

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL019023	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 08/27/2026
NAME OF PROVIDER OR SUPPLIER CHATHAM RIDGE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517		
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D 000	Initial Comments The Adult Care Licensure Section and the Chatham County Department of Social Services conducted a follow-up survey and complaint investigation from August 25, 2026 to August 27, 2026. The complaint investigations were initiated by the Chatham County Department of Social Services on July 28, 2026 and August 19, 2026.	D 000		
D 067	10A NCAC 13F .0305 (h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) in facilities with at least one resident who is determined by a physician or is otherwise observed by staff to be disoriented or exhibits wandering behavior, a continuously sounding device that is activated when the door is opened shall be located on each exit door that opens to the outside. The sound shall be audible in the facility. If a central system of remote sounding devices is provided, the control panel shall be powered by the facility's electrical system, and be in a location accessible by staff to operate the control panel. Notwithstanding the requirements of Rule .0301, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure 5 of 9 exit doors which were accessible to 3 of 5 sampled	D 067		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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D 067	Continued From page 1 residents who were identified as intermittently disoriented (#2, #4, and #5) had a continuous sounding device that was activated and audible in the facility when the doors were opened to alert staff. The findings are: Review of the facility's current license, effective 01/01/26 revealed the facility was licensed as an assisted living facility with a capacity of 91 beds, 57 assisted living (AL), and 34 Special Care Unit (SCU). Review of the facility's census on 08/25/2026 revealed there were 22 residents residing in the AL. Review of the facility's Elopement/Missing Resident Policy dated 06/12/26 revealed: -The purpose of the policy was to provide a logical, systematic process if a resident was unaccounted for at any given time. -The definition of an elopement was when a resident left the facility without staff awareness or supervision and did not have a logical/explainable reason to do so. -The moment a resident stepped across the threshold without staff awareness, it was considered a successful elopement, not just an attempted elopement. -If a resident was determined to be missing and/or a resident was found outside the facility, it was defined as an elopement. Observations of the front entrance on 08/25/26 at 8:45am, 1:45pm, and 4:58pm revealed: -The double doors automatically opened when anyone approached the door, and no alarm sounded when the door was opened.	D 067		

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D 067	Continued From page 2 -There was no alarm box on either entry door. Observation of the dining room on 08/25/26 at 2:59pm revealed: -There were two exit doors, and no alarm sounded when either door was opened. -Both doors had an alarm box in the upper right-hand corner of the door. Observation of hallway C on 08/25/26 at 3:01pm revealed: -There was an exit door before entering the hallway, and no alarm sounded when the door was opened. -There was a second exit door at the end of the hallway that alarmed when opened, with a continuous alarm that had to be turned off with a key. -There was a third exit door in the physical therapy room that alarmed when opened, with a continuous alarm that had to be turned off with a key. Observation of hallway B on 08/25/26 at 3:04pm revealed: -There was a living room halfway down the hallway, and inside the room, there was an exit door, and the alarm sounded when the door was opened, with a continuous alarm that had to be turned off with a key. -There was an exit door at the end of the hallway, and no alarm sounded when the door was opened. -Both doors had an alarm box in the upper right-hand corner of the door. Observation of hallway A on 08/25/26 at 3:07pm revealed there was an exit door at the end of the hallway, and the alarm sounded when the door was opened with a continuous alarm that had to	D 067		

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D 067	Continued From page 3 be turned off with a key. Observation of the front entrance on 08/26/26 at 7:30am revealed the double doors automatically opened when anyone approached the door, and no alarm sounded when the door was opened. Interview with a personal care aide (PCA) on 08/26/26 at 9:53am revealed: -The medication aides (MA) had keys to the exit doors. -The PCAs were not responsible for checking the exit doors to ensure they were alarmed because they did not have a key. -She had heard the exit doors alarm before, but when she looked out the door, she did not see a resident outside the facility. Interview with a second PCA on 08/26/26 at 11:45am revealed: -She had found door alarms that had been cut off and she notified her supervisor. -The exit doors in the dining room were the responsibility of the dietary staff. Interview with a concierge at the facility on 08/26/26 at 10:00am revealed: -There was usually a concierge in the front office from 9:00am-5:00pm Monday through Friday and from 8:30am-4:30pm on the weekend. -She had other things she was responsible for when she was in the office. -She did not know when the front doors to the facility were locked. Interview with the Maintenance Director on 08/26/26 at 10:02am revealed: -He checked the door alarms daily, usually around 7:15am. -He had found doors were unalarmed when he	D 067		

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D 067	Continued From page 4 checked the doors. -He reported the door alarms being turned off to the Administrator. -Once the alarm was activated, a key was used to turn the alarm off. -The managers and housekeepers had keys to the exit doors. -There was no alarm on the front door. -During the day, there was a concierge at the front office area who could see when residents entered and exited the facility. -The front doors were locked at night by 8:00pm and unlocked in the mornings by 7:00am. -Residents signed out at the front desk when they went outside. Interview with the facility's Health and Wellness Director (HWD) on 08/26/26 at 11:13am revealed: -There was a paved trail around the facility. -Residents did not have to sign out to go outside if they stayed on the premises. -The premises were the front parking lot and around the back of the facility. -There were no residents who needed supervision to be outside of the facility who resided in the AL. Interview with a MA on 08/26/26 at 11:23am revealed: -She did not know if there was an alarm on the front door. -The doors were usually unlocked around 6:00am when the dietary staff were coming to work. -Staff turned the alarms off on the doors to take the trash out, but the alarms were turned back on when they came back inside the facility. -It was important to turn the alarms back on because a resident could go outside and no one would know. -No residents had gone out any of the exit doors	D 067		

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D 067	Continued From page 5 that she was aware of, other than the front door. -She had found door alarms had been turned off and she reported it to her Supervisor. -The only door she had seen unlocked when she checked the doors was the exit door staff used to take the trash out. -The door alarms on the dining room exit doors were the responsibility of dietary staff. -The alarms were on the doors for the safety of the residents. Interview with another MA on 08/26/26 at 4:16pm revealed the front doors were locked at 8:00pm and unlocked by 6:00am. Telephone interview with a third MA on 08/27/26 at 2:10pm revealed: -She checked the door alarms when she worked. -She had found doors unalarmed and would turn the alarms back on. -She did not tell anyone when she found doors unalarmed; she just made sure the alarms were turned back on. Interview with the Resident Care Coordinator (RCC) on 08/26/26 at 12:54pm revealed: -All exit doors should have alarms to let staff know when a resident went out the door. -Staff could see when residents went out the front exit door. -The front door was locked in the evenings around 8:00pm and unlocked in the mornings around 6:45am-7:00am. -At one point, she recalled the front door had a "ding" on it when someone went in/out the front door. -She could not recall the last time she heard the "ding," but it was not that long ago. -Part of the plan of correction after the January 2026 survey was to have an alarm on the front	D 067		

