a large rectangular brown stain near the shower drain. -There were 3 brown stained areas at the back of the showers floor. Based on observations and interviews it was determined the residents who resided in resident room #507/509 was not interviewable. d. Observation of resident rooms #508/510 on the AL hall on 10/02/25 at 1:35pm revealed: -There was a small common area with a bathroom and two resident rooms adjacent to the common area. -There was a Y shaped crack in the fiberglass on the shower floor that extended from the shower drain to the center wall of the shower. Based on observations and interviews it was determined the residents who resided in resident room #508/510 was not interviewable. Observation of resident room #606 on the AL hall on 10/02/25 at 1:44pm revealed: -There was surface cracking in the fiberglass on the shower floor near the shower drain. -There was extensive yellow-brown staining on the shower floor and walls.	D 105		

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D 105	Continued From page 28 Based on observations and interviews it was determined the residents who resided in resident room #606 was not interviewable. Interview with the Activity Director on 10/02/25 at 3:30pm revealed: -A couple residents from the AL complained about the cracked floors in their showers at the Resident Council Meetings. -She told the Maintenance Director after the residents complained. -The Maintenance Director told her he kept fixing them, but he was not responsible for replacing them. _____ Interview with the Maintenance Director on 10/01/25 at 10:25am revealed: -He was aware the facility had showers with cracks and damaged floors; there were a lot that needed to be replaced. -The Regional Maintenance Director looked at the showers the last time he was in the facility and was aware the fiberglass floors were damaged in several of the showers. -The Regional Maintenance Director did a walk-through inspection when he was in the facility in June 2025. -The PCAs gave the residents in the SCU showers in the spa so the residents would not get hurt. -He had attempted to patch some of the cracks and to make a smooth flat surface in some of the shower floors. -The shower floors deteriorated after he attempted to patch them; some of the floors even split. -He was concerned residents could get injured if they used the showers with the cracked and damaged floors.	D 105		

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D 105	Continued From page 29 -The residents could cut their feet, or because the floors were uneven it could cause them to lose their balance and fall. -He thought there were about 10 showers in the AL and the SCU that needed to be replaced. -An outside contractor company needed to come in and replace the floors in the showers. -The Regional Maintenance Director talked to him in the earlier part of the year about a contractor coming in to replace the floors. -The Regional Maintenance Director Did not give him a date, and a contractor had not been to the facility yet. Telephone interview with the Administrator on 10/03/25 at 4:10pm revealed: -She did not do inspections of resident rooms because the Maintenance Director did inspections. -She was made aware of the showers with damaged floors during and inspections by the Division of Health Services Regulation (DHSR) Construction Section on 08/13/25. -She was not aware of a plan to repair the damaged shower floors. -The facility was still waiting for a company to be contracted to do the repairs. -She did not know why there was a delay for a repair company; maybe the company needed to be licensed to do ceramic work. -The Regional Maintenance Director was handling the shower repairs. -She did not know how many showers needed to be repaired and she and not seen the damaged showers. -She was concerned about the damaged shower floors because a resident could become injured, the cracks could cause mold infestation. -She was not told the residents were not able to use their own showers; they should not have to	D 105		

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D 105	Continued From page 30 go to another room to shower. -The residents had not complained about the damaged showers. -She expected the staff in the SCU to let the Maintenance Director know when there was something that needed to be repaired. -She expected the Maintenance Director to let her know what needed to be repaired and to do repairs as needed. Attempted telephone interview with the facility's Regional Maintenance Director on 10/02/25 at 2:40pm was unsuccessful. 4. Observation of resident room #409 on the Assisted Living side on 10/02/25 at 4:23pm revealed: -There was a battery-operated smoke detector in her room. -The smoke detector was beeping, indicating the battery needed to be changed. Interview with the resident who resided room #409 on 10/02/25 at 4:23pm revealed: -She could not sleep due to the beeping sound from the smoke detector. -The smoke detector had been beeping for several months. -The beeping sound from the smoke detector occurred approximately every 30 seconds. -She had informed staff of the beeping noise on several different occasions and was told the Maintenance Director would fix it. Interview with the Maintenance Director on 10/02/25 at 5:19pm revealed: -He was aware the smoke detector in resident room #409 was beeping and needed to have the battery changed but he had not gotten around to changing the battery.	D 105		

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D 105	Continued From page 31 -He had not changed the battery in the smoke detector due to being the only Maintenance Technician in the facility and having other responsibilities. -He checked battery operated smoke detectors in the facility once a month. Interview with a medication aide (MA) on 10/02/25 at 5:00pm revealed: -She was aware the smoke detector in resident room #409 was beeping. -She could not recall if she informed anyone that the smoke detector was beeping. -The MAs did not change the smoke detector batteries. Interview with the Administrator on 10/02/25 at 5:30pm revealed: -The smoke detector in resident room #409 began beeping on 08/13/25. -The battery for the smoke detector was at the facility so the Maintenance Director could change it. -Her expectation was that smoke detector batteries would be replaced within a timely manner. _____ The facility failed to ensure the sprinkler system, heating, ventilation, air-conditioning (HVAC) system, and plumbing system was functioning properly. The sprinkler system in the facility had not been working properly for at least 2 years which placed the residents at risk of not knowing if a fire broke out in the facility. The HVAC system was broken down during July and August 2025. A temperature in the dining room, where the residents had their meals, registered 85 degrees, making the environment uncomfortable for the residents, and a temperature in the activity room, where residents participated in activities,	D 105		

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D 105	Continued From page 32 registered 89 degrees. Residents complained of feeling nauseous and had to leave the activity. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/03/25. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 17, 2025.	D 105		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure referral and follow-up to meet the routine healthcare needs for 2 of 5 sampled residents related to notifying the Mental Health Provider (MHP) of a new referral (#2) and notifying the primary care provider (PCP) when a nutritional supplement was substituted (#5). The findings are: 1. Review of Resident #2's current FL2 dated 08/11/25 revealed: -Diagnoses included dementia and Wernicke's encephalopathy. -He was intermittently disoriented.	D 273		

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D 273	Continued From page 33 Review of Resident #2's care plan dated 09/17/25 revealed: -Resident #2 was verbally abusive. -A referral was made for Mental Health (MH) services on 08/01/25. -The care plan was signed by the PCP. Review of an Incident/Accident Report dated 09/14/25 revealed: -Resident #2 was angry for an unknown reason and threw a chair at another resident. -Resident #2 was aggressive toward a staff member. -Resident #2 was verbally aggressive. -The PCP was notified. Review of an Incident/Accident Report dated 09/16/25 revealed: -Resident #2 was shouting and using foul language. -The PCP was notified. Review of an Incident/Accident dated 09/20/25 revealed: -Resident #2 threw wet toilet tissue on another resident. -The PCP was notified. Interview with a personal care aide (PCA) on 10/01/25 at 11:03am revealed: -Resident #2 was combative with care. -He used rude and used foul language. -He was difficult to redirect. -On 09/14/25, when he threw the chair at another resident, she tried to de-escalate the situation by redirecting Resident #2. -She did not know if Resident #2 was seen by the MHP.	D 273		

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D 273	Continued From page 34 Interview with a second PCA on 10/01/25 at 4:03pm revealed: -Resident #2 had days when he was quiet and days when he was agitated. -It could be anything that set him off. -One day she was joking around with him, and he got angry and began yelling at her. -She did not know if Resident #2 was seen by the MHP. Interview with a medication aide (MA) on 10/02/25 at 9:31am revealed: -Resident #2 was relaxed with her; he did not have any agitation with her. -When Resident #2 was first admitted, he got angry when it was his shower day; she left him alone and re-approached him later and he agreed. -The Special Care Unit Coordinator (SCC) handled referrals to other providers. Interview with the SCC on 10/02/25 at 9:45am revealed: -Resident #2 was a very nice guy but got anxious and upset. -Other residents' behaviors on the unit made him anxious and he would yell out and curse. -He had one or two episodes of physical aggression, no residents were injured. -The PCP was notified. -She stated the MHP saw Resident #2 but did not leave any new orders Interview with the Resident Care Coordinator (RCC) on 10/02/25 at 3:00pm revealed: -When a resident was admitted, consents for outside providers were collected. -Resident #2's family signed a consent for MH services to be provided. -She emailed the MHP of the new referral for	D 273		

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D 273	Continued From page 35 Resident #2. -She typically got an email back that confirmed the referral was received. -The MHP would then see the resident on her next visit. -A MH referral should have been made for Resident #2. -The MH provider had not seen Resident #2. -Resident #2's PCP saw him after the incident on 09/14/25 but did not tell her to refer him to MH. Telephone interview with the MHP on 10/03/25 at 11:21am revealed: -The facility emailed or faxed MH referrals to the administrative office and the office would let her know there was a new referral. -She would see the resident on her next visit. -She visited the facility monthly. -She did not see Resident #2 for a MH referral. -She did not receive the referral from 08/01/25, when Resident #2 was admitted. -She had educated the staff at the facility repeatedly on the process. -The incident on 09/14/25 when Resident #2 threw a chair at another resident could have been prevented if she received the referral when he was admitted in August 2025. Interview with the Administrator on 10/02/25 at 2:34pm revealed: -She was aware Resident #2 had some aggressive behavior. -She knew his PCP saw him and wanted to try an antianxiety gel but wanted to talk to the MHP first. -Resident #2 had not been seen by the MHP yet. -The RCC was responsible for getting referrals to the MHP. -The MHP should have seen Resident #2 by now, which could have prevented some of his behaviors.	D 273		

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D 273	Continued From page 36 Attempted telephone interviews with the PCP on 10/01/25 at 3:30pm, 10/02/25 at 1:26pm. and 10/03/25 at 12:00pm were unsuccessful. 2. Review of Resident #5's FL2 dated 03/11/25 revealed diagnoses included Alzheimer's disease, dementia, intellectual disabilities, hypertension, atrial fibrillation, peripheral vascular disease, acute kidney failure, and hypothyroidism. Review of Resident #5's signed physician's order dated 03/11/25 revealed there was an order to start nutritional supplements two times a day in between meals. Observation of the kitchen on 09/30/25 at 10:50am revealed: -There were three cases of a nutritional supplement in the dry storage area. -Each case contained twelve, 32-ounce cartons of butter pecan flavored nutritional supplements. -There were two cases with a delivery date of 04/03/25 and were labeled 1 of 2 and 2 of 2; both cases were opened. -The case labeled 1 of 2 had ten 32-ounce cartons in it and the case labeled 2 of 2 had eleven 32-ounce cartons of nutritional supplement in it. -There was a third case of nutritional supplements with a delivery date of 09/04/25 and was labeled 1 of 1; the case was unopened and had twelve 32-ounce cartons in it. -There were no nutritional supplements stored in the coolers or the freezer in the kitchen. Review of the online label of a 4-ounce carton of a nutritional supplement shake revealed: -The carton was 4 ounces. -The total fat was 7gm, sodium was 100mg,	D 273		

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D 273	Continued From page 37 carbohydrate was 33gm, protein was 6gm and the calories were 220 per serving. Review of the label on the 32-ounce carton of the nutritional supplement revealed: -The serving size was 8 ounces. -The total fat was 17gm, sodium was 310mg, carbohydrate was 62gm, protein was 20gm and calories were 480 per serving. Review of the facility's contracted food vender's invoices revealed: -On 04/03/25, four cases of seventy-five 4-ounce cartons of nutritional supplement shakes were ordered, but only two cases were delivered; two cases were out of stock. -On 04/03/25, two cases of twelve 32-ounce cartons of nutritional supplements were substituted for the nutritional supplement shakes. -On 09/04/25, four cases of seventy-five 4-ounce cartons of nutritional supplement shakes were ordered, but only three cases were delivered. -On 09/04/25, one case of twelve 32-ounce cartons of nutritional supplements were substituted for the nutritional supplement shakes. -On 09/11/25, 09/18/25, 09/24/25 no nutritional supplement shakes were ordered. Observation of the SCU on 10/01/25 at 1:45pm revealed there was an opened 32-ounce carton of a nutritional supplement on the top of the medication cart. Interview with a medication aide (MA) on 10/01/25 at 1:45pm revealed: -The kitchen staff gave the nutritional supplements to the MAs. -The residents who were ordered nutritional supplements all got the same supplement, a nutritional shake.	D 273		

