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THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

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{D 000}	Initial Comments The Adult Care Licensure Section and the Vance County Department of Social Services conducted a follow-up survey and complaint investigation from 09/23/25-09/26/25 and 09/29/25. The complaint investigation was initiated by the Vance County Department of Social Services on 08/05/25.	{D 000}		
{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. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure that the floors were kept clean in the hallways, common areas, and residents' rooms in the Assisted Living (AL) and Special Care Unit (SCU).	{D 074}		

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{D 074}	Continued From page 1	{D 074}		

The findings are:

Review of the environmental inspection report from the local county health department dated 04/09/25 revealed:
-The facility received one demerit.
-There was documentation of soiled linen stored on the floor.

Review of the facility's pest control service inspection reports revealed:
-On 07/14/25, the facility was treated for American cockroaches and ants.
-On 07/23/25, the facility was treated for bed bugs.
-On 08/05/25, the facility was inspected for bed bugs, and no live bed bugs were seen.
-On 09/03/25, the facility was treated with an insecticide for a broad spectrum of pests.

Review of the United States Environmental Protection Agency (EPA) publication dated 10/28/24 revealed:
-Roaches and their droppings may trigger an asthma attack.
-Their feces, saliva, eggs, outer covering, or cuticles left behind on surfaces contained substances that were allergenic to humans, especially those with asthma or other respiratory conditions.
-Within and on the surface of their bodies, roaches carried bacteria that could cause salmonella, staphylococcus, and streptococcus if deposited in food.

According to the EPA-affiliated National Pesticide Information Center's publication dated 07/18/25 cockroach debris, including dead cockroaches and feces, should be cleaned, because roaches

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{D 074}	Continued From page 2 were attracted to the pheromones and materials left behind by their own kind. 1. Review of an undated facility deep cleaning schedule for the AL revealed: -The rooms in the AL were deep cleaned as follows: -Rooms 101, 102, 103, and 104 on Mondays. -Rooms 105, 106, 107, and 108 on Tuesdays. -Rooms 109, 110, 111, and 112 on Wednesdays. -Rooms 113, 115, 117, 201, and 315 on Thursdays. -Rooms 203, 205, 206, 207, 311, 312, 313, and 314 on Fridays. -Rooms 208, 209, 211, 213, 307, 308, 309, and 310 on Saturdays. -Rooms 215, 301, 302, 303, 304, 305, and 306 on Sundays. -All furniture was moved, the room was swept and mopped. -The bathroom was cleaned, swept, and mopped. -The trash was removed. -There was no documentation of when routine cleaning occurred. Observations of hallways and the common areas on 08/25/25 from 10:40am to 11:20am revealed: -There were three hallways (100 hall, 200 hall, and 300 hall) where the resident rooms were. -There was dirt and debris on the floors in the hallways. -There was dirt and debris on the floors in the AL dining room. Observation of the 100-hall living room in AL on 08/19/25 at 10:40am revealed: -The floor was dirty and needed sweeping and mopping. -There was dirt on the floor that was pushed on the baseboards.	{D 074}		

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{D 074}	Continued From page 3 Observation of the dining hall in AL on 08/25/25 at 11:10am revealed: -The floor had black spots and crumbs of food on the floor. -There was a buildup of dirt on the baseboards. Observation of the 200-hall living room in AL on 08/25/25 at 11:20am revealed: -There were black spots on the floor in the hallway. -There was trash on the floor beside the fireplace. -There was a buildup of dirt along the baseboards. Observation of the 300-hall living room in AL on 08/25/25 at 11:30am revealed: -There were black spots on the floor in the hallway. -There was a buildup of dirt along the baseboards. Interview with a resident on 08/25/25 at 11:35am revealed: -The facility had never deep-cleaned her room as "promised". -Her family had to clean her room weekly. -She had attempted to clean her room on her own. -She had only seen housekeeping come into her room to get the trash. Interview with a second resident on 08/25/25 at 12:00pm revealed: -The facility did not clean her room often. -She had to buy her own supplies to clean her room. -The housekeepers did not deep clean the room, and she had to clean the room after they left. -Her room only looked clean because her family	{D 074}		

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{D 074}	Continued From page 4 cleaned her room weekly. Interview with the Resident Care Coordinator (RCC) 08/25/25 at 11:10am revealed: -Housekeeping was responsible for ensuring the residents' rooms were cleaned. -The facility currently had two new housekeepers, but they were part-time. -She was aware that the residents had been complaining about the cleanliness of their rooms and the facility -Housekeeping had been trying to keep the floors clean, but the type of flooring made it hard to keep them clean. -On days when the housekeepers did not deep clean, they spot-cleaned instead. Observations of 200-hallway in AL on 09/23/25 at 8:15am revealed: -There was a buildup of dirt and debris on the floors. -The housekeeper was pushing an automated machine to mop and dry the floors. Observation of the hallway floor exiting the dining room on 09/23/25 at 8:12am revealed there were multiple dead insects and debris on the floor. Observation of the hallway floor exiting the dining room on 09/29/25 at 8:00am revealed a dead millipede on the floor; the millipede remained on the floor at 7:09pm. Interview with a resident on 09/23/25 at 8:12am revealed: -Her family came to the facility weekly to visit and swept her floors. -Housekeeping staff cleaned her room and bathroom once a week.	{D 074}		