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D 067	Continued From page 6 exit door. -Someone may have turned the alarm off because it was so aggravating when it went off. -Not a lot of residents went outside the facility. -Residents only signed out if they were leaving the premises, outside of the parking lot, or leaving with someone. -If there were any concerns that a resident needed supervision to be outside, the resident would be moved to the SCU. Interview with the RCC on 08/27/26 at 4:10pm revealed: -The managers and MAs checked the door alarms throughout the day, including at the beginning and end of the day and randomly throughout the day. -The MAs were assigned halls, and they checked the doors on those halls. -She hoped the Dining Services Director would monitor the doors in the dining room. -Everyone was ultimately responsible for ensuring the door alarms were turned on. -She wanted to know if there were door alarms that had been turned off so she could prevent it from happening again for the safety of the residents. Interview with the Dining Services Director on 08/27/26 at 4:53pm revealed he did not know he was responsible for the door alarms in the dining room until he was given a key on 08/25/26. Interview with the facility's Corporate Nurse Consultant on 08/26/26 at 1:28pm revealed: -Door alarms were to alert staff if anyone exited the facility for the safety of the residents. -If a resident who had dementia went out a door that they did not usually go out, they could become disoriented.	D 067		

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D 067	Continued From page 7 -If a resident went out the front door, staff might not know because the door was not alarmed. -All the other exit doors were alarmed. -Some of the residents were forgetful and could get mixed up when they went outside. -Staff should know which residents had confusion and needed supervision and conduct checks on the residents to make sure they were okay when outside. -There was no alarm on the front door. -There was no system in place to keep a resident from going out the front door without staff's knowledge. -Residents had a right to go outside, but it was the facility's responsibility to ensure the residents' well-being. Interview with the Regional Director of Operations on 08/26/26 at 1:47pm revealed: -The purpose of the door alarms was to notify staff when the door had opened and someone may have exited the door, for safety reasons. -Residents used the front door to enter and exit the facility. -The front door did not have an alarm but was under observation of staff. -The care staff were at the nurses' station and could see who went outside. -A mini-mental examination (used to screen for cognitive impairment and measure general cognitive status) was completed on every resident at admission and if there was any change in condition. -If a resident scored less than 17, there would be a discussion of what interventions might be needed for the resident. -If a resident needed additional supervision, it would populate on the resident's task sheet. -Staff logged in daily to the facility's computer system and would see what the resident's tasks	D 067		

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D 067	Continued From page 8 were. Telephone interview with the Administrator on 08/27/26 at 5:31pm revealed: -Door alarms were to be turned on at all times. -She knew the doors were unlocked when staff took the trash out but expected the alarms to be turned back on as soon as staff returned inside the facility. -The Maintenance Director checked the door alarms every morning. -The MAs checked the door alarms every shift. -The MAs were responsible for checking the dining room exit doors. Interview with the facility's contracted primary care provider (PCP) on 08/26/26 at 12:25pm revealed: -The facility should be following their policy for alarming exit doors. -They should alarm exit doors to ensure the safety of the residents. 1. Review of Resident #2's current FL2 dated 08/19/26 revealed: -Diagnoses included dementia, Type 2 diabetes, and essential hypertension. -He was ambulatory and constantly disoriented. -He was identified as a wanderer. -The recommended level of care was memory care. Review of Resident #2's previous FL2 dated 05/27/26 revealed: -Diagnoses included dementia (12/01/25), Type 2 diabetes, and essential hypertension. -He was ambulatory and constantly disoriented. -He wandered. -The recommended level of care was assisted living facility.	D 067		

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D 067	Continued From page 9 Review of Resident #2's Resident Register revealed: -There was no admission date, and the signature was 05/27/26. -Resident #2 had significant memory loss and had to be directed. Review of Resident #2's care assessment dated 05/29/26 revealed: -He was sometimes disoriented, forgetful, and needed reminders. -He was independent for ambulation with limited ability requiring a walker. -The care plan was signed on 06/03/26. Review of Resident #2's facility assessed Mini-mental status examinations revealed: -On 05/20/26, Resident #2 scored 9 out of 30. -On 08/02/26, Resident #2 scored 8 out of 30. -The maximum score for best mental evaluations was 30, and 0-10 was severe impairment and likely to require 24-hour supervision and assistance with activities of daily living (ADL). Review of Resident #2's Incident/Accident reports revealed: -On 07/31/26 at 5:45pm, Resident #2 was observed by a facility staff member walking across the parking lot toward the adjacent office complex; the staff member contacted the resident and redirected him to the facility; and no injuries were observed. -On 08/01/26 at 10:20am, Resident #2 was observed off site near a store front adjacent to the parking lot of the facility; he was redirected back to the facility. -There were no injuries. -Resident #2's vital signs were obtained. Review of the facility's Care Notes revealed:	D 067		

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D 067	Continued From page 10 -There was no documentation for Resident #2's elopement on 07/31/26. -There was documentation for Resident #2's elopement on 08/01/26. -On 08/01/26 at 11:15am, the facility arranged for a sitter to start with Resident #2 at 3:00pm. -The facility would provide a staff member providing one on one supervision until the sitter arrived at 3:00pm. Telephone interview with a representative from the facility's contracted private duty companion program on 08/27/26 at 11:26am revealed: -Resident #2 had wandered out of the facility a couple of times and needed to be monitored per the facility staff. -Resident #2 had a private duty companion that started at 2:00pm on 08/01/26, and coverage was provided 24/7. -On 08/01/26, the companion worked from 2:00pm-8:00am on 08/02/26. -She received a complaint that the companion was sleeping and the resident had walked out of his room into the hallway; that companion did not work with Resident #2 anymore after that incident. -On 08/04/26, there was a 2-hour gap when coverage was not available. -Coverage was provided 24/7 until 08/19/26. Review of Resident #2's after visit summary and physician's order dated 08/02/26 revealed: -Resident #2 was seen at a local emergency department for change of his catheter bag and was diagnosed with a urinary tract infection (UTI). -Resident #2 was ordered an antibiotic twice a day for 10 days to treat a UTI. Interview with a personal care aide (PCA) on 08/26/26 at 11:30am revealed:	D 067		

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D 067	Continued From page 11 -Resident #2 liked to go outside ever since he came to the facility in May 2026. -He usually went out the front sliding doors and sat in the front of the building. -Resident #2 was forgetful but easily redirected. -There were 3 times she was aware of when Resident #2 went further out into or across the parking lot. -The front doors were never alarmed, but locked at night. -She liked to go outside and frequently sat outside with residents to keep an eye on them. -The front doors were not alarmed during the day shift. Interview with a second PCA on 08/26/26 at 12:00pm revealed: -Resident #2 was always walking around with his walker. -He liked to go outside to walk around the front of the building. -Recently his behavior of walking further away from the building had gotten worse. -He was easily redirected back toward the facility. -She had seen him walking toward the offices across the parking lot on one occasion recently. -Nobody said he could walk outside alone. -The front doors were not alarmed during the day shifts. Interview with a medication aide (MA) on 08/26/26 at 2:10pm revealed: -The doors to the facility were always supposed to be alarmed, except the front door because it did not have an alarm box to activate. -The front door was locked at night but not during the day. -There was not an alarm on the front sliding doors. -Resident #2 was sometimes confused,	D 067		