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D 273	Continued From page 38 -The nutritional shakes came in a small carton and were either chocolate, strawberry or vanilla. -There were always enough of the nutritional supplement shakes to give to all the residents with supplement orders; she had never run out. -Today, 10/01/25, the kitchen staff gave her a large container of a nutritional supplement to give to the residents. -The large carton was a different brand than the smaller cartons and was a butter pecan flavor. -She poured the nutritional supplement from the large carton into a disposable drink up and administered them to the residents. -She was not sure how much she poured but the cup was almost full. -She had used the large carton of butter pecan flavored nutritional supplement about a month ago. -She used what the kitchen staff gave her. Interview with the Kitchen Manager on 10/02/25 at 10:08am revealed: -She ordered three cases of nutritional supplement shakes once a week. -The food supply company had substituted the order for the nutritional shakes with another product about three months ago. -The nutritional supplement the food supply company provided was in a larger carton and was not the same brand name as the nutritional shakes. -She gave the large cartons of nutritional supplements to the MAs to administer and told them to use it up. -She did not let the Special Care Unit Coordinator (SCC), or the Administrator know the nutritional supplements were not the same as the nutritional shakes she usually ordered. -She had received the nutritional supplement in the large cartons today, 10/02/25, as a substitute	D 273		

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D 273	Continued From page 39 for the nutritional shakes. -She did not let anyone know about the substitution because she thought the nutritional supplements were the same if the food supply company sent them. Telephone interview with Resident #5's primary care provider (PCP) on 10/01/25 at 4:20pm revealed: -The facility had a house order for nutritional supplement shakes for the residents with an order for a nutritional supplement. -She had not been notified that the facility had issues getting the nutritional shakes from their supplier and they had a different nutritional supplement. -She was not familiar with the nutritional supplement the food company had substituted and would like to compare the substitute to the nutritional shake. -She wanted to make sure the nutritional supplement was a good substitute for the residents. Telephone interview with the SCC on 10/03/25 at 1:14pm revealed: -The facility used a brand name nutritional supplement shake for the residents; it was a house order for the nutritional shakes. -One time the facility was waiting on the food delivery truck to bring nutritional shakes, and they administered the nutritional shakes once the supply was delivered; residents did not miss their scheduled nutritional supplement administration. -She did not recall a time when the facility was out of the nutritional shakes. -The MA or the kitchen staff would have let her know if they had to substitute with another nutritional supplement. -She had not seen the substituted nutritional	D 273		

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D 273	Continued From page 40 supplement on the medication carts that week; the MAs or the kitchen staff did not let her know there were no nutritional shakes to administer. -The kitchen staff should have let her know because the nutritional shakes were an order. -If the kitchen had to substitute a nutritional supplement, she would have to ask the PCP if it was an acceptable substitute to give to the residents. -If she had known there was a different nutritional supplement she would have notified the PCP. Interview with the Resident Care Coordinator (RCC) on 10/02/25 at 5:19pm revealed: -The facility had a house order for a nutritional supplement shake. -She knew the facility had trouble getting the nutritional shake from the food supply company; because the Kitchen Manager had told her. -The food supply company had substituted another nutritional supplement. -There had been a couple of times the facility had to use the substituted nutritional supplement in place of the nutritional supplement shakes. -She was not sure how many times they had to use the substituted nutritional supplement. -They had never run out of something to give to the residents because they had the substituted nutritional supplement. -She had not notified the PCP about the substitution of the nutritional supplement because she assumed they were all the same. -She had not looked at the nutritional content information to compare the nutritional supplement to the nutritional shakes. -Now she would look at the two different nutritional supplements and compare them and notify the PCP because she would not want to give the residents a supplement they were not supposed to have.	D 273		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 41 Telephone interview with the Administrator on 10/03/25 at 3:39pm revealed: -She was not aware the food supply company had been substituting a different nutritional supplement for the nutritional supplement shakes the residents were ordered until yesterday, 10/02/25. -She did not know there was a difference between the nutritional supplement that was substituted, and the nutritional shakes the residents were ordered -She did not realize it was something that the PCP should have been contacted for until the Kitchen Manager and the SCC brought it to her attention yesterday, 10/02/25. Based on observations, interviews and record reviews it was determined Resident #5 was not interviewable. _____ The facility failed to ensure Resident #2 was seen by the mental health provider (MHP) after a referral was made on 08/01/25, and the resident had one incident where he was verbally aggressive and threw a chair at another resident. The resident continued to be verbally abusive to staff and residents, and have aggressive behaviors including placing wet toilet paper on his roommate. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/02/25. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 17, 2025.	D 273		

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D 276	Continued From page 42	D 276		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to ensure physicians' orders were implemented for 1 of 5 sampled residents (#1) related to an order for finger stick blood sugar (FSBS) checks three times daily for seven days. The findings are: Review of Resident #1's current FL-2 dated 04/08/25 revealed: -Diagnoses included vascular dementia, Alzheimer's disease, hyperlipidemia, hypertension and irritable bowel syndrome. -Resident #1 resided in the special care unit (SCU). Review of Resident #1's hospital after visit summary dated 09/21/25 revealed: -Resident #1 was seen at the local emergency department (ED) following a fall. -The local Emergency Medical Services (EMS) reported FSBS results were below 70. -Resident #1's FSBS result was 76 at the ED.	D 276		

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D 276	Continued From page 43 -Resident #1 had a new order for FSBS checks three times a day before meals. Review of Resident #1's physician's order dated 09/23/25 revealed: -There was an order for FSBS checks three times daily for one week. -Notify Resident #1's primary care provider (PCP) if FSBS results were less than 100 or greater than 400. Review of Resident #1's September 2025 electronic medication administration record (eMAR) revealed there was no entry for FSBS checks three times daily and to notify the PCP when results were less than 100 or greater than 400. Review of the local EMS incident reports revealed: -On 09/21/25, at 5:09pm, EMS responded to a call from the facility because Resident #1 had fallen. -Resident #1's FSBS was 66 at 5:30pm and 69 at 5:40pm when EMS checked it. -The EMS administered 15gms of oral glucose to Resident #1; his condition improved. -Resident #1 was transported by EMS to the hospital. -On 09/29/25, at 11:30am, EMS responded to a call from the facility for Resident #1 because of a fall. -Resident #1's FSBS was 87 at 11:51am. -Resident #1 was transported by EMS to the hospital. Telephone interview with the Director of EMS on 10/01/25 at 2:48pm revealed: -The EMS were called to the facility on 09/21/25, because Resident #1 fell.	D 276		

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D 276	Continued From page 44 -When EMS checked Resident #1's FSBS the result was 66. -The EMS repeated the FSBS check, and the result was 69. -The EMS were called to the facility on 09/29/25 because Resident #1 fell again. -Resident #1's FSBS result was 87. -The EMS protocol was for FSBS results higher than 70; if FSBS results were less than 70 the resident could become dizzy, confused and fall. Telephone interview with a representative from the facility's contracted pharmacy on 10/03/25 at 10:44am revealed: -The pharmacy put new orders in the eMAR when they received them from the facility, then facility staff approved the order on the eMAR. -The pharmacy did not have an order for FSBS checks for Resident #1 dated 09/21/25 or 09/23/25. Telephone interview with Resident #1's PCP on 10/01/25 at 4:05pm revealed: -She wrote an order for Resident #1 to have FSBS checks three times a day before meals for seven days after his fall on 09/21/25. -Resident #1's FSBS was less than 70 when he arrived at the hospital on 09/21/25. -The hospital had written an order for FSBS checks before meals three times daily. -Resident #1 was hypoglycemic (had low blood sugar) when she saw him on 09/23/25, she did not recall his FSBS value. -She wrote the order for the FSBS checks three times a day with parameters at the visit on 09/23/25. -She wanted to be notified if his FSBS results were less than 100 because anything below 70 became a concern. -If Resident #1's FSBS result was 100 it could	D 276		

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D 276	Continued From page 45 continue to drop even lower, and she wanted to be aware of his results. -She wanted to be sure Resident #1 was eating because his FSBS would drop even lower. -FSBS results below 70 could cause Resident #1 to become lethargic or lightheaded and he could fall again. -It was a concern when Resident #1's FSBS result was 87 on 09/29/25 because it could continue to drop. -She was not aware Resident #1's FSBS checks were not being done. Interviews with a medication aide (MA) on 09/30/25 at 9:50am and 3:25pm revealed: -There were no residents in the SCU with FSBS checks. -Resident #1 had a fall last week on 09/21/25 and was sent to the ED via EMS. -Resident #1 returned to the facility from the hospital on 09/21/25, with an after visit summary. -She faxed any orders and the hospital after visit summary to the pharmacy. -She did not recall what the orders were on the hospital after visit summary dated 09/21/25. -Resident #1 had a second fall on 09/29/25 and was sent to the hospital. Interview with a second MA on 10/01/25 at 1:45pm revealed: -Resident #1 had an order for FSBS checks when he returned from the hospital on 09/21/25. -The order was on the hospital after visit report. -Resident #1's FSBS checks had not been started; she did not know why. -She read the hospital after visit report and spoke to the PCP after he returned. -The order for FSBS checks was not on the eMAR. -The pharmacy was supposed to put the order for	D 276		

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D 276	Continued From page 46 FSBS checks on the eMAR. -Resident #1 had a second fall on 09/29/25. -She did not know who sent the order from the PCP or the hospital after visit summary to the pharmacy. Interview with the Special Care Unit Coordinator (SCC) on 10/02/25 at 2:33pm revealed: -She checked for new orders from the hospital when a resident returned and when the PCP wrote them. -She or the MAs sent orders to the pharmacy. -The pharmacy put FSBS orders in the eMAR once they received them. -She was responsible for checking the eMAR to make sure new orders were in the eMAR and were correct. -She recalled the PCP's order for Resident #1's FSBS checks on 09/23/25 because she spoke to the PCP about them to be sure the order was correct. -Resident #1's FSBS checks were never implemented because the FSBS order was never sent to the pharmacy. Telephone interview with the Administrator on 10/03/25 at 4:10pm revealed: -The SCC was responsible for ensuring medication orders were sent to the pharmacy and on the eMAR. -The SCC should have checked to see if Resident #1's orders for FSBS checks were done and on the eMAR. -The PCP's orders for Resident #1's FSBS checks should have been sent to the pharmacy and followed. _____ The facility failed to ensure new orders were implemented for Resident #1 who, following a fall with low FSBS values, had an order for FSBS	D 276		

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D 276	Continued From page 47 checks three times daily and to notify the PCP if the FSBS was less than 100. The FSBS checks were not implemented, and the resident had a second fall and their FSBS value was less than 100. This failure was detrimental to the health, safety and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/17/25 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 17, 2025.	D 276		
D 285	10A NCAC 13F .0904(a)(4) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (a) Food Procurement and Safety in Adult Care Homes: (4) There shall be a three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the menus established in Paragraph (c) of this Rule for both regular and therapeutic diets. For the purpose of this Rule "perishable food" is food that is likely to spoil or decay if not kept refrigerated at 40 degrees Fahrenheit or below, or frozen at zero degrees Fahrenheit or below and "non-perishable food" is food that can be stored at room temperature and is not likely to spoil or decay within seven days.	D 285		