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{D 074}	Continued From page 5 Interview with another resident on 09/23/25 at 8:30am revealed: -The housekeepers had never deep-cleaned her room. -The housekeepers were only "deep cleaning" the floors today, 09/23/25, because the surveyors were in the facility. -The resident and her family member would clean her room weekly because housekeeping did not clean under the chairs or tables. Interview with a third resident on 09/23/25 at 12:04pm revealed: -She cleaned her own room because housekeeping did not clean her room regularly. -The housekeepers rushed when they cleaned her room. -Housekeeping staff cleaned her room once a week and removed her trash daily. -She moved into the facility when it first opened, and it was "going downhill". -The common areas and hallways were always nasty with debris on the floors. -She had not seen housekeeping staff cleaning the floors until today. Interview with a personal care aide (PCA) on 09/24/25 at 12:38pm revealed: -The residents in AL complained about not having their floors swept and mopped. -When a resident complained, she would tell a housekeeper, and the housekeeper would sweep or mop the room if it was needed. -Housekeeping staff cleaned the residents' rooms and bedrooms twice a week. -She removed trash in the residents' rooms whenever she worked. Interview with a housekeeper on 09/24/25 at 10:16am revealed:	{D 074}		

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-He worked 5 days each week and every other weekend.
-He was responsible for sweeping and mopping the common areas of the facility and the residents' rooms and bathrooms.
-He cleaned the residents' rooms daily.
-Deep cleaning occurred twice each week.
-Deep cleaning involved removing the furniture out of the room, sweeping and mopping the floors, and cleaning the bathroom.
-Some residents complained about their rooms not being cleaned daily.
-No housekeeping staff worked at night.

Interview with the RCC 09/24/25 at 5:14pm revealed:
-Housekeeping was responsible for ensuring the residents' rooms were cleaned twice each week.
-The housekeepers "deep cleaned" the residents' rooms once a week.
-She observed dirty floors in AL; it was due to the wheelchair use in the hallways.
-She encouraged the residents and their families to keep the residents' rooms cleaned.

Refer to the interview with the facility's Maintenance Director on 09/24/25 at 10:26am.

Refer to the interview with the Administrator on 09/25/25 at 8:12am.

2. Review of an undated facility deep cleaning schedule for the SCU revealed:
-The rooms in the SCU were deep cleaned as follows:
-Rooms 401, 402, 403, and 405 on Mondays.
-Rooms 407, 409, 501, and 502 on Tuesdays.
-Rooms 503, 504, 505, and 506 on Wednesdays.
-Rooms 507, 508, and 509 on Thursdays.
-All furniture was moved, the room was swept

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and mopped.
-The bathroom was cleaned, swept, and mopped.
-The trash was removed.
-There was no documentation of when routine cleaning occurred.

Observations of the hallway and the dayroom in the SCU on 09/23/25 at various times between 8:19am-3:00pm revealed:
-At 8:18am, there were multiple dead millipedes, centipedes, and unidentified dead insects and debris in the hallway.
-At 8:19am, there was debris on the floor in the dayroom.
-At 8:27am, there was a live centipede crawling on the floor and baseboard in the hallway.
-At 8:45am, there was an unidentified insect crawling on the floor in the same hallway.
-At 9:10am, there was a live centipede crawling on the floor and baseboard in a second hallway.

Observations of the hallway and the dayroom in the SCU on 09/29/25 at various times between 8:00am to 9:48am revealed there were multiple dead millipedes, centipedes, unidentified insects, and spiders in the hallways.

Observation of resident room #509 on 09/23/25 at 8:36am revealed:
-There were unidentified dead insects on the floor, including millipedes, and other unidentified insects.
-There was a live spider in a web in the corner of the room.
-There was a buildup of dirt and grime around the edges of the floor.
-There were pieces of paper under the air-conditioning unit.
-There were several unidentified dead insects in the trash can that appeared to have been picked

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{D 074}	Continued From page 8 up with a tissue. Interview with the resident who resided in resident room #509 on 09/23/25 at 8:36am revealed: -"There are so many bugs." -She hated bugs and thought that with a relatively new facility, the staff would be more attentive to the bug situation. -The staff knew there were bugs in the facility; it was obvious. -The bugs scurried all over the place. -She had picked up several bugs today and put them in the trash can. -She did not specify what types of bugs she had seen. Observation of resident room #407 on 09/23/25 at 8:21am revealed: -There was blood on the floor. -The resident's walker was on the bed. -The resident's bedcovers and pillow were on the floor. Observation of the resident who resided in resident room #407 on 09/23/25 at 11:56am revealed the resident had bruising on her forehead, and her lip was swollen and bloody. Interview with the resident who resided in resident room #407 on 09/23/25 at 11:56am revealed: -She had a fall. -"I got after a bug." Telephone interview with the resident's family member on 09/23/25 at 5:50pm revealed: -It was not unusual to see bugs on the floor. -The bugs were very prevalent a few weeks ago but had improved. -If the resident said she fell going after a bug, it could be accurate.	{D 074}		

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{D 074}	Continued From page 9 -If the resident saw a bug, she would have gone to get it because she wanted to clean all the time. Interview with another resident's family member on 09/23/25 at 12:25pm revealed he saw a live insect in his family member's room on 09/22/25. Interview with a third resident's family member on 09/24/25 at 10:30am revealed the floors at the facility needed to be cleaned a lot of times when she visited. Telephone interview with a fourth resident's family member on 09/24/25 at 10:49am revealed: -The floors at the facility needed to be cleaned. -She had been to her family members' bathroom, and there would be feces on the floor that had been tracked, and it had been there so long it had dried, and she could not get it up. -The floors were "just nasty". Confidential telephone interview with a resident's family member revealed: -No one had cleaned her family member's room since he moved in. -She had cleaned and mopped the resident's