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D 067	Continued From page 12 wandered around the assisted living (AL) unit and could not always find his room. -Resident #2 did not have additional supervision to go outside. -Resident #2 did not tell staff when he was going outside the front door. Interview with a third PCA on 08/26/28 at 4:25pm revealed: -Resident #2 would go outside most days to sit in front of the facility. -He also liked to walk to the sides of the building to watch for deer or squirrels playing. -The front doors did not routinely alarm to inform staff if residents were going outside. Telephone interview with Resident #2's family member on 08/26/26 at 5:00pm revealed: -Resident #2 had a diagnosis of dementia. -Resident #2's memory had been declining and had an incident in the parking lot of a veterinary clinic prior to be admitted to the facility where he was disoriented and had driven to the clinic but had no pet. -Resident #2's cognitive status was declining, and he felt the resident should no longer be at home alone. -Recently, the facility had reported he had eloped across the parking lot on 07/31/26 and again on 08/01/26. -He had employed a full-time sitter for Resident #2 until a bed became available in the Special Care (SCU) when he entered the front sliding door of the facility. Interview with Resident #2's primary care provider (PCP) on 08/26/26 at 12:25pm revealed: -Resident #2 was treated for a UTI on 08/03/26. -A UTI could have further exacerbated his loss of cognitive ability and aided his elopement past his	D 067		

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D 067	Continued From page 13 normal outside boundary on 07/31/26 and 08/01/26. -Resident #2 was moved from the AL on 08/19/26 to the SCU due to cognitive decline and elopement from the facility on 2 occasions. Based on observations, interviews, and record review it was determined Resident #2 was not interviewable. 2. Review of Resident #4's current FL2 dated 12/19/25 revealed: -Diagnoses included dementia and anxiety disorder. -She was intermittently disoriented. -She was ambulatory. Review of Resident #4's previous FL2 dated 05/28/25 revealed the resident was constantly disoriented. Review of Resident #4's Resident Register revealed: -There was no admission date. -Resident #4 was forgetful and needed reminders. Review of Resident #4's record revealed an admission date of 06/02/25. Review of Resident #4's care plan dated 05/20/26 revealed: -She was forgetful and needed reminders. -She was sometimes disoriented. -She was independent with transferring and ambulation. Review of Resident #4's mini-mental examination dated 01/17/25 revealed: -She scored 22 of 30.	D 067		

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D 067	Continued From page 14 -A score of 20-25 was considered a mild impairment and might require some supervision, support, and assistance. Review of Resident #4's electronic progress notes dated 07/26/26-08/23/26 revealed: -Resident #4 was pocketing her medications. -Resident #4 was refusing to take her medications. -Resident #4 was observed spitting her medications out. -Resident #4 said she did not want to take her medications. Review of Resident #4's primary care provider's (PCP) after-visit summary dated 06/18/26 revealed Resident #4 was seen for dementia without behavioral disturbances, depression, abnormal glucose, and high blood pressure. Interview with Resident #4 on 08/25/26 at 9:50am revealed: -She was waiting for her "boyfriend" to pick her up, and when he did not show up, she started walking to meet him. -Someone from the facility brought her back. -She was not sure if this happened that day, 08/25/26, or the previous day, 08/24/26. -She was going with the boyfriend to another city to get married. -She did not want to be at the facility. -She walked outside a lot. -She did not sign out to walk outside; she just went outside whenever she wanted to. Interview with Resident #4's family member on 08/25/26 at 4:25pm revealed: -She received a call that morning, 08/25/26, before 10:00am, that Resident #4 was seen by a staff member with items in her hands, and	D 067			

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D 067	Continued From page 15 Resident #4 said she was going to meet someone. -Staff said the resident was going to meet her boyfriend, but she was not aware that the resident had a boyfriend. -The staff member said something about a hill but did not know where the hill was. -Resident #4 was usually good about going outside, walking around the outside of the facility, and coming right back in. -Resident #4 usually walked outside multiple times per day. -The facility staff told her Resident #4 needed to be medically evaluated as soon as possible and someone had to sit with Resident #4. -Resident #4 was taken to her PCP today, 08/25/26, and both urinalysis and lab work were done, but the results were pending. Interview with a medication aide (MA) on 08/25/26 at 4:06pm revealed: -Resident #4 was found outside the facility, she thought, the previous day, 08/24/26. -The resident was found going up the hill looking for her boyfriend. Interview with a personal care aide (PCA) on 08/25/26 at 4:12pm revealed: -There were no residents who needed supervision when outside the facility. -Resident #4 had an elopement earlier today, 08/25/26. -She was not sure what happened but knew the resident's family member was staying with her. Interview with the facility's Health and Wellness Director (HWD) on 08/26/26 at 11:13am revealed: -It was normal for Resident #4 to go outside and take walks around the facility. -When she was coming into work on 08/25/26,	D 067		

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D 067	Continued From page 16 she saw Resident #4 exiting the front door. -It was not normal for Resident #4 to have a box of tissues and several other items in her hands when she went outside to walk, so when she saw her with these items, she asked the resident where she was going, and she said she was going with her boyfriend. -She came inside the facility and told a PCA to follow Resident #4. -The PCA reported Resident #4 walked around the facility and was going up the hill, and this was out of the ordinary. -The PCA redirected Resident #4 back inside the facility. -She was new and was still getting to know the residents. -There had not been any concerns that she was aware of related to Resident #4. Interview with a PCA on 08/26/26 at 11:23am revealed: -When the HWD told her to watch Resident #4 on 08/25/26, the resident was walking down the front walkway around the facility, and she could not "catch up" with her, so she came back inside the facility and went out the back door. -When she went out the back door, she could see that Resident #4 had made it halfway up the ramp exiting the back lot. -It was not good for Resident #4 to be on the ramp because that was where trucks came in. -She had not seen Resident #4 confused before 08/25/26. -Resident #4 had been getting up really early, which was out of the norm for her, but the resident had not gone outside the facility. -When she got Resident #4 to come back inside the facility, she had a box of tissues, some pads, and a roll of paper towels with her.	D 067		

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D 067	Continued From page 17 Interview with another MA on 08/26/26 at 4:16pm revealed: -Resident #4 was not at risk to "walk away." -Resident #4 walked outside after dinner and would come back in on her own. Interview with the Resident Care Coordinator (RCC) on 08/26/26 at 12:54pm revealed Resident #4 leaving the walking path around the facility was out of the ordinary because she had a UTI that was diagnosed after her PCP visit on 08/25/26. Attempted telephone interview with Resident #4's PCP on 08/26/26 at 11:00am was unsuccessful. 3. Review of Resident #5's current FL2 dated 12/31/25 revealed: -Diagnoses included concern for major neurocognitive disorder, insomnia, and major depressive disorder. -She was intermittently disoriented. -She was ambulatory. Review of Resident #5's Resident Register revealed: -She was admitted on 01/07/25. -Resident #5 was forgetful and needed reminders. Review of Resident #5's care plan dated 06/17/26 revealed: -She was forgetful and needed reminders. -She was sometimes disoriented. -She was independent with transferring and ambulation. Review of Resident #5's mini-mental examinations revealed: -On 12/13/24, she scored 25 of 30.	D 067		