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D 285	Continued From page 48 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure a 3-day supply of perishable food and a 5-day supply of nonperishable fruits and vegetables were available. The findings are: Review of the facility's current license effective 01/01/25 revealed the facility was licensed for 62 beds. Review of the facility's census on 09/30/25 revealed there were 46 residents residing in the facility; two residents were out of the facility. Observation of the food supply in the kitchen on 09/30/25 at 10:50am revealed: -There were three #10 cans (a large can with 21 half cup servings per can) of turnip greens. -There were four #10 cans of cut sweet potatoes. -There were two #10 cans of sliced carrots. -There was no fresh fruit, no canned fruit and no frozen fruit available to serve. -There were no fresh vegetables, and no frozen vegetables available to serve. Review of the facility's lunch menu for 09/30/25 revealed the menu for lunch listed 3 ounces of BBQ glazed meatballs, 4 ounces of celery, a dinner roll, and half a cup of grapes. Observation of the lunch meal on 09/30/25 at 12:15pm revealed the residents were served 3 each BBQ meatballs, 2 ounces of green beans, and grapes in a green gelatin.	D 285		

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D 285	Continued From page 49 Review of the facility's breakfast menu for 10/01/25 revealed one egg, one ounce of breakfast ham and a half a cup of fresh fruit were to be served. Observation of the breakfast meal on 10/01/25 at 8:10am revealed the residents were served one third of a cup of scrambled eggs, a 2-ounce portion of kielbasa, and no fruit. Review of the food delivery invoices for September 2025 revealed: -The food was delivered every Thursday. -The invoices averaged $1881.03 for each delivery. -On 09/04/25, 24 pounds of frozen cut green beans were delivered; 96 half cup servings. -There were 24 pounds of frozen broccoli florets delivered; 96 half cup servings -There were 30 pounds of frozen Italian vegetable blend delivered; 120 half cup servings. -There were 50 pounds of fresh cabbage heads; approximately 160 half cup servings of usable cabbage. -There were 6 #10 cans of carrots delivered; 126 half cup servings. -There was no fruit on the food delivery on 09/04/25. -On 09/11/25, 30 pounds of frozen cut green beans were delivered; 120 half cup servings. -There were 6 #10 cans of carrots delivered; 126 half cup servings. -There was no fruit on the food delivery on 09/04/25. -On 09/18/24, 24 pounds of frozen cut green beans were delivered; 96 half cup servings. -There were 30 pounds of frozen Italian vegetable blend delivered; 120 half cup servings. -There were 24 pounds of frozen mixed vegetables delivered; 96 half cup servings.	D 285		

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D 285	Continued From page 50 -There were 14 stalks for fresh broccoli delivered; approximately 84 half cup servings. -There were 10 pounds of frozen whole strawberries; 40 half cup servings. -There were six #10 cans of fruit cocktail delivered: 126 half cup servings. -There were six #10 cans of sliced peaches delivered: 126 half cup servings. -There were six #10 cans of mandarin oranges delivered: 126 half cup servings. -On 09/24/25, 24 pounds of frozen cut green beans were delivered; 96 half cup servings. -There were 24 pounds of frozen vegetable blend delivered; 96 half cup servings. -There were 6 #10 cans of carrots delivered; 126 half cup servings. -There was no fruit on the food delivery on 09/25/25. Confidential interview with a staff revealed: -The residents' portions of food were too small. -She was told by the Kitchen Manager they could not give seconds because there was not enough food. Interview with the Activity Director on 10/02/25 at 3:04pm revealed: -The residents complained at Resident Council meetings about the kitchen staff running out of desserts at meals and not everyone getting one. -The residents complained at Resident Council meetings about not getting condiments like sugar, ketchup, and vinegar. -Sometimes there were no snacks available for the residents. -The Kitchen Manager told her the food budget made it hard to get enough supplies in. Interview with the Kitchen Manager on 09/30/25 at 10:55am revealed:	D 285		

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D 285	Continued From page 51 -She did a food order based on the weekly menu and what the residents preferred and submitted the order to corporate to approve. -She had to make a lot of substitutions to the menu because they did not have everything they needed for some of the meals. -She tried to keep the food orders to $1,800.00 per delivery. -She had to submit the orders to cooperate for approval. -If a food order was above $1,800.00, they would cancel the whole order, and she would have to start over. Interview with the Kitchen Manager on 10/02/25 at 9:39am revealed: -Sometimes she had to go to the grocery store to purchase items they ran out of including fresh fruit, milk, bread, and snacks two to three times a week. -She did not serve fruit on 10/01/25 because she did not have fruit to serve to the residents. -There was no fresh or canned fruit in the kitchen and there was no one who could go purchase fruit from the store. -Sometimes she did not have the budget to purchase condiments for the residents. -The kitchen had a food delivery today 10/02/25; it did not look like enough food to last the facility until the next delivery. -The couple of days before a food delivery she did not feel she had enough food on hand for even three days. Telephone interview with the Administrator on 10/03/25 at 3:14pm revealed: -She approved the food orders after the Kitchen Manager completed them. -She sent the orders to the facility's corporate office for approval.	D 285		

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D 285	Continued From page 52 -She looked at the order to be sure what was ordered was what was on the menu. -She also looked to see if they were staying within the budget. -The facility's corporate office would approve the food order as long as it was within the budget. -They had run out of items from time to time and had to purchase them from the local grocery store. -They had purchased bread, cheese and milk from the local grocery store. -She had to purchase items seven to eight times a month. -The budget did not increase or decrease with the resident census. -It was difficult to provide food at the current budget. -She knew it was a struggle the days before the food delivery truck came. -She was not aware the facility was required to have a supply of three-day perishable and five-day nonperishable food. -It was almost impossible to obtain the requirement on the current budget the facility had for food. -If there was a weather emergency and she could not get a food delivery she was concerned the facility might not have an adequate food supply for the residents after three days.	D 285		
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes: (1) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage	D 286		

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D 286	Continued From page 53 containers. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure mealtime table service in the Special Care Unit (SCU) included a place setting consisting of a knife, fork, and spoon. The findings are: Observation of the lunch meal on 09/30/25 from 11:42am to 12:15pm revealed: -There were two dining rooms in the SCU; 11 residents in one dining room and 13 in the second. -Each resident received a napkin with a fork and a spoon rolled inside; there were no knives. -The residents were served BBQ glazed meatballs, green beans, a slice of bread, and grapes. -Staff were using the residents' forks and cutting their meatballs for them. -The staff were using the side of the forks to cut the residents' meatballs. -One resident used the side of his spoon to hold the meatball and used his fingers to break it in half. -There was a resident who stabbed his meatball with his fork and ate the meatball by taking bites of the meatball while it was on the end of the fork. Observation of the breakfast meal on 10/01/25 from 8:10am to 8:30am revealed:	D 286		

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D 286	Continued From page 54 -There were two dining rooms in the SCU; 12 residents in one dining room and 12 in the second. -Each resident received a napkin with a fork and a spoon rolled inside; there were no knives. -The residents were served scrambled eggs, a piece of kielbasa cut in half length wise and some had a piece of bread or oatmeal. -Several of the residents stabbed their kielbasa with their fork and took bites from the fork. -One resident held the kielbasa down with her spoon and attempted to cut it with the side of her fork. -Two residents picked the kielbasa up with their fingers and ate it. Observation of the lunch meal service in the dining room in the SCU on 09/30/25 at 12:02pm revealed: -Each resident had a fork and a spoon. -There were no knives at any of the place settings. -There was a resident using a fork to cut her meatballs. Observation of the breakfast meal service in the dining room in the SCU on 10/01/25 at 8:30am revealed: -Each resident had a fork and a spoon. -There were no knives at any of the place settings. -There was a resident using a fork to cut her sausage. Interview with a medication aide (MA) in the SCU on 10/01/25 at 2:10pm revealed: -She noticed the residents did not get knives. -The SCU staff cut the residents' food if they needed help. -She thought the residents did not get knives	D 286		

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NAME OF PROVIDER OR SUPPLIER
CASWELL HOUSE

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YANCEYVILLE, NC 27379

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D 286	Continued From page 55 because it was the SCU and they could hurt themselves. Interview with the Kitchen Manager on 10/02/25 at 9:39am revealed: -The personal care aids (PCA) wrapped the silverware in paper napkins for breakfast. -The kitchen staff wrapped the silverware in paper napkins for lunch and dinner. -The silverware wraps for the SCU only had a spoon and a fork; the SCU residents never got a knife. -She was told by the previous Administrator never to give the residents in the SCU a knife. -She did not know why the SCU residents did not get a knife, she thought because the residents had dementia and might hurt themselves. -She did not think the residents in the SCU could hurt themselves with a butter knife. -She had plenty of knives and could give every resident in the SCU a knife. Telephone interview with the Special Care Unit Coordinator (SCC) on 10/03/25 at 1:32pm revealed: -The residents who resided in the SCU should not have knives because they could hurt themselves or another resident with them. -It had never happened, but it could. -The staff were always available to cut the residents' food if they needed too. Telephone interview with the Administrator on 10/03/25 3:00pm revealed: -She did rounds in the SCU dining room three to four times a week. -She was aware the residents were supposed to have a full place setting including a fork, knife and spoon. -She had not noticed the residents in the SCU did	D 286		

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D 286	Continued From page 56 not have knives to use but she had not looked for knives because she was looking for other things related to meals. -The kitchen had plenty of knives so they should be giving the residents in the SCU one at each meal.	D 286		
D 292	10A NCAC 13F .0904(c)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition and Food Service (c) Menus In Adult Care Home: (3) Any substitutions made in the menu shall be of equal nutritional value, in order to maintain the daily dietary requirements in Subparagraph (d)(3) of this Rule, appropriate for therapeutic diets, and documented in records maintained in the kitchen to indicate the foods actually served to residents. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to maintain a record of menu substitutions documenting what was served to residents. The findings are: Review of the menu for lunch on 09/30/25 revealed BBQ glazed meatballs, celery stick, a dinner roll, grapes and milk were to be served.	D 292		

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D 292	Continued From page 57 Observation of the facility's main dining room on 09/30/25 at 11:49am revealed: -There was a daily menu in a stand at the entrance to the main dining room. -The lunch menu listed BBQ glazed meatballs, celery sticks, dinner roll, milk and grapes were to be served. -There were lines marking out the celery sticks and the dinner roll from the list on the lunch menu. -Green beans were handwritten to the right of the marked-out celery sticks and loaf bread was handwritten beside the marked-out dinner roll. Observation of the lunch meal on 09/30/25 at 11:42am revealed BBQ glazed meatballs, green beans, a slice of loaf bread, grapes and milk were served. Review of the breakfast menu on 10/01/25 revealed scrambled egg, breakfast ham, fresh fruit, juice and milk were to be served. Observation of the facility's main dining room on 10/01/25 at 7:45am revealed: -There was a daily menu in a stand at the entrance to the main dining room. -The breakfast menu listed scrambled egg, breakfast ham, fresh fruit, juice and milk. -The breakfast ham was marked out and sausage was handwritten to the side. Observation of the breakfast meal on 10/01/25 at 8:10am revealed scrambled egg, kielbasa, milk and coffee were served. Interview with the Kitchen Manager on 10/02/25 at 9:39am revealed: -She had to make substitutions to the menu for almost every meal due to resident preferences,	D 292		

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D 292	Continued From page 58 food orders and issues with deliveries. -She crossed out the menu item and wrote the substituted menu items on the weekly and daily menus that were posted outside of the main dining room. -She did not document the substitutions anywhere else. -She substituted each item on the menu for a similar item. -She did not keep a copy of the menus she wrote on. -She did not realize she had to keep documentation of the menu substitutions, so she tossed them out. Telephone interview with the Administrator on 10/03/25 at 3:00pm revealed: -The cooks had to make substitutions on the menu. -The cooks were supposed to substitute a "like item for a like item", meats for meats etc. -The Kitchen Manager or the cook wrote the substitutions on the menu so the residents would know what was being served for the meal. -She did not know if the Kitchen Manager kept the menus after she wrote on them. -She did not know the substitutions needed to be logged and kept.	D 292		
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages shall be offered in accordance with each residents' prescribed diet or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks.	D 298		

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D 298	Continued From page 59	D 298		

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to offer snacks or make available three snacks a day for the residents.