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D 067	Continued From page 18 -On an undated mini-mental examination, she scored 24 of 30. -On 11/10/25, she scored 21 of 30. -A score of 20-25 was considered a mild impairment and might require some supervision, support, and assistance. Review of Resident #5's electronic progress notes revealed: -On 07/13/26, she was agitated and yelling at her caregivers. -She had been showing abnormal behaviors for the past several days. -On 07/22/26, she was agitated, yelling at staff, and very aggressive toward residents. -On 07/31/26, she was on an antibiotic for a urinary tract infection (UTI). -On 07/26/26, she was yelling loudly and had aggressive behavior. -On 07/30/26, she was repeating things over and over and telling the same story. -On 08/06/26, she was aggressive and very confused. -On 08/11/26, she cursed at staff and was yelling about someone in her bathroom; no one was in her bathroom. -On 08/13/26, she was aggressive, hit a staff member, and was transported to the hospital to be evaluated, where she scored 13 out of 30 on the mini-mental examination. -On 08/16/26-08/17/26, she continued to be repetitive, yell, and tell people to get out of her room when there was no one in her room. -On 08/22/26, she was screaming that someone was in her room; no one was there. Review of Resident #5's mental health provider's after-visit summary dated 07/02/26 revealed Resident #5 had major neurocognitive disorder, like Alzheimer's disease, considering its	D 067		

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D 067	Continued From page 19 progression. Review of Resident #5's mental health provider's after-visit summary dated 08/20/26 revealed: -Resident #5 had a cognitive impairment that was chronic and progressive. -She was alert and oriented to self. Interview with Resident #5 on 08/27/26 at 4:34pm revealed: -She liked to go and sit out front if it was not too hot. -She never went outside by herself. -When asked if she told anyone when she went outside, she said, "Who am I to tell?" -She did not go out the front door because it was too hot. Telephone interview with a medication aide (MA) on 08/27/26 at 2:10pm revealed: -Resident #5 had dementia and was very confused. -She did not think Resident #5 needed supervision because she did not wander around. -Resident #5 went outside, would sit, and then would come back into the facility. Telephone interview with Resident #5's family member on 08/27/26 at 3:34pm revealed: -Resident #5 was living in an Independent Living (IL) facility prior to moving to AL. -She moved to AL because the IL facility staff thought Resident #5 needed more assistance. -Resident #5 had been on a steady decline for about five years. -Resident #5 had long-term memory, but her short-term memory was an issue. -Resident #5's memory had changed so quickly over the past three months.	D 067		

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D 067	Continued From page 20 Interview with the Resident Care Coordinator (RCC) on 08/26/26 at 12:54pm revealed Resident #5 was ambulatory with a walker, and she had no concerns the resident would leave the facility's premises. Attempted telephone interview with Resident #5's PCP on 08/26/26 at 11:00am was unsuccessful. The facility failed to ensure all exit doors were equipped with functioning audible alarms to alert staff when residents exited the facility. Five of nine exit doors were observed without functioning audible alarms, including the front entrance, which was routinely used by residents to enter and exit the facility. One resident with dementia and significant memory loss became increasingly confused when experiencing a UTI and was found outside the facility after walking across the parking lot toward a nearby office complex (#2). Another resident with dementia and intermittent disorientation was observed exiting the front door with personal items and walking beyond the facility's established walking path while stating she was going to meet her boyfriend (#4). A third resident had a chronic and progressive cognitive impairment, was increasingly confused and agitated, and had demonstrated significant changes in her behaviors and memory (#5). The facility's failure was detrimental to the health, safety, and welfare of the residents and constituted a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/26/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 11, 2026.	D 067		

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D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide personal care for 1 of 5 sampled residents (#3) related to toenails that needed to be trimmed. The findings are: Review of Resident #3's current FL-2 dated 12/17/25 revealed: -Diagnoses included dementia and anxiety. -She required staff assistance with bathing and dressing. -She was intermittently disoriented. -Level of care was special care unit (SCU). Review of Resident #3's Care Plan dated 04/09/26 revealed she required limited assistance with grooming, bathing, and dressing. Observation of Resident #3's toenails on 08/25/26 at 9:31am revealed: -The first toenail on her left foot extended beyond the end of the toe by ½ of an inch and was jagged. -The first toenail on her right foot extended beyond the end of the toe by ½ of an inch and was jagged.	D 269		

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D 269	Continued From page 22 -The second toenail on her right foot extended beyond the end of the toe, curled underneath the toe, and was pressing into the bottom of the toe. -The third toenail on her right foot extended beyond the end of the toe, was twisted, and was growing sideways toward the fourth toe. -The fourth and fifth toenails extended beyond the end of the toes and curled over the ends of the toes. Interview with Resident #3 on 08/25/26 at 9:31am revealed: -She did not recall when her toenails had been cut. -Her toenails needed to be cut. -Her toenails did not hurt "yet." Telephone interview with Resident #3's family member on 08/27/26 at 10:45am revealed: -No one had notified him that Resident #3 had refused podiatry services. -Resident #3 was usually pretty docile, and he could have contacted one of her private duty companions to be there when the podiatrist was at the facility. -He expected to be notified if Resident #3's toenails needed to be cut and she had refused podiatry services. Telephone interview with Resident #3's private duty companion on 08/27/26 at 11:08am revealed: -She told a staff member a month ago that the resident needed to be on the list for podiatry services; she did not recall who she told. -Resident #3 needed to have someone at the facility encourage her to get her toenails cut. -She had trimmed Resident #3's toenails a little bit two months ago, but she did not cut them much.	D 269		

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D 269	Continued From page 23 Telephone interview with a medication aide (MA) on 08/27/26 at 2:10pm revealed: -She had not seen Resident #3's toenails because the resident usually had on socks and shoes. -The PCAs should let her know when a resident needed to be seen by the podiatrist so the resident's name could be added to the podiatry list. Telephone interview with a physical therapist (PT) on 08/27/26 at 3:25pm revealed: -She spoke to someone earlier this week about the length of Resident #3's toenails. -She called the PCP to request the resident be seen by podiatry. -She was told by facility staff that Resident #3 refused to be seen by podiatry. -The resident may require PRN medications prior to seeing the podiatrist. -Resident #3's toenails were long and could dig into her skin and cause a break in skin integrity. Interview with Resident #3's primary care provider (PCP) 08/26/26 at 12:26pm revealed: -Resident #3's toenails were long, which put her at risk for an infection. -Resident #3 had to have an as needed (PRN) medication for anxiety and agitation before personal care. -She had written an order on 08/24/26 for Resident #3 to receive PRN medication before seeing the podiatrist after being notified by the PT. Telephone interview with a representative from the contracted podiatrist's office on 08/27/26 at 10:38am revealed: -Resident #3 was last seen by podiatry services	D 269		

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D 269	Continued From page 24 on 05/14/25. -Resident #3 refused services in July 2025 and on 12/19/25. -Resident #3 was discharged from their services due to the resident or family not wanting the resident to be seen. Telephone interview with the facility's contracted podiatrist on 08/27/26 at 10:53am revealed: -If Resident #3's toenails were long, she would be concerned that the resident's toenails could get hung on something and tear/pull off. -Long toenails were also concerning because the resident could scratch herself, which could not only be painful but also put the resident at risk for an infection. -Resident #3 needed to be encouraged by staff to have her toenails cut because the podiatry staff usually had on masks and goggles, which could be frightening. Interview with the Special Care Unit (SCU) Coordinator on 08/27/26 at 3:09pm revealed: -She knew Resident #3 refused to see the podiatrist frequently. -It took a lot of coaching to get Resident #3 to allow staff to help with her personal care. -She received notification this week from a therapist that Resident #3's toenails needed to be cut. -Resident #3's family should have been called when the resident refused podiatry services. -Her concern would be that the resident would be at risk for infections and sores. Interview with the Director of Clinical Services on 08/27/26 at 4:37pm revealed: -She expected staff to ensure a resident's toenails had been cut. -Long toenails could contribute to infections,	D 269			

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D 269	Continued From page 25 wounds, and a lot of issues. Interview with the Regional Director of Clinical Services on 08/27/26 at 5:19pm revealed: -She knew Resident #3 refused podiatry services frequently. -The toenails could be painful for the resident and could cause skin breakdown. Telephone interview with the Administrator on 08/27/26 at 5:31pm revealed: -The goal would be to have the podiatrist cut the resident's toenails, but if the resident was not diabetic, the personal care aides could cut the resident's toenails. -If the resident was refusing to have their toenails cut, she expected the staff to contact the Director of Clinical Services to obtain guidance on what to do. -The family should have also been notified to work with the resident to get her toenails cut.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.	D 270		

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D 270	Continued From page 26 This Rule is not met as evidenced by: Based on observations, interviews, and record review the facility failed to provide supervision in accordance with the assessed needs for 1 of 5 sampled residents related to a resident with dementia who was constantly disoriented. The findings are: Review of Resident #2's previous FL2 dated 05/27/26 revealed: -Diagnoses included dementia (12/01/25), Type 2 diabetes, and essential hypertension. -He was ambulatory and constantly disoriented. -He was not identified as a wanderer. -The recommended level of care was assisted living facility. Review of Resident #2's current FL2 dated 08/19/26 revealed: -Diagnoses included dementia (12/01/25), Type 2 diabetes, and essential hypertension. -He was ambulatory and constantly disoriented. -He was identified as a wanderer. -The recommended level of care was memory care. Review of Resident #2's Resident Register revealed: -There was no admission date, and the signature was 05/27/26. -Resident #2 had significant memory loss and had to be directed. -He was admitted to the assisted living unit of the facility. Review of Resident #2's care assessment dated 05/29/26 revealed: -He was sometimes disoriented, forgetful, and needed reminders.	D 270		

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D 270	Continued From page 27 -He was independent for ambulation with limited ability requiring a walker. -The care plan was signed on 06/03/26. Review of Resident #2's facility assessed Mini-mental status examinations revealed: -On 05/20/26, Resident #2 scored 9 out of 30. -On 08/02/26, Resident #2 scored 8 out of 30. -The maximum score for best mental evaluations was 30, and 0-10 was severe impairment and likely to require 24-hour supervision and assistance with activities of daily living (ADL). Review of Resident #2's facility Incident/Accident reports revealed: -On 07/31/26 at 5:45pm, Resident #2 was observed by a facility staff member walking across the parking lot toward the adjacent office complex. The staff member contacted the resident and redirected him to the facility. No injuries observed. -On 08/01/26 at 10:20am, Resident #2 was observed off site near a store front adjacent to the parking lot of the facility. He was redirected back to the facility. There were no injuries, and vital signs were obtained. Review of Resident #2's after visit summary and physician's order dated 08/02/26 revealed: -Resident #2 was seen at a local emergency department for change of his catheter bag and determined to have a urinary tract infection (UTI). -Resident #2 was ordered an antibiotic twice a day for 10 days to treat a UTI. Review of the facility's Care Notes revealed: -There was no documentation for the elopement on 07/31/26. -There was documentation for the elopement on 08/01/26.	D 270		

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D 270	Continued From page 28 -On 08/01/26 at 11:15am, the facility arranged for a sitter to start with Resident #2 at 3:00pm. The facility would provide a staff member providing one on one supervision until the sitter arrived at 3:00pm. Telephone interview with Resident #2's family member on 08/26/26 at 5:00pm revealed:(move up to 1st) -Resident #2 had a diagnosis of dementia. -Resident #2's memory had been declining and had an incident related to an incident in the parking lot of a veterinary clinic prior to be admitted to the facility. He was disoriented and had driven to the clinic but had no pet. -Resident #2's cognitive status was declining, and he felt the resident should no longer be at home alone. -Recently, the facility had reported he had eloped across the parking lot on 07/31/26 and again on 08/01/26. -He had employed a full-time sitter for Resident #2 until a bed became available in the secured memory unit of the facility. -Resident #2 was moved to the SCU of the facility on 08/19/26 to help with his supervision. Interview with Resident #2's primary care provider (PCP) on 08/26/26 at 12:25pm revealed:(move up after family) -Resident #2 was treated for a urinary tract infection (UTI) on 08/03/26. -A UTI could have further exacerbated his loss of cognitive ability and aided his elopement past his normal outside boundary on 07/31/26 and 08/01/26. -Resident #2 was moved from the AL on 08/19/26 to the special care unit (SCU) due to cognitive decline and elopement from the facility on 2 occasions.	D 270		

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D 270	Continued From page 29 Telephone interview with a representative from the facility's contracted private duty companion program on 08/27/26 at 11:26am revealed: -Resident #2 had wandered out of the facility a couple of times and needed to be monitored per the facility staff prior to 08/19/26. -Resident #2 had a private duty companion that started at 2:00pm on 08/01/26, and coverage was provided 24/7. -On 08/01/26, the companion worked from 2:00pm-8:00am on 08/02/26. -She received a complaint that the companion was sleeping and the resident had walked out of his room into the hallway. -On 08/04/26, there was a 2-hour gap when coverage was not available. -Coverage was provided 24/7 until 08/19/26. Interview with a personal care aide (PCA) on 08/26/26 at 11:30am revealed: -Resident #2 liked to go outside ever since he came to the facility in May 2026. -He usually went out the front sliding doors and sat in the front of the building. -Resident #2 was forgetful but easily redirected. -There were 3 times she was familiar with when Resident #2 went further out into or across the parking lot. -The front doors were not alarmed, but she liked to go outside and frequently sat outside with residents to keep an eye on them. -The front doors were not alarmed during her day shift. -Resident #2 was moved to the Special Care Unit (SCU) on 08/19/26. Interview with a second PCA on 08/26/26 at 12:00pm revealed: -Resident #2 was always walking around with his	D 270		

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D 270	Continued From page 30 walker. -He liked to go outside to walk around the front of the building. -Recently his behavior of walking further away from the building had gotten worse. -He was easily redirected back toward th facility. -She had seen him walking toward the offices across the parking lot on one occasion recently. -Nobody said he could walk outside alone. -The front doors were not alarmed during the day shifts. Interview with a third PCA on 08/26/28 at 4:25pm revealed:(move under the other PCA interviews) -Resident #2 would go outside most days to sit in front of the facility. -He liked to also walk to the sides of the building to watch for deer or squirrels playing. -She usually watched Resident #2 when he was outside to ensure he did not wander away from the front of the building. Interview with a Corporate Nurse Consultant on 08/26/26 at 1:30pm revealed: -If a resident residing in the assisted living (AL) unit had memory loss, the resident could go out side but should be supervised by facility staff. -There were a "select few residents" on the AL unit with cognitive loss that were allowed to sit outside the front door of the facility in view of the facility staff. -Residents should be re-assessed for any changes from normal behavior patterns, like going further into the parking lot, to rule out changes in cognitive abilities or underlying factors like a UTI. Interview with the Business Office Manager (BOM) on 08/27/26 at 1:30pm revealed: -She was called to the facility on 08/01/26 after	D 270			