The findings are:

Review of the facility's cycle week-at-glance menu for the current week revealed snacks were not listed on the menu.

Review of the facility's resident census for 09/30/25 revealed 25 residents resided in the special care unit (SCU) and 37 residents resided in the assisted living (AL).

Observations of the SCU on 10/01/25 from 9:45am to 11:45am and 1:45pm to 2:45pm to revealed snacks were not offered in the SCU.

Observation of a resident in the SCU on 10/01/25 at 11:45am revealed he came into the day room and announced he was hungry and wanted to eat.

Observations of the dining room in the AL on 10/02/25 from 9:30pm to 10:45am revealed:
-The doors to the main dining room were closed and there were no staff or residents in the dining room.
-There was a cart in the back of the dining room outside of the kitchen door with resealable bags

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D 298	Continued From page 60 of cream filled sandwich cookies and water. -The cart stayed in the dining room and no residents came into the dining room to get snacks. Observation of the activity room on 10/02/25 at 3:41pm revealed: -The activity room was located on the AL side of the facility. -A resident came into the activity room and told the Activity Director he was hungry. -The Activity Director offered him a snack. -The Activity Director gave the resident an individual size bag of chips and some water. -The resident sat at a table in the activity room and ate the snack. -The resident asked for a second bag of chips. -The Activity Director gave the resident a second bag of chips and the resident ate them. Interview with a resident on 09/30/25 at 9:30am revealed: -Sometimes he got a snack at night before he went to bed. -The snack was usually a peanut butter and jelly sandwich. Interview with a second resident on 09/30/25 at 9:20am revealed: -He did not get snacks. -He had never been offered snacks. -He would eat a snack if they gave him one. -He had not been hungry, but he could always eat. Interview with a third resident on 10/02/25 at 3:59pm revealed: -The facility had stopped offering snacks at 10:00am, 2:00pm and 8:00pm. -Sometimes there was a cart in the dining room	D 298		

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D 298	Continued From page 61 that contained bags of chips, but this did not happen every day. -If a resident had their own money, the facility would offer to take the resident shopping to buy their own snacks. Interview with a fourth on 10/02/25 at 3:43pm revealed: -He ate lunch today, 10/02/25, but he was still hungry. -He did not have snacks today and did not get snacks every day. -He did not go into the dining room to get snacks. -The Activity Director usually had snacks. -He was still hungry after the first bag of chips, so he asked for a second bag. Confidential interview with a staff revealed: -The residents did not get snacks three times a day. -The Kitchen Manager had to pick and choose what to order because the food budget was so tight and the snacks could not always be ordered. -Residents complained to staff about not getting snacks. -Sometimes the staff bought snacks out of their own pocket and gave them to the residents. Interview with the Activity Director on 10/02/25 at 3:04pm revealed: -At Resident Council meetings the residents in the AL complained about not having snacks three times a day. -She purchased boxes of individual packaged snacks out of her own money to give to the residents. -When she did activities she provided food; she did not know if the facility counted the food served during an activity as a snack. -The Administrator was given the minutes of the	D 298		

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D 298	Continued From page 62 Resident Council meetings. Interview with a personal care aide (PCA) in the SCU on 10/01/25 at 11:25am revealed: -The residents in the SCU did not always get snacks. -The residents in the SCU were always hungry and would ask for something to eat. -She had called the kitchen staff and asked for a snack and was told there were no snacks. -There were never snacks on the weekends or sometimes in the evenings. -Staff brought in snacks to give to the residents because they felt bad for them. Interview with a second PCA in the SCU on 10/01/25 at 11:45am revealed: -The residents in the SCU did not get snacks all the time. -The residents in the SCU got individual bags of chips yesterday but there were not enough so the PCAs opened the bags and split them between two residents. -The kitchen staff said it was all the chips they had. -The residents did not have snacks today. -Snacks were supposed to be served to the residents three times a day at 10:00am, 2:00pm and in the evening. -She did not complain to anyone in management anymore. Interview with a medication aide (MA) on 10/01/25 at 2:10pm revealed: -The residents were supposed to have snacks at 10:00am, 2:00pm and 8:00pm. -The kitchen staff gave the SCU a cart with snacks on them. -The residents in the SCU did not always get snacks, it depended if the kitchen had any	D 298		

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D 298	Continued From page 63 snacks. -They did not have snacks today. -The kitchen staff gave the SCU residents applesauce a few days ago but it was not enough for all the residents. -Some of the SCU staff had gone out before and got snacks for the residents in the SCU. -Sometimes the residents went all week without snacks during the day. -The residents were not served snacks over the past weekend at all. Interview with the Kitchen Manager on 10/02/25 at 9:39am revealed: -Snacks were served or offered at 10:00am and 2:00pm in the SCU. -The kitchen staff sent about 25 snacks to the SCU including applesauce or pudding for pureed diets. -There was a snack cart in the dining room on the AL side with about 35 snacks; the residents could come in the dining room and help themselves. -If there was enough staff the PCAs offered snacks in the AL by taking the snack cart around. -She ordered individual sized packages of cookies and chips for the residents' snacks depending on the food budget for the week. -About twice a week she had to go to the store to purchase snacks. -She did not know snacks were not being offered on the weekends. Telephone interview with the Special Care Unit Coordinator (SCC) on 10/03/25 at 1:32pm revealed: -The residents were supposed to be given snacks three times a day at 10:00am, 2:00pm and 8:00pm. -The snacks included fruit, peanut butter and jelly sandwiches, chips, cakes, cookies and water.	D 298		

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D 298	Continued From page 64 -The staff were supposed to notify her when there were no snacks. -The staff was supposed to ask the kitchen or her if they did not get snacks. -She was not aware the residents were not getting snacks three times a day or on the weekends. -The residents liked to have something to eat between meals, or they might be a little hungry and they would eat the snacks if they were offered. Interview with the Resident Care Coordinator (RCC) on 10/02/25 at 5:19pm revealed: -The residents complained about not getting snacks three times a day. -The residents wanted snacks more often because they did not always get snacks three times a day. -Snacks were supposed to be offered three times a day at 10:00am, 2:00pm and 8:00pm. -The staff tried to pass snacks when they had time. -The residents came to get the snacks out of the dining room. -The residents wanted the snacks they used to get such as peanut butter crackers, small bags of potato chips, and oatmeal cream pies. -The residents did not get the same snacks as they used to or as often because of the food budget. -The census had increased but the food budget had not. -Someone at the corporate office decided what food the kitchen could purchase. -They had run out of snacks at snack time, but they always tried to give something else when they ran out. Telephone interview with the Administrator on	D 298		

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D 298	Continued From page 65 10/03/25 at 3:00pm revealed: -Snacks were supposed to be served three times a day between meals and after dinner; she was not sure of the times. -The kitchen staff were supposed to monitor the snacks and ensure they were served three times a day to the residents. -The kitchen had carts they used to deliver snack carts around the facility. -The SCU staff went to every resident with the snack cart. -When kitchen staff did not bring the snack cart to the SCU they should have notified the kitchen or the SCC. -The residents in the AL knew the snack cart was stationary in the dining room. -The staff were supposed to go to the individual rooms of the residents that they knew would not come down or could not come down to the dining room in the AL. -She was not aware there were times when there were not enough snacks for all the residents. -Staff should have let her know the residents were not getting snacks; if they had let her know she could have done something about it before now.	D 298		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by:	D 310		

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D 310	Continued From page 66 Based on observations, record reviews, and interviews, the facility failed to ensure that therapeutic diets were served as ordered for 2 of 3 sampled residents (#1 and #3), including an order for a pureed diet that was not served according to the menu (#1, #3) and and an order for double portions (#1). The findings are: Review of the facility's therapeutic diet lunch menu for 09/30/25 revealed the pureed therapeutic menu for lunch listed 3 ounces of pureed BBQ glazed meatballs, 4 ounces of pureed vegetables, a pureed dinner roll, 4 ounces of pureed fruit and 8 ounces of milk. Review the facility's therapeutic diet breakfast menu for 10/02/25 revealed the pureed therapeutic menu for breakfast listed 3 ounces of pureed scrambled eggs, 1 ounce of pureed ham, and 4 ounces of pureed fresh fruit. 1. Review of Resident #1's current FL-2 dated 04/08/25 revealed: -Diagnoses included vascular dementia, Alzheimer's disease, hyperlipidemia, hypertension and irritable bowel syndrome. -Resident #1 resided in the Special Care Unit (SCU). -There was an order for a pureed diet with nectar thick liquids. Review of Resident #1's physician's orders dated 07/22/25 revealed he was ordered double portions at meals. Observation of the lunch meal on 09/30/25 from 11:42am to 12:15pm revealed: -Resident #1 was served 4-5 ounces of pureed	D 310		

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D 310	Continued From page 67 BBQ meatballs, 4 ounces of pureed green beans, eight ounces each of nectar thick water and milk. -Resident #1 ate 100 percent of his pureed meatballs and pureed green beans. -Resident #1 drank 100 percent of his nectar thick fluids. -Resident #1 was not served double portions of pureed green beans. -Resident #1 was not served pureed bread or pureed fruit. Observation of the breakfast meal on 10/02/25 from 8:10am to 8:35am revealed: -Resident #1 was served 3 ounces of pureed scrambled eggs, 2 ounces of pureed kielbasa, 8 ounces of nectar thick orange juice, milk and coffee. -Resident #1 ate 100 percent of his meal and drank 100 percent of his beverages. -Resident #1 was not served 4 ounces of pureed fruit and he was not served double portions. Telephone interview with Resident #1's primary care provider (PCP) on 10/01/25 at 4:20pm revealed: -Resident #1 was ordered a pureed diet to help him eat better and provide comfort. -Resident #1 was ordered double portions to prevent weight loss. -She expected Resident #1's entire meal to be double portions not just the protein. -The facility should follow the order for the pureed diet by following the therapeutic menu for pureed diets. Interview with the Kitchen Manager on 10/02/25 at 9:39am revealed: -Residents who had an order for double portions were served double portions of protein only and nothing else.	D 310		

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D 310	Continued From page 68 -She was trained by the previous Administrator to only give double portions of the protein. -She had no problem with giving double portions of the entire meal; she did not know that was what the order was for. Based on observations, interviews and record reviews it was determined Resident #1 was not interviewable. Refer to the interview with the cook on 09/30/25 at 10:48am. Refer to the interview with the Kitchen Manager on 10/02/25 at 9:39am. Refer to the telephone interview with the Special Care Unit Coordinator (SCC) on 10/03/25 at 1:32pm. Refer to the telephone interview with the Administrator on 10/03/25 at 3:00pm. 2. Review of Resident #3's FL2 dated 06/14/25 revealed: -Diagnoses included dementia, hypertension, asthma, and diabetes. -There was an order for a pureed diet. Review the facility's therapeutic diet breakfast menu for 10/01/25 revealed the pureed therapeutic menu for breakfast listed pureed scrambled eggs and pureed sausage. Observation of the breakfast meal service in the dining room of the Special Care Unit (SCU) on 10/01/25 at 8:30am revealed Resident #3 was served oatmeal and pureed eggs. Interview with the Kitchen Manager on 10/02/25	D 310		