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D 270	Continued From page 31 Resident #2 was found beyond the facility's parking lot. -She and the Administrator were not aware of any previous incident when Resident #2 was beyond the front parking lot. -While completing the incident report for 08/01/26, the BOM and Administrator learned Resident #2 had wandered from the building on 07/31/26 at 5:45pm. -An incident report was completed for the 07/31/26 event and the 08/01/26 event. -She contacted the resident's family member regarding Resident #2's elopement and the facility's policy to have a 24 hour sitter until the resident arrangements for increased supervision were made. -She contacted the facility's contracted private duty companion program for 24 hour one-on-one supervision for Resident #2. -The facility's contracted private duty companion program had a staff member at the facility by 2:00pm on 08/01/26 and remained in place until Resident #2's paperwork was completed to transfer the resident to the facility's SCU for increased supervision. Interview with a medication aide (MA) on 08/26/26 at 2:10pm revealed: -Resident #2 was sometimes confused, wandered around the assisted living (AL) unit and could not always find his room. -Resident #2 did not have additional supervision to go outside. -Resident #2 did not tell staff when he was going outside the front door prior to being moved to the SCU. Interview with the Regional Director of Clinical Services on 08/27/26 at 5:30pm revealed: -She was authorized to respond in the	D 270			

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D 270	Continued From page 32 Administrator's absence. -Review of Resident #2's care notes and incident reports related to the elopements on 07/31/26 and 08/01/26 documented Resident #2 was sent to the local emergency department and treated for a UTI. -There was no information related to the resident eloping on 07/31/26 at 5:45pm until the facility's administrative staff were obtaining information related to the 08/01/26 incident. -The facility immediately contacted the facility's contracted private duty companion program for 24 hour one-on-one supervision for Resident #2. Based on observations, interviews, and record review it was determined Resident #2 was a poor historian and not interviewable.	D 270		
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: Based on interviews and record reviews, the facility failed to ensure health care coordination and follow-up for 1 of 5 sampled residents (#2) as related to failing to coordinate an office visit to the primary care provider (PCP), an ophthalmology appointment, and a geriatric provider. The findings are: Review of Resident #2's current FL2 dated 08/19/26 revealed: -Diagnoses included dementia (12/01/25), Type 2 diabetes, and essential hypertension.	D 273		

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D 273	Continued From page 33 -He was ambulatory and constantly disoriented. -He was identified as a wanderer. -The recommended level of care was memory care. Review of Resident #2's Resident Register revealed there was no admission date, and the signature was 05/27/26. Review of Resident #2's local emergency department after visit summary dated 05/28/26 revealed: -Resident #2 had a return continuity visit with his private PCP dated 06/10/26 at 9:00am. -Resident #2 had a return ophthalmology visit scheduled for 06/18/26 at 1:00pm. -Resident #2 had a new visit with a gerontologist scheduled for 07/15/26 at 9:00am. Telephone interview with Resident #2's family member on 08/26/26 at 5:00pm revealed: -He resided in another state adjacent to the resident's facility. -He was very active in Resident #2's care. -The facility was aware of Resident #2's scheduled appointments. -The facility was responsible for arranging transportation to Resident #2's appointments. -He routinely drove to the appointments to be present with the resident. -He drove to the 06/10/26 appointment and Resident #2 was not there. He picked up Resident #2 at the facility and was seen by the PCP that day with a work-in appointment. The PCP reminded the resident and family member of the appointment on 07/15/26 with gerontology. -He was not contacted by the facility to meet Resident #2 on 06/18/26 regarding the scheduled appointment with ophthalmology . -He was not contacted by the facility to meet	D 273		

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D 273	Continued From page 34 Resident #2 on 07/15/26. -He was attempting to schedule an appointment to be seen by gerontology closer to the family member's home. Review of Resident #2's provider visit notes and facility progress notes revealed: -There was no documentation of Resident #2 being seen on 06/10/26 by his private PCP. -There was no documentation of Resident #2 being seen on 06/18/26 by ophthalmology. -There was no documentation of Resident #2 being seen on 07/15/26 by a gerontologist. Review of Resident #2's facility appointment schedule sheet on 08/26/26 revealed: -There was no documentation of staff scheduling an appointment on 06/10/26 with his private PCP. -There was no documentation of staff scheduling an appointment on 06/18/26 with ophthalmology. There was no documentation of staff scheduling an appointment on 07/15/26 with a geriatric provider. Telephone interview with a scheduler at Resident #2's ophthalmology clinic on 08/26/26 at 4:20pm revealed: -Resident #2 had an appointment on 06/18/26 at 1:00pm scheduled. -Resident #2 was a "no show" for the appointment meaning the resident did not come to the appointment or call to cancel or reschedule the appointment. -There was no rescheduled appointment for Resident #2. Interview with a Corporate Nurse (CN) on 08/27/26 at 9:55am revealed: -The facility should address the follow-up appointments scheduled for residents on after	D 273		

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D 273	Continued From page 35 visit summaries. -The Director of Clinical Services (DCS) was the facility nurse. -The DCS was responsible for addressing the referral appointments and coordinating with family members or responsible party transportation to the appointment. -The DCS was responsible the add the appointment to the transportation appointment sheet. -There was a staff turnover in the DCS position. -The new DCS had been in the potion for less than 2 weeks and was still training with the CN. -The DCS would have no prior knowledge of the missed appointments for Resident #2. Interview with the Regional Director of Clinical Services (RDCS) on 08/27/26 at 5:30pm revealed: -She was acting on behalf of the Administrator that was not available. -The DCS was responsible for ensuring residents' appointments were scheduled by the facility. -The Care Manager for the unit assisted the DCS in reviewing the discharge and after visit summary paperwork but the DCS was responsible. -The facility should have ensured Resident #2's appointments were kept or rescheduled. Attempted telephone interview with a scheduler at Resident #2's Geriatric clinic on 08/27/26 at 10:19am was unsuccessful.	D 273			
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration	D 367			

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D 367	Continued From page 36 record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the electronic medication administration record (eMAR) was accurate for 1 of 5 sampled residents (#3), including a controlled medication used to treat anxiety and agitation. The findings are: Review of Resident #3's current FL-2 dated 12/17/25 revealed diagnoses included dementia and anxiety. Review of Resident #3's signed physician's order dated 06/17/26 revealed there was an order for lorazepam (used to treat anxiety and agitation) 1mg, take one tablet as needed every eight hours for anxiety and agitation.	D 367		

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D 367	Continued From page 37 Review of Resident #3's July 2026 eMAR revealed: -There was an entry for lorazepam 1mg, take one tablet every 8 hours as needed for anxiety and agitation. -There was documentation lorazepam 1mg was administered on 07/01/26 and 07/05/26. -There was no documentation lorazepam 1mg was administered on 07/19/26 and 07/31/26. Review of Resident #3's July controlled substance count sheet (CSCS) from 07/08/26-07/31/26 revealed: -On 07/16/26, the facility received 30 tablets of lorazepam 1mg. -There was no documentation lorazepam 1mg was administered on 07/01/26 and 07/05/26. -On 07/19/26 at 6:00pm, one tablet of lorazepam 1mg was documented as administered. -On 07/31/26 at 7:30pm, one 1mg tablet of lorazepam was documented as administered. Review of Resident #3's August 2026 eMAR from 08/01/26-08/25/26 revealed: -There was an entry for lorazepam 1mg, take one tablet every 8 hours as needed for anxiety and agitation. -There was no documentation lorazepam 1mg was administered on 08/01/26 and 08/21/26. Review of Resident #3's August 2026 CSCS from 08/01/26-08/25/26 revealed: -On 07/16/26, the facility received 30 tablets of lorazepam 1mg. -On 08/01/26 at 5:00pm, one tablet of lorazepam 1mg was documented as administered. -On 08/21/26 at 8:00am, one 1mg tablet of lorazepam was documented as administered.	D 367		

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D 367	Continued From page 38 Telephone interview with a medication aide (MA) on 08/27/26 at 2:10pm revealed: -When Resident #3's lorazepam was administered, it would be documented on the eMAR and the CSCS. -If there were times when she did not document that she administered the lorazepam on the eMAR but it was documented on the CSCS, it was because things were "hectic" at the moment and she missed it. Telephone interview with a second MA on 08/27/26 at 3:07pm revealed: -When she administered Resident #3's lorazepam, she documented it on both the eMAR and the CSCS. -If she documented on the eMAR that she had administered a medication, then she administered it, and may have missed documenting it on the CSCS. Interview with the Special Care Unit (SCU) Coordinator on 08/27/26 at 3:09pm revealed: -Staff should document the administration of all medications on the eMAR. -Staff should also document on the CSCS when a controlled medication was administered. -Staff should review the eMAR and the CSCS before administering medication. -She was concerned the MAs were not documenting correctly. Telephone interview with the Administrator on 08/27/26 at 5:31pm revealed: -The administration of controlled medications should be documented on both the eMAR and the CSCS. -Audits should be done by the MAs by comparing the eMAR to the CSCS and letting the SCC know of any discrepancies.	D 367		

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D 375	10A NCAC 13F .1005 (a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION The Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 3 sampled residents (#7) had a physician's order to self-administer creams used to treat pain. The findings are: Review of the facility's Self-Managed Medications policy dated 06/11/26 revealed: -Any self-administered medication required an order from the resident's physician. -The Director of Clinical Services, Resident Care Coordinator (RCC), or Designee would assess	D 375		

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NAME OF PROVIDER OR SUPPLIER CHATHAM RIDGE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 114 POLKS VILLAGE LANE CHAPEL HILL, NC 27517		
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D 375	Continued From page 40 the resident's ability to self-medicate utilizing the Self-Administration of Medication Assessment upon admission and on a quarterly basis, or per state regulations, to ensure ongoing competency. Review of Resident #7's current FL2 dated 02/18/26 revealed: -Diagnoses included acute renal failure, shortness of breath, sleep apnea, type 2 diabetes, and heart failure. -There was no order for self-administration of any medication. Observation of Resident #7's room on 08/25/26 at 10:03am revealed a tube of Voltaren gel (topical nonsteroidal anti-inflammatory drug (NSAID) used mainly to relieve joint pain and inflammation from osteoarthritis) and a roll-on bottle of lidocaine (a topical pain reliever that numbs aggravated nerves to provide temporary relief from minor muscle aches, joint pain, and arthritis). Review of Resident #7's record revealed: -There was a physician's order dated 05/28/26 for Voltaren gel, apply topically 2 grams to left hand three times a day as needed for pain/arthritis. Do not exceed 32 grams over all joints in 24 hours. -There was no physician's order to self-administer Voltaren or lidocaine. -There was no self-administration assessment. Review of Resident #7's August 2026 electronic medication administration record (eMAR) from 08/01/26-08/25/26 revealed: -There was an entry for Voltaren gel, apply topically, 2 grams to left hand three times a day as needed for pain/arthritis. Do not exceed 32 grams over all joints in 24 hours. -Voltaren gel was not documented as	D 375		

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D 375	Continued From page 41 administered. -There was no entry for lidocaine. Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/27/26 at 9:26am revealed: -Resident #7 did not have an order to self-administer Voltaren gel or lidocaine gel. -Voltaren gel should be monitored when used to ensure the recommended dosage was not exceeded, as it could cause skin irritation. Interview with Resident #7 on 08/25/26 at 10:03am revealed: -He did not have an order to keep the creams in his room. -He knew not to use much of the Voltaren gel because of the NSAID. -He did not use the Voltaren or the lidocaine every day. -He did not know the creams should be locked in a lock box. Interview with a personal care aide (PCA) on 08/25/26 at 4:12pm revealed: -She had not seen any cream in Resident #7's room. -If she saw any medications/creams in a resident's room, she would let the MA know. Interview with a medication aide (MA) on 08/26/26 at 4:16pm revealed: -Resident #7 did not have an order to self-administer any creams. -Resident #7 had good and bad days as far as his memory, and she would not recommend that he self-administer medications. Interview with the RCC on 08/27/26 at 4:10pm revealed:	D 375		

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D 375	Continued From page 42 -Staff were trained to do room "sweeps" daily, usually on first shift. -If a resident was going to self-administer any medications, the Clinical Services Director would do a self-administration assessment to determine if the resident was able to self-administer their medications. -Resident #7 would ask for his cream when he needed it, but she did not recall him asking for it recently. Interview with the Director of Clinical Services on 08/27/26 at 4:37pm revealed: -She was responsible for completing the medication self-administration assessments. -She had not completed any self-administration assessments since she started two weeks ago. -She did not know the policy of room sweeps, but hoped staff were checking to ensure that if there were medications in the residents' rooms, there was an order and the medications were properly stored. Telephone interview with the Administrator on 08/27/26 at 5:31pm revealed: -Residents needed to have an order to self-administer anything the resident wanted to keep in their room. -She would want to be sure Resident #7 knew how often, what it was used for, and how to apply. Attempted telephone interview with Resident #7's primary care provider (PCP) on 08/27/26 at 4:30pm was unsuccessful.	D 375		
D 377	10A NCAC 13F .1006 (a) Medication Storage 10A NCAC 13F .1006 Medication Storage (a) Medications that are self-administered and	D 377		