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D 310	Continued From page 69 at 9:50am revelaed: -Every meat was pureed except bacon. -She was not sure why Resident #3 was not served pureed sausage as she did not prepare the breakfast for that morning. Based on observations, interviews and record reviews it was determined Resident #3 was not interviewable. Refer to the interview with the cook on 09/30/25 at 10:48am. Refer to the interview with the Kitchen Manager on 10/02/25 at 9:39am. Refer to the telephone interview with the Special Care Unit Coordinator (SCC) on 10/03/25 at 1:32pm. Refer to the telephone interview with the Administrator on 10/03/25 at 3:00pm. _____ Interview with the cook on 09/30/25 at 10:48am revealed: -He was new and had only worked at the facility for about a week. -The Kitchen Manager and another cook trained him on how to puree the food for the therapeutic menu. -He followed the diet list posted in the kitchen when he plated the residents' meals. -He followed the therapeutic menu when he pureed the food. Interview with the Kitchen Manager on 10/02/25 at 9:39am revealed: -The kitchen staff were trained to follow the therapeutic menu when they prepared meals. -She substituted items on the pureed therapeutic	D 310		

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D 310	Continued From page 70 menu when she did not have an item due to orders or food delivery issues. -The residents who had orders for pureed diets should have been served everything on the therapeutic menu; nothing should ever be skipped over or eliminated. -The therapeutic diet menu called for different food items than the regular menu. -It was difficult to have all the items on the therapeutic menu so she would just puree the items on the regular menu. -The residents with a pureed diet should have been served pureed bread, pureed fruit and pureed desserts. -She did not know why the cook did not follow the therapeutic menu and skipped items for the pureed diet. -She did not serve fruit on 10/01/25 because she did not have fruit to serve to the residents. -There was no fresh or canned fruit in the kitchen and there was no one who could go purchase fruit from the store. -She did not puree bacon for pureed diets because they were not allowed to have it. -She served pureed oatmeal in place of pureed bacon on the menu; she did not know why she served oatmeal and the kielbasa to one of the residents who had a pureed diet order. -Residents who had an order for double portions were served double portions of protein only and nothing else. -She was trained by the previous Administrator to only give double portions of the protein. -She had no problem with giving double portions of the entire meal; she did not know that was what the order was for. Telephone interview with the Special Care Unit Coordinator (SCC) on 10/03/25 at 1:32pm revealed:	D 310		

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D 310	Continued From page 71 -She monitored at least one meal a day; she usually monitored lunch. -She monitored the residents with therapeutic diet orders and made sure they were served the correct diet based on the diet list. -If there was an item missing from a resident's meal the personal care aides (PCAs) could call the kitchen, and the kitchen would send it to the SCU. -She was not aware some of the therapeutic diets were not served as ordered. Telephone interview with the Administrator on 10/03/25 at 3:00pm revealed: -She observed the meals in the facility three to four times a week. -The SCC was required to observe meals once a day in the SCU for either lunch or dinner. -She and the SCC looked to ensure the residents were served the correct diet and that the diets were the correct consistency. -The cooks should follow the therapeutic diet order and serve all items that were on the menu including desserts. -The residents on therapeutic diets should be served what the residents on the regular menu were served just prepared differently. -If therapeutic menu items were not prepared correctly or were not the correct item the residents could choke. -If menu items were eliminated from the menu long term the residents would not get enough nutritionally and could have weight loss.	D 310		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the	D 358		

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D 358	Continued From page 72 preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 4 residents (#7) observed during the medication pass including errors with a medication used to treat dementia, an iron supplement, and a pain relieving gel; and 3 of 5 sampled residents (#1, #3, and #5) for record review including errors with a medication for gout prevention (#1), and medications for reducing blood pressure (#3, #5). The findings are: Review of the facility's Medication Services policy dated 09/2021 revealed, the Executive Director, Resident Care Coordinator (RCC), or designee would ensure that medication administration services required for each resident were provided. 1. The medication error rate was 10% as evidenced by the observation of 3 errors out of 30 opportunities during the 8:00am medication pass on 10/01/25. a. Review of Resident #7's current FL2 dated 09/23/25 revealed diagnoses included dementia, coronary artery disease, hypertension, schizophrenia, high cholesterol, and	D 358		

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D 358	Continued From page 73 gastroesophageal reflux disorder. -There was an order for ferrous sulfate (an iron supplement) 325mg one tablet daily. Observation of the morning medication pass on 10/01/25 at 8:00am revealed: -The medication aide (MA) removed the multi-dose pack for Resident #7 from the medication cart. -The MA opened the pack of medications for that morning's medication pass and poured them into a small plastic cup. -Ferrous Sulfate 325mg was not included in Resident #7's morning medications. Review of Resident #7's October 2025 electronic medication administration record (eMAR) for 10/01/25 revealed: -There was an entry for ferrous sulfate 325mg daily. -Ferrous Sulfate 325mg was documented as not administered on 10/01/25 due to being unavailable. Observation of medications on hand for Resident #7 on 10/01/25 at 8:08am revealed there was no ferrous sulfate 325mg tablets available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 10/01/25 at 2:05pm revealed: -Resident #7 had an order for ferrous sulfate 325mg daily. -The pharmacy received a refill request for ferrous sulfate 325mg that morning. -The last time the pharmacy received a prescription for the ferrous sulfate 325mg was 10/22/24. -The pharmacy dispensed 30 tablets of ferrous	D 358		

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D 358	Continued From page 74 sulfate 325mg on 12/23/24. -There were no dispense dates for ferrous sulfate 325mg after 12/23/24. Interview with the MA on 10/01/25 at 10:25am revealed: -Resident #7 did not have ferrous sulfate 325mg to administer during the medication pass. -She had to order the medication from the pharmacy. -She documented the ferrous sulfate 325mg was not available on the eMAR. -She did not know when Resident #7 ran out of ferrous sulfate. Interview with Resident #7 on 10/02/25 at 8:00am revealed he took an iron tablet and thought he took it every day. b. Review of Resident #7's current FL2 dated 09/23/25 revealed there was an order for diclofenac sodium (a pain-relieving gel) 1% apply a small amount to bilateral knees and lower legs twice a day. Observation of the morning medication pass on 10/01/25 at 8:00am revealed: -The MA removed the multi-dose pack for Resident #7 from the medication cart. -The MA opened the pack of medications for that morning's medication pass and poured them into a small plastic cup. -The MA administered Resident #7's medications then moved on to the next resident. -The MA did not apply diclofenac gel to Resident #7. Review of Resident #7's October 2025 eMAR for 10/01/25 revealed: -There was an entry for diclofenac sodium 1%	D 358		

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D 358	Continued From page 75 apply a small amount to bilateral knees and lower legs twice a day, scheduled at 8:00am and 8:00pm. -Diclofenac gel 1% was documented as not administered for 10/01/25 due to being unavailable. Observation of medications on hand for Resident #7 on 10/01/25 at 8:08am revealed there was no diclofenac gel 1% available for administration. Telephone interview with a representative from Resident #7's pharmacy on 10/01/25 at 2:05pm revealed: -Resident #7 had an order for diclofenac sodium 1% apply a small amount to bilateral knees and lower legs twice a day. -One tube of diclofenac 1% gel was dispensed to the facility for Resident #7 on 07/23/25. -There were no dispense dates after 07/23/25. -It was difficult to say how long the diclofenac gel would last; it would depend on how much was used during each application. -Resident #7 should not be out of the medication; someone from the facility should have ordered more. Interview with the MA on 10/01/25 at 10:25am revealed: -Resident #7 did not have diclofenac gel to apply during the medication pass. -She had to order the medication from the pharmacy. -She documented the diclofenac gel was not available on the eMAR. -She did not know when Resident #7 ran out of diclofenac gel. -She thought Resident #7's family brought the diclofenac gel in but she had not called them to tell them it was out.	D 358		

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D 358	Continued From page 76 Interview with Resident #7 on 10/02/25 at 8:00am revealed: -He did not have diclofenac gel applied today and could not remember when he used it last. -He had knee and lower leg pain that bothered him sometimes. c. Review of Resident #7's current FL2 dated 09/23/25 revealed there was an order for Aricept (a medication used to treat dementia) 10mg daily. Observation of the morning medication pass on 10/01/25 at 8:00am revealed: -The MA removed the multi-dose pack for Resident #7 from the medication cart. -The MA opened the pack of medications for that morning's medication pass and poured them into a small plastic cup. -The multi-dose pack of medications for Resident #7 contained a 5mg tablet of Aricept and a 10mg tablet of Aricept. -The MA administered Resident #7's medications and then moved on to the next resident. Review of Resident #7's October 2025 eMAR for 10/01/25 revealed: -There was an entry for Aricept 10mg daily. -There was not an entry for Aricept 5mg daily. -Aricept 10mg was documented as administered. Observations of medications on hand for Resident #7 on 10/01/25 at 8:08am revealed there was Aricept 10mg and Aricept 5mg tablets in the morning multi dose pack for 10/01/25 to 10/07/25. Telephone interview with a representative from Resident #7's pharmacy on 10/01/25 at 2:05pm revealed:	D 358		

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D 358	Continued From page 77 -Resident #7 had an order for Aricept 10mg daily, and also had an order for Aricept 5mg daily. -The pharmacy did not receive an order to discontinue the Aricept 5mg. -The pharmacy did not receive a copy of the 09/23/25 FL2. Review of a pharmacist drug review dated 06/18/25 revealed: -Resident #7 had an order for Aricept 10mg daily and Aricept 5mg daily. -The pharmacist recommended to discontinue the current orders and begin Aricept 5mg daily for 4 weeks then increase to 10mg daily. -The pharmacist drug review was signed by Resident #7's primary care provider (PCP) on 07/01/25. Interview with the MA on 10/01/25 at 10:25am revealed: -She administered Aricept 10mg and Aricept 5mg to Resident #7 that morning during the medication pass. -She must have overlooked that there was a 10mg tablet of Aricept and a 5mg tablet of Aricept in the multi-dose pack. Interview with the RCC on 10/02/25 at 3:00pm revealed: -She recalled Resident #7's Aricept 5mg was discontinued in September 2025. -The pharmacy must not have received the order to discontinue Aricept 5mg. -She was responsible for sending current FL2s to the pharmacy. Interview with Resident #7 on 10/02/25 at 8:00am revealed: -He took a bunch of medications daily and sometimes twice a day.	D 358		

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D 358	Continued From page 78 -He was not sure whether he took Aricept or not; he did not know what the medication was. Attempted telephone interviews with Resident #7's primary care provider (PCP) on 10/01/25 at 3:30pm, 10/02/25 at 1:26pm, and 10/03/25 at 12:00pm. Refer to the interview with Resident #7 on 10/02/25 at 8:00am. Refer to the interview with the RCC on 10/07/25 at 3:00pm revealed: Refer to the interview with the Administrator on 10/02/25 at 2:45pm. 2. Review of Resident #3's FL2 dated 06/14/25 revealed: -Diagnoses included dementia, hypertension, asthma, and diabetes. -She was constantly disoriented. Review of Resident #3's signed physician's orders dated 06/14/25 revealed there was an order for amlodipine (used to lower blood pressure) 10mg take 1 tablet daily. Review of Resident #3's July 2025 electronic medication administration record (eMAR) revealed: -There was an entry for amlodipine 10mg take 1 tablet daily scheduled for administration at 8:00am. -There was documentation amlodipine 10mg was administered from 07/01/25 to 07/31/25 once daily. Review of Resident #3's August 2025 eMAR revealed:	D 358		

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D 358	Continued From page 79 -There was an entry for amlodipine 10mg take 1 tablet daily scheduled for administration at 8:00am. -There was documentation amlodipine 10mg was administered from 08/01/25 to 08/31/25 once daily. Review of Resident #3's September 2025 eMAR revealed: -There was an entry for amlodipine 10mg take 1 tablet daily scheduled for administration at 8:00am. -There was documentation amlodipine 10mg was administered from 09/01/25 to 09/30/25 once daily. Observation of Resident #3's medications on hand on 09/30/25 at 3:49pm revealed there was no amlodipine 10mg available for administration. Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/30/25 at 4:30pm revealed: -There was a current order on file for amlodipine 10mg take 1 tablet daily for Resident #3. -Amlodipine 10mg was last dispensed on 02/10/25 for a quantity of 3 tablets. -Amlodipine was used to lower Resident #3's blood pressure -If amlodipine was not administered as ordered he expected Resident #3's blood pressure to increase or remain the same. Interview with a medication aide (MA) on 10/01/25 at 12:08pm revealed: -She administered Resident #3's medications according to the eMAR entries. -When administering medications, she compared eMAR orders to the medications she administered.	D 358		

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D 358	Continued From page 80 -She did not notice there was no amlodipine available for administration for Resident #3. -If a medication was not available for administration, she would document accordingly and contact the pharmacy so a refill could be sent. Interview with a second MA on 10/02/25 at 10:00am revealed: -She administered Resident #3's medications according to the eMAR entries. -She audited her medication cart daily. -She was not aware Resident #3 did not have amlodipine 10mg available for administration. Interview with the Special Care Unit Coordinator (SCC) on 10/01/25 at 11:50am revealed: -Based on her records, Resident #3 had an order for amlodipine 10mg take 1 tablet daily. -She remembered calling the pharmacy regarding Resident #3's amlodipine about a month or so ago. -No one had informed her that Resident #3 did not have amlodipine 10mg available for administration. -She completed eMAR and medication cart audits on the special care unit (SCU) weekly. -The MAs also completed eMAR and medication cart audits weekly. Interview with the Resident Care Coordinator (RCC) on 10/02/25 at 10:30am revealed she was not aware Resident #3 did not have amlodipine 10mg available for administration. Interview with the Administrator on 10/02/25 at 2:00pm revealed: -She was not aware Resident #3 did not have amlodipine 10mg available for administration. -Miscommunication between MAs and the	D 358		

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D 358	Continued From page 81 pharmacy may have been the cause of this error. Attempted telephone interview with Resident #3's primary care provider (PCP) on 10/03/25 at 11:57am unsuccessful. Based on observations, interviews, and record reviews, it was determined Resident #3 was not interviewable. Refer to the interview with the RCC on 10/02/25 at 10:37am. Refer to the interview with the Administrator on 10/02/25 at 2:19pm. 3. Review of Resident #5's FL2 dated 03/11/25 revealed diagnoses included Alzheimer disease, dementia, intellectual disabilities, hypertension, atrial fibrillation, peripheral vascular disease, acute kidney failure, and hypothyroidism. a. Review of Resident #5's signed physician orders dated 08/11/25 revealed there was an order for metoprolol (used to lower blood pressure) 25mg take half a tablet daily. Review of Resident #5's after visit summary dated 09/10/25 revealed there was an order to stop metoprolol. Review of Resident #5's September 2025 electronic medication administration record (eMAR) revealed: -There was an entry for metoprolol 25mg take half a tablet daily scheduled for administration at 8:00am. -There was documentation half a tablet of metoprolol 25mg was administered once daily from 09/01/25 to 09/30/25.	D 358		

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D 358	Continued From page 82 Observation of Resident #5's medications on hand on 10/01/25 at 3:34pm revealed there was 5 morning multidose packages of medication with half tablets of metoprolol 25mg available for administration. b. Review of Resident #5's signed physician orders dated 08/11/25 revealed there was an order for diltiazem (used to lower blood pressure) 30mg take 1 tablet twice a day. Review of Resident #5's signed after visit summary dated 09/10/25 revealed there was an order to stop diltiazem. Review of Resident #5's September 2025 eMAR revealed: -There was an entry for diltiazem 30mg take 1 tablet twice a day scheduled for administration at 8:00am and 8:00pm. -There was documentation diltiazem 30mg was administered twice a day from 09/01/25 to 09/30/25. Observation of Resident #5's medications on hand on 10/01/25 at 3:34pm revealed there was 5 morning and 6 bedtime multidose packages of medication which included tablets of diltiazem 30mg available to be administered. c. Review of Resident #5's signed physician orders dated 08/11/25 revealed there was an order for hydrochlorothiazide (used to treat symptoms of high blood pressure) 25mg take 1 tablet twice a day. Review of Resident #5's after visit summary dated 09/10/25 revealed there was an order to stop hydrochlorothiazide.	D 358		

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D 358	Continued From page 83 Review of Resident #5's September 2025 eMAR revealed: -There was an entry for hydrochlorothiazide 25mg take 1 tablet twice a day scheduled for administration at 8:00am and 2:00pm. -There was documentation hydrochlorothiazide 25mg was administered twice a day from 09/01/25 to 09/30/25. Observation of Resident #5's medications on hand on 10/01/25 at 3:34pm revealed there was 5 morning and 5 midday multidose packages of medication which included tablets of hydrochlorothiazide 25mg available to be administered. d. Review of Resident #5's signed physician orders dated 08/11/25 revealed there was an order for tramadol (used to manage chronic pain) 25mg take half a tablet three times a day. Review of Resident #5's after visit summary dated 09/10/25 revealed there was an order to stop tramadol. Review of Resident #5's September 2025 eMAR revealed: -There was an entry for tramadol 25mg take half a tablet three times a day scheduled for administration at 8:00am, 2:00pm, and 8:00pm. -There was documentation tramadol 25mg was administered three times a day from 09/01/25 to 09/30/25. Observation of Resident #5's medications on hand on 10/01/25 at 3:34pm revealed: -There was a bubble pack with 46 of 90 tablets of tramadol available for administration and was dispensed on 09/13/25.	D 358		

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D 358	Continued From page 84 -The order on the label was for tramadol 25mg take half a tablet three times a day. Interview with a medication aide (MA) on 10/02/25 at 10:19am revealed: -She was not aware Resident #5 had orders on her after visit summary dated 09/10/25 to stop taking certain medications. -The MAs did not have the ability to discontinue medications in the eMAR. -When after visit summaries were received from a physician, orders were entered into a progress note and faxed to the facility's contracted pharmacy. -The MAs, the Special Care Unit Coordinator, or RCC were all responsible for obtaining after visit summaries and faxing new orders to the pharmacy. Interview with the SCC on 10/02/25 at 10:30am revealed: -When after visit summaries were received, new orders from the after visit summary were sent to the pharmacy. -The after visit summary for Resident #5 dated 09/10/25 may have gotten lost which was why the new orders were never implemented. -Her expectation was that when after visit summaries were received from a physician, whichever staff member received the after visit summary would enter a progress note and fax it to the pharmacy. Interview with the RCC on 10/02/25 at 10:37am revealed: -When after visit summaries were received, if there were new orders to be implemented, a progress note would be written and sent to the pharmacy. -The SCC and RCC could go into the eMAR to	D 358		

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D 358	Continued From page 85 stop an order, however the pharmacy would not be alerted of the change. -Her expectation was that new orders would be implemented in a timely manner. Interview with the Administrator on 10/02/25 at 2:19pm revealed she expected that when a physician ordered a medication to be stopped, the medication would be stopped as ordered and the proper procedure of discarding stopped medications would be taken. Attempted telephone interview with Resident #5's primary care provider (PCP) on 10/03/25 at 11:57am unsuccessful. Based on observations, interviews, and record reviews, it was determined Resident #5 was not interviewable. Refer to the interview with the RCC on 10/02/25 at 10:37am. Refer to the interview with the Administrator on 10/02/25 at 2:19pm. 4. Review of Resident #1's current FL-2 dated 04/08/25 revealed: -Diagnoses included vascular dementia, Alzheimer's disease, hyperlipidemia, hypertension and irritable bowel syndrome. -Resident #1 resided in the Special Care Unit (SCU). -There was an order for allopurinol (used to treat gout) 100mg once daily. Review of Resident #1's signed physician's order sheet dated 07/08/25 revealed there was an order for allopurinol 100mg once daily.	D 358		

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D 358	Continued From page 86 Review of Resident #1's September 2025 electronic medication administration record (eMAR) revealed: -There was an entry for allopurinol 100mg once daily scheduled at 8:00am. -Resident #1's allopurinol was documented as administered once daily from 09/01/25 to 09/19/25. -There was a second entry for allopurinol 100mg once daily scheduled at 8:00am. -Allopurinol was documented as administered once daily from 09/23/25 to 09/30/25. -Allopurinol was not documented as administered on 09/20/25 and 09/21/25; there were no exceptions documented. -On 09/22/25, there was documentation Resident #1 had a new order. -There were no other entries for allopurinol 100mg on the September 2025 eMAR. Observation of Resident #1's medication on hand on 09/30/25 at 3:18pm revealed: -Seven tablets of Resident #1's allopurinol 100mg was dispensed on 09/25/25, in a seven-day multidose package. -The multidose package was dated to begin administration on 09/30/25. -Resident #1's morning medications dated 09/30/25 had been administered; there were six tablets of allopurinol available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 10/01/25 at 4:35pm revealed: -Resident #1 had a current order for allopurinol 100mg once daily dated 04/03/25. -Resident #1's allopurinol was on cycle fill refill and was dispensed once a week in a multidose package.	D 358		

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D 358	Continued From page 87 -Seven tablets of allopurinol 100mg were dispensed on 09/11/25, 09/18/25, and 09/25/25. -The medication package had medication cups that were dated for the date of administration and included the medication name, dosage and the time of day to administer the medication. -Allopurinol was ordered for Resident #1 to prevent gout; Resident #1 could have an increased chance of a gout attack if he missed doses of allopurinol. Telephone interview with Resident #1's primary care provider (PCP) on 10/01/25 at 4:05pm revealed: -Resident #1 had an order for allopurinol 100mg once daily because he had a diagnosis of gout. -She had not held or discontinued Resident #1's allopurinol order. -His allopurinol should not have been stopped and started. -Allopurinol was used to prevent a gout flare up. -Resident #1 could have had a possible gout flare up while not on the allopurinol. -Resident #1 had dementia and was nonverbal so it would be hard to tell if he had a gout flare up. Interview with the medication aide (MA) on 10/01/25 at 1:45pm revealed: -If she documented a medication as a new order on the eMAR then it was not administered that day. -New medication orders were entered on the eMAR by the pharmacy; the Special Care Unit Coordinator (SCC) approved the entry, and once they appeared on the eMAR the medication could be administered. -An "X" on the eMAR indicated the medication was not administered; probably because it did not appear on the eMAR during medication pass. -If Resident #1 had an "X" on the eMAR on	D 358		

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D 358	Continued From page 88 09/21/25 and 09/22/25 then the medication was not administered on those dates. Telephone interview with the SCC on 10/03/25 at 1:14pm revealed: -When a medication was discontinued it would show on the eMAR as discontinued. -If there was nothing documented on the eMAR then the medication was not administered, or it was administered and not documented as given. -Resident #1's allopurinol should have been administered because there was no discontinue order. -The allopurinol was in the multidose package, it should have been compared to the order on the eMAR and should have been administered. -If the tablet was in the multidose package but not on the eMAR the MA should have called the pharmacy and asked about the order. -There should have been a progress note as to why Resident #1 was not administered the allopurinol. -The MA should have notified her, the pharmacy or the PCP, about Resident #1's allopurinol; it should not have been stopped. Telephone interview with the Administrator on 10/03/25 at 3:39pm revealed: -She was not sure what happened with Resident #1's allopurinol; it should have been on the eMAR. -If the order was on the eMAR then the MA should have administered it. -If the allopurinol was not on the eMAR but was in the multidose package then the MA should have let the SCC know or the pharmacy so they could have followed up. Refer to the interview with the Resident Care Coordinator (RCC) on 10/02/25 at 3:00pm.	D 358		