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D 377	Continued From page 43 stored in the resident's room shall be stored in a safe and secure manner as specified in the adult care home's medication storage policy and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure self-administered medications stored in a resident's room were stored in a safe and secure manner for 2 of 2 sampled residents (#6 and #8). The findings are: Review of the facility's Medication and Treatment Self-Administration of Medication Policy dated 06/12/26 revealed all residents who self-administered medications must secure their medications in a lock box and keep their doors locked when not in their room. 1. Review of Resident #8's current FL2 dated 02/03/26 revealed: -Diagnoses included delirium due to physiological condition and hypertension. -He was intermittently disoriented. Review of Resident #8's record revealed there was a physician's order dated 08/10/26 to self-administer triamcinolone (a prescription steroid used to reduce redness, itching, and swelling from skin conditions), apply to rash on arms, legs, back, scalp, and neck twice daily as needed for itch. Review of Resident #8's Medication Self-Administration Assessment dated 07/08/26 revealed: -The reason for the assessment was a quarterly	D 377		

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D 377	Continued From page 44 review. -Resident #8 had orders for self-administration of oral medications and topical creams. -Resident #8 demonstrated proper/secure storage of medications kept in his room. Observation of Resident #8's room on 08/25/26 at 9:53am revealed: -A tub of triamcinolone cream inside a lock box that was too small for the tub, and the lock box would not close completely and had the key inside the lock. -The lock box was sitting on the resident's end table. Second observation of Resident #8's room on 08/25/26 at 12:45pm revealed the tub of triamcinolone cream was not in the lock box that was too small for the container and had been placed in a larger lock box in the resident's bathroom closet. Interview with Resident #8 on 08/10/26 at 9:53am revealed: -He administered creams and medications himself. -He stored his creams and medications in a lock box. -He knew the tub of triamcinolone cream did not fit in the lock box. -The cream was "in a lock box, it did not say the lock box had to be locked." Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/27/26 at 9:26am revealed: -Triamcinolone was a topical steroid that could cause irritation if not used correctly. -Triamcinolone should be used in a manner that avoided the eyes and mouth.	D 377		

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D 377	Continued From page 45 Interview with a medication aide (MA) on 08/26/26 at 4:16pm revealed: -Resident #8 had an order to self-administer medications. -Resident #8 had a lock box in his room to store medications. -She had not seen any medications in Resident #8's room that were not in his lock box. Attempted telephone interview with Resident #8's primary care provider (PCP) on 08/27/26 at 4:30pm was unsuccessful. Refer to the interview with the Director of Clinical Services on 08/27/26 at 4:37pm. Refer to the interview with the Resident Care Coordinator (RCC) on 08/27/26 at 4:10pm. Refer to the telephone interview with the Administrator on 08/27/26 at 5:31pm. 2. Review of Resident #6's current FL2 dated 07/20/26 revealed diagnoses included diabetes and hypertension. Review of Resident #6's record revealed there was a physician's order dated 07/31/26 to self-administer hydrocortisone cream (a mild topical steroid used to reduce skin inflammation, redness, and itching), apply to rash three times daily as needed for rash/itch; may self-administer and keep in room. Review of Resident #6's pre-screening questionnaire dated 07/15/26 revealed the resident could self-administer medications. Review of Resident #6's Medication	D 377		

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D 377	Continued From page 46 Self-Administration Assessment dated 07/30/26 revealed: -The reason for the assessment was an initial review. -Resident #6 had orders for self-administration of oral medications and topical creams, including hydrocortisone cream. -Resident #6 demonstrated proper/secure storage of medications kept in her room. Observation of Resident #1's room on 08/25/26 at 11:38am revealed: -A container of hydrocortisone cream was on the table beside the resident 's chair. -The cream was not in a lock box. Interview with Resident #1 on 08/25/26 at 11:39am revealed: -She used the hydrocortisone cream for dry spots on her face. -She did not know if she had an order to self-administer the cream. -She did not know she was required to keep the cream in a lock box. Second observation of Resident #6's room on 08/25/26 at 2:10pm revealed the resident's door was open, the resident was not in her room, and the tube of hydrocortisone remained on the bedside table. Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/27/26 at 9:26am revealed hydrocortisone was a mild topical steroid that did not have any warnings for use unless there was an allergy. Interview with a medication aide (MA) on 08/26/27 at 4:16pm revealed: -Resident #6's medications should be kept in a	D 377		

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D 377	Continued From page 47 lock box. -She had not seen any medications/creams in Resident #6's room out of the lock box. Attempted telephone interview with Resident #6's primary care provider (PCP) on 08/27/26 at 4:30pm was unsuccessful. Refer to the interview with the Director of Clinical Services on 08/27/26 at 4:37pm. Refer to the interview with the Resident Care Coordinator (RCC) on 08/27/26 at 4:10pm. Refer to the telephone interview with the Administrator on 08/27/26 at 5:31pm. Interview with the Resident Care Coordinator (RCC) on 08/27/26 at 4:10pm revealed: -Medications kept in the residents' room to be self-administered needed to be stored in a locked box. -Staff were trained to do room "sweeps" daily, usually on first shift. Interview with the Director of Clinical Services on 08/27/26 at 4:37pm revealed: -Medications that were being administered by the residents should be stored in a locked box. -She did not know the policy of room sweeps, but hoped staff were checking to ensure that if there were medications in the residents' room, there was an order and the medications were properly stored. Telephone interview with the Administrator on 08/27/26 at 5:31pm revealed: -The staff should check to ensure medications were securely stored weekly. -She expected all self-administered medications	D 377			

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D 377	Continued From page 48 to be securely stored in a locked box.	D 377		
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. (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 review and interviews, the facility failed to ensure that 2 of 6 sampled staff	D 468		

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D 468	Continued From page 49 (Staff A and Staff B) completed 20 hours of SCU specific training within the first six months of employment. The findings are: Review of the facility's current census on 08/25/26 revealed there was a total of 23 residents residing in the Special Care Unit (SCU). 1. Review of Staff A's, medication aide (MA), personnel record revealed: -Staff A was hired on 11/12/24. -There was no documentation that Staff A completed 20 hours of SCU specific training within the first six months of employment. Attempted telephone interview with Staff A on 08/27/26 at 4:56pm was unsuccessful. Refer to the interview with the Business Office Manager on 08/27/26 at 4:57pm. Refer to the interview with the Administrator on 08/27/26 at 5:58pm. 2. Review of Staff B's, personal care assistant (PCA), personnel record revealed: -Staff B was hired on 08/26/25. -There was no documentation that Staff B completed 20 hours of SCU specific training within the first six months of employment. Attempted telephone interview with Staff B on 08/27/26 at 4:51pm was unsuccessful. Refer to the interview with the Business Office Manager on 08/27/26 at 4:57pm. Refer to the interview with the Administrator on	D 468		

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D 468	Continued From page 50 08/27/26 at 5:58pm. Interview with the Business Office Manager (BOM) on 08/27/26 at 4:57pm revealed: -The Team Member Services Director (TMSD) was responsible for hiring, orientation, maintaining employee files, and training, both quarterly and annually. -The current TMSD was new and had completed training the previous week at a sister facility. -There had been multiple staff changes involving the TMSD since 2025. -The last known staff record audit had been conducted in 2025. Telephone interview with the TMSD on 08/27/26 at 5:14pm revealed she had been in training and had not audited any staff records. Interview with the Administrator on 08/27/26 at 5:58pm revealed: -The Team Member Services Director (TMSD) was responsible for ensuring the 20-hour training was completed. -She was unaware that there were staff who had not completed the SCU training.	D 468		