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D 358	Continued From page 89 Refer to the interview with the Administrator on 10/02/25 at 2:45pm. _____ Interview with the RCC on 10/02/25 at 3:00pm revealed: -Her expectation was for MAs to compare eMAR orders to the medications they administered. -If a medication was missing, she expected MAs to follow up with the pharmacy on why the medication was missing. Interview with the Administrator on 10/02/25 at 2:45pm revealed: -She was not a clinical person and did not know about the residents' medications. -She was unaware of any medication cart audits that were being completed. -Her expectation was for MAs to compare eMAR orders to the medications they administered and if a medication was missing, she expected the MAs to follow up with the pharmacy on why the medication was missing and obtain it immediately. -She expected the medications to be administered as ordered. _____ The facility failed to administer medications as ordered to a resident who had memory loss and knee and leg pain who did not receive an ordered pain relieving gel (#7), a resident with dementia who had gout that did not receive a gout preventing medication and would not be able to report symptoms of a flare up (#1); and a resident who had high blood pressure that did not receive a blood pressure lowering medication and would not be able to report symptoms of high blood pressure (#3). This failure was detrimental to the health and safety and welfare of the residents and constitutes a Type B Violation.	D 358		

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D 358	Continued From page 90 The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/01/25. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 17, 2025.	D 358		
D 378	10A NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure that medications were stored safely and securely for 1 of 1 residents (#5) who had an unknown cream on the edge of the sink in her room in the special care unit (SCU). The findings are: Review of Resident #5's FL2 dated 03/11/25 revealed: -Diagnoses included Alzheimer disease, dementia, intellectual disabilities, hypertension, atrial fibrillation, peripheral vascular disease, acute kidney failure, and hypothyroidism. -She was constantly disoriented. -She resided in the SCU.	D 378		

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D 378	Continued From page 91 Observation of Resident #5's bathroom on 09/30/25 at 9:06am revealed: -Resident #5 resided in resident room #208 in the SCU. -There was a bathroom adjacent to the resident room. -There was a disposable glove laying on the right-hand corner on the back of the sink. -There was a quarter cup of a white cream in the palm of the disposable glove. Review of Resident #5's signed physician orders dated 08/11/25 revealed there was no order for a barrier cream. Review of Resident #5's care plan dated 05/06/25 revealed she had moderate cognitive impairment. Observation of Resident #5's medications on hand on 10/01/25 at 3:34pm revealed there was no cream on the medication cart available to administer. Interview with the housekeeper on 09/30/25 at 12:07pm revealed: -He had not noticed the cream on the glove in resident room #208. -He had not been told what to do if he found creams and medications in a resident room. -He would probably throw the glove away and then tell someone about it. Interview with a personal care aide (PCA) on 10/01/25 at 11:05am revealed: -Resident #5 had a red spot on her bottom. -The staff applied a barrier cream to Resident #5's bottom when they provided incontinent care. -The PCAs got the tube of barrier cream from the medication aide (MA). -They were not allowed to leave the barrier cream	D 378		

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D 378	Continued From page 92 in Resident #5's room. -Resident #5 or another resident could find the barrier cream and put it in their mouth or eyes. Interview with a MA on 10/01/25 at 1:45pm revealed: -Resident #5 had an order for a silver sulfadiazine cream (used to prevent and treat wounds for infections) for her legs at one time but it had been discontinued. -Resident #5 had a barrier cream for her buttocks because she had redness. -The PCAs could get the cream from a MA to apply to Resident #5 after they provided incontinent care. -She preferred to apply the barrier cream herself, so she knew the tube was returned to the medication cart. -She would either take the entire tube of barrier cream or put some in a small medication cup to take with her. -After a medication cup was used to put cream in, the cup had to be discarded in the trash on the medication cart and not in a resident's room because a resident could get the medication cup out of the trash. -She never left the medication in the bathroom because she did not want a resident to "get a hold of it". Telephone interview with the Special Care Unit Coordinator (SCC) on 10/03/25 at 1:14pm revealed: -The MAs applied any barrier creams to the residents. -The PCAs did not apply barrier creams to the residents. -The MAs put the barrier cream in a medication cup and took it to the resident's room or bathroom to apply.	D 378		

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D 378	Continued From page 93 -The barrier cream should never be squeezed into a glove to be taken to a resident's room for application. -The barrier cream was usually applied while the resident was in the bathroom. -There should not be any barrier cream left over after application and the medication cup should be disposed of in the trashcan on the medication cart. -The barrier cream should not be left in the resident's bathroom because the residents on the SCU might get confused and see the barrier cream as food and eat it or try to apply the cream themselves. Telephone interview with the Administrator on 10/03/25 at 3:39pm revealed: -The MA's job was to apply barrier creams. -The barrier cream should not have been put on a disposable glove and left in the bathroom. -The residents in the SCU had dementia and it could have been ingested by one of them. -The barrier cream should have been applied from a medication cup and the cup disposed of in a trashcan that was not in the resident's bathroom. Attempted telephone interviews with Resident #5's primary care provider (PCP) on 10/01/25 at 3:30pm, 10/02/25 at 1:26pm and 10/03/25 at 11:57am were unsuccessful. Attempted telephone interview with a pharmacist from the facility's contracted pharmacy on 10/02/25 at 8:45am was unsuccessful. Based on observations, interviews, and record reviews, it was determined Resident #5 was not interviewable.	D 378		

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D 394	Continued From page 94	D 394		
D 394	10A NCAC 13F .1008 (c & d) Controlled Substance 10A NCAC 13F .1008 Controlled Substance (c) Controlled substances that are expired, discontinued or no longer required for a resident shall be returned to the pharmacy within 90 days of the expiration or discontinuation of the controlled substance or following the death of the resident. The facility shall document the resident's name; the name, strength and dosage form of the controlled substance; and the amount returned. There shall also be documentation by the pharmacy of the receipt or return of the controlled substances. (d) If the pharmacy will not accept the return of a controlled substance, the administrator or the administrator's designee shall destroy the controlled substance within 90 days of the expiration or discontinuation of the controlled substance or following the death of the resident. The destruction shall be witnessed by a licensed pharmacist, dispensing practitioner, or designee of a licensed pharmacist or dispensing practitioner. The destruction shall be conducted so that no person can use, administer, sell or give away the controlled substance. Records of controlled substances destroyed shall include the resident's name; the name, strength and dosage form of the controlled substance; the amount destroyed; the method of destruction; and, the signature of the administrator or the administrator's designee and the signature of the licensed pharmacist, dispensing practitioner or designee of the licensed pharmacist or dispensing practitioner.	D 394		

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D 394	Continued From page 95	D 394		

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews the facility failed to ensure an expired controlled substance for 1 of 3 residents (#1) was destroyed or returned to the pharmacy within 90 days of the expiration date.

The findings are:

Review of Resident #1's current FL-2 dated 04/08/25 revealed:
-Diagnoses included vascular dementia, Alzheimer's disease, hyperlipidemia, hypertension and irritable bowel syndrome.
-Resident #1 resided in the special care unit (SCU).
-There was an order for morphine (used to treat pain) 100mg/5mL give 5mg/0.25mL every three hours as needed for pain.

Observation of Resident #1's medication on hand on 09/30/25 at 3:18pm revealed:
-There were 20 5mg/0.25mL syringes of morphine 100mg/5mL dispensed on 01/15/25.
-The expiration date on the morphine syringes was 06/20/25.
-There were 20 syringes of morphine available for administration.

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D 394	Continued From page 96 Interview with a medication aide (MA) on 10/01/25 at 1:45pm revealed: -The MAs audited the mediation cart weekly. -They looked for expired dates on medication as part of the cart audit. -They documented the audit as completed on a log. -They notified the primary care provider (PCP) when a medication expired. -They waited to discard the expired medication until the new medication came from the pharmacy. -She did not know why they waited to discard the expired medication. -She did not know how long expired medication could be kept on the medication cart. -She could not administer expired medication to a resident, even if there was nothing else to administer. -Resident #1's morphine should have been discarded before now. Interview with the Special Care Unit Coordinator (SCC) on 10/02/25 at 2:15pm revealed: -She conducted medication cart audits once a week or more. -The MAs did cart audits every day, they looked for expiration dates on medications. -She checked expiration dates when she did cart audits. -If a medication had expired or was about to expire, she let the PCP or the pharmacy know in case the medication needed a new order. -She did not know there was a required time frame for removing expired medication from the medication cart. -Any expired medication should be removed from the medication cart immediately. -Narcotics were also removed from the cart when it expired and returned to the pharmacy for	D 394		

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D 394	Continued From page 97 disposal. -She was not aware Resident #1's morphine syringes had expired on 06/20/25; the morphine had expired over ninety days ago. -The morphine should never have been on the cart that long and needed to be removed right away. Telephone interview with the Administrator on 10/03/25 at 3:39pm revealed: -The MAs did medication cart audits. -The MAs to look for expired medications during the cart audits. -Any expired medication should have been discarded. -She was not aware of a required time frame for discarding controlled substances. Attempted telephone interview with a pharmacist from the facility's contracted pharmacy on 10/02/25 at 8:45am was unsuccessful. Attempted telephone interviews with Resident #1's PCP on 10/01/25 at 3:30pm, 10/02/25 at 1:26pm and 10/03/25 at 11:57am were unsuccessful.	D 394		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid.	D 451		

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D 451	Continued From page 98 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to notify the local county Department of Social Services (DSS) of an incident/accident that required emergency medical evaluation for 1 of 2 sampled residents (#1), who was sent to the hospital after two falls and received sutures after each fall. The findings are: Review of Resident #1's current FL-2 dated 04/08/25 revealed: -Diagnoses included vascular dementia, Alzheimer's disease, hyperlipidemia, hypertension and irritable bowel syndrome. -Resident #1 was constantly disoriented and was semi-ambulatory. -Resident #1 resided in the Special Care Unit (SCU). Observation of Resident #1 on 09/30/25 at 9:46am revealed: -He was seated in a wheelchair in the day room in the SCU. -He had sutures in his right temple and the area around his temple was purple and deep blue. -He had purple and blue bruising to the back of both hands that continued down the length of his fingers past his knuckles. -He had red and purple marks on the left side of his forehead and the bridge of his nose. -He had sutures in his left temple down the length of his face past his cheekbone. -His left eye was swollen and the area around and under his left eye was purple and red.	D 451		

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D 451	Continued From page 99 -There was a bandage above his left elbow with a visible quarter sized spot of blood. -His left arm had a protective sleeve from his elbow to his wrist that had multiple large spots where blood had seeped through. -His sleeve was removed by staff, and he had deep purple and black areas on his left arm and two nickel sized open wounds on the top of his wrist. a. Review of Resident #1's incident report dated 09/21/25 revealed: -Resident #1 had an unwitnessed fall with an injury in the dining room at 5:15pm. -Resident #1 had a laceration to the right side of his head. -Resident #1 was transported to the local Emergency Department (ED) by Emergency Medical Services (EMS). Review of Resident #1's hospital after visit summary dated 09/21/25 revealed he had a hematoma, a laceration and required sutures to his head. Review of a facsimile transmittal confirmation dated 10/02/25 revealed DSS was not notified of Resident #1's incident on 09/21/25 until 10/02/25 at 10:46am. b. Review of Resident #1's incident report dated 09/29/25 revealed: -Resident #1 had a witnessed fall with an injury in the day room at 11:27am. -Resident #1 had a laceration to the left side of his face. -Resident #1 was transported to the local ED by EMS. Review of Resident #1's hospital after visit	D 451		

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D 451	Continued From page 100 summary dated 09/29/25 revealed he had a laceration and required sutures to his head. Review of a facsimile transmittal confirmation dated 10/02/25 revealed DSS was not notified of Resident #1's incident on 09/29/25 until 10/02/25 at 10:47am. Telephone interview with the Administrator on 10/03/25 at 3:00pm revealed: -She was aware the county DSS was to be notified when a resident had an injury that resulted in being sent to the hospital. -She was responsible for sending notification to DSS when a resident had an injury. -The facility had a lot going on and things had been chaotic from 09/21/25 to 09/30/25. -There had been a lot of falls. -It was her fault DSS was not notified sooner; she sent notification to DSS on 10/02/25 of Resident #1's two incidents.	D 451		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement.	D 468		

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D 468	Continued From page 101 (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that 2 of 6 sampled staff, (Staff B and Staff E) completed 6 hours of orientation on the nature and needs of the residents of the Special Care Unit (SCU) within the first week of employment, and failed to ensure that 4 of 6 sampled staff, (Staff B, Staff C, Staff E, and Staff F) completed 20 hours of orientation on the nature and needs of the residents of the SCU within 6 months of employment. The findings are: Review of the facility's current license dated 01/01/25 revealed the facility was licensed as an Adult Care Home with a SCU with a capacity of 42 residents. Review of the facility's current census on 09/30/25 revealed there was a total of 25 residents residing in the SCU.	D 468		

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D 468	Continued From page 102 1. Review of Staff B's medication aide (MA) personnel record revealed: -Staff B was hired on 10/27/17. -There was no documentation of a 6-hour orientation on the nature and needs of the SCU residents for Staff B. -There was no documentation of a 20-hour orientation on the nature and needs of the SCU residents for Staff B. Interview with Staff B on 10/02/25 at 9:31am revealed: -She was not aware of the requirement for SCU training. -She completed the courses that were loaded for her on the computer when she started. -She could not remember what all the courses were. Refer to the interview with the Administrator on 10/03/25 at 2:50pm. 2. Review of Staff C's medication aide (MA) personnel record revealed: -Staff C was hired on 03/03/25. -There was no documentation of a 20-hour orientation on the nature and needs of the SCU residents for Staff C. Attempted telephone interview with Staff C on 10/02/25 at 4:25pm was unsuccessful. Refer to the interview with the Administrator 10/03/25 at 2:50pm. 3. Review of Staff E's medication aide (MA) personnel record revealed: -Staff E was hired on 10/16/18. -There was no documentation of a 6-hour orientation, completed within the first week of	D 468		

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D 468	Continued From page 103 employment, on the nature and needs of the SCU residents for Staff E. -There was no documentation of a 20-hour orientation, completed within six months of employment, on the nature and needs of the SCU residents for Staff E. Refer to the interview with the Administrator on 10/03/25 at 2:50pm. 4. Review of Staff F's medication aide (MA) personnel record revealed: -Staff F was hired on 10/24/22. -There was no documentation of a 20-hour orientation completed within six months of employment on the nature and needs of the SCU residents for Staff F. Refer to the interview with the Administrator on 10/03/25 at 2:50pm. _____ Interview with the Administrator on 10/03/25 at 2:50pm revealed: -The Business Office Manager (BOM) was responsible for ensuring all training was completed and all personnel records were complete. -Someone from the corporate office loaded the required training into the system and each employee completed the training upon hire. -She was unaware there were staff that did not complete the required training. -She expected all staff to have the required SCU training and personnel records to be complete.	D 468		
D 510	10A NCAC 13F .0309 (q) Fire Safety and Emergency Preparedness Plans 10A NCAC 13F .0309 Fire Safety and Emergency	D 510		

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D 510	Continued From page 104 Preparedness Plans (q) Where a fire alarm or automatic sprinkler system is out of service, the facility shall immediately notify the fire department, the fire marshal, and the Division of Health Service Regulation Construction Section and, where required by the fire marshal, a fire watch shall be conducted until the impaired system has been returned to service as approved by the fire marshal. The facility will adhere to the instructions provided by the fire marshal related to the duties of staff performing the fire watch. The facility will maintain documentation of fire watch activities which shall be made available upon request to the DHSR Construction Section and fire marshal. The facility shall notify the DHSR Construction Section when the facility is no longer conducting a fire watch as directed by the fire marshal. Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to conduct a fire watch as instructed by the fire marshal until the sprinkler system was repaired. The findings are: Review of the facility's undated policy titled Fire Watch Procedure revealed assigned staff selected for fire watch shall be solely dedicated to the fire watch and have no other facility related activities or events assigned while on patrol.	D 510		

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D 510	Continued From page 105 Review of a fire inspection report dated 03/28/25 revealed: -Next to the entry "fire resistant construction not compromised" was marked "fail". -There was an additional note on the report dated 04/01/25 that read "sprinkler system is still not functioning properly causing alarms". Review of a fire watch log revealed: -Areas for monitoring consisted of the medication room, nurses station, laundry room, linen closet, electrical room, activity room, dining room, kitchen, salon, special care unit, spa, rooms 100-400, rooms 500-600, oxygen tank room, television room, entrances and exits throughout building. -The last date the fire watch was completed was 08/25/25. -There were no fire watch logs available after 08/25/25. Observation of the 500 and 600 halls on 09/30/25 between 8:40am and 9:30am revealed: -Residents were going up and down the hallways. -There was a medication aide (MA) stationed at a medication cart going room to room administering medications. -There was no dedicated staff member conducting a fire watch. Observation of the Special Care Unit (SCU) on 10/01/25 at 11:03am revealed: -There was a personal care aide (PCA) in the nurses' station. -There was a second PCA in the dayroom with several residents. -There were no other staff members observed doing a fire watch. -There was not a staff member stationed at the	D 510		

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D 510	Continued From page 106 door of the SCU. Telephone interview with a representative from the company that completed the fire inspection on 10/03/25 at 8:12am revealed: -The facility failed the inspection on 03/28/25 because the sprinkler system was malfunctioning. -The facility was due to have another inspection completed. -If the sprinkler system was not functioning properly, it would not pass the inspection. -The facility had not passed a fire inspection in years. -The facility refused to get licensed individuals to look at and fix the issues. -They currently had mixed metals in the system and whatever repairs that had been done, had been done wrong. -He instructed the facility staff to initiate fire watch. A fire watch would mean checking each resident room, common areas, laundry room, kitchen, medication rooms, nurses' stations, bathrooms, oxygen storage rooms, linen closet, electrical room, and all doors in the facility around the clock every 30 minutes. -A staff member would need to be at the door to the SCU to alert other staff in the event of the fire. Interview with a MA on 10/02/25 at 5:07pm revealed: -She used to do fire watch. -She used a log that listed all the rooms she had to check. -She did the fire watch every 30 minutes. -No one instructed her to stop the fire watch. -She stopped doing the fire watch on her own because sometimes she was the only MA for the whole facility, and she could not get it all done.	D 510		

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D 510	Continued From page 107 Interview with the Activity Director on 10/02/25 at 3:43pm revealed: -The facility had been on a fire watch since January 2025 because the sprinkler and the fire alarm system did not work. -The sprinkler system was leaking in multiple places in the facility. -The facility had not been able to get the fire alarm system or the sprinkler system repaired. -A repair company was at the facility today, 10/02/25, and was working on the sprinkler system. -She was not aware of any repairs done on the fire alarm system or the sprinkler system until today. -She had answered telephone calls from a communication center or a command center that would call the facility and ask if they were still under a fire watch. -She had not been trained on what to do for fire watch and management never discussed a plan for what to do because of a fire watch. -All staff should know what a fire watch was and what to do during one. -The facility conducted routine fire drills, but she was worried some of the residents in the facility would not be able to get out during an actual fire. Interview with the Business Office Manager (BOM) on 10/02/25 at 4:40pm revealed: -The facility put themselves on a fire watch because the fire alarm panel would go off and would be a false alarm; it was just to be cautious. -She would call the local fire department and tell them not to report to the facility because it was a false alarm. -She would then call the company who maintained the fire alarm panel and report the false alarm to them. -The panel "acted up every once in a while" and	D 510		

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D 510	Continued From page 108 set off a false alarm. -The fire alarm company would call the facility and ask if they were still under fire watch. -The fire alarm company only kept the facility on fire watch for eight hours. -Someone from the facility would notify the fire alarm company every 8 hours to let the company know if they were still on a fire watch. -If the fire alarm company did not hear from anyone, they would call the facility. -The fire alarm panel had been giving false alarms off and on for about six months. Interview with the facility's Maintenance Director on 10/02/25 at 5:16pm revealed: -He worked at the facility for less than one year. -He was the only one in the maintenance department. -There were a lot of issues in the facility. -The sprinkler system was currently being replaced. -The sprinkler system worked on an off; someone would come out and fix something, it would work for a while and then break again. -Right now, he thought there was only one section of the facility (100 hall) that had yet to be replaced. -The company would be back next week to finish the work on the sprinkler system. -If the sprinkler system was not functioning properly, that meant the alarms would not sound and the fire department might not be aware if there was an emergency. -The facility was supposed to be on fire watch. -Fire watch duties were assigned to the MA. -He did not check the fire watch logs for completeness. Telephone interview with the county fire marshal on 10/03/25 at 8:22am revealed:	D 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	HAL017054		R-C 10/03/2025

NAME OF PROVIDER OR SUPPLIER
CASWELL HOUSE

STREET ADDRESS, CITY, STATE, ZIP CODE
535 US HIGHWAY 158 WEST
YANCEYVILLE, NC 27379

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D 510	Continued From page 109 -The fire department had been told the sprinkler system at the facility was being replaced multiple times for the last 3 years. -When the sprinkler system did not function properly, the fire alarm system could not function properly and that put the residents and staff at risk of not knowing if a fire broke out. -He had instructed the staff multiple times what a fire watch was and they did not do it. -Alarm response staff had physically placed facility staff at the doors to the SCU and told them that was where they needed to stay. -A fire watch included checking all entrances and exits, all resident rooms, all common areas, the kitchen, electrical room, medication rooms, electrical rooms, spas, oxygen storage room, linen closet, laundry room, and all bathrooms. -A fire watch was important when the sprinkler system was not functioning properly. -The facility needed to have someone who walked around the facility 24/7. -He did not instruct anyone at the facility to stop the fire watches. Interview with the Administrator on 10/02/25 at 10:48am revealed: -She knew the facility was on a fire watch. -The MA on the the assisted living unit was assigned to conduct fire watch. -She was not instructed that a staff member had to be in the hallway at all times; the Maintenance Director may have received those instructions, but she had not. -There was a fire watch log that was to be completed by the assigned staff member. -She did not check to make sure the fire watch log was completed every day. -She expected the maintenance director to check the fire watch logs and ensure they were being done.	D 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
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D 510	Continued From page 110 -Fire drills were being conducted monthly. -The sprinkler system had been malfunctioning since she began working at the facility -The sprinkler system was being replaced and should be completed next week. Attempted follow-up telephone interview with the Maintenance Director on 10/03/25 at 10:08am was unsuccessful. _____ The facility failed to ensure a fire watch was being conducted around the clock while the sprinkler system was not functioning properly. The fire system, which was connected to the sprinkler system, would not function properly which put the residents at risk if a fire broke out. This failure resulted in substantial risk for physical harm of the residents and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/03/25. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 2, 2025.	D 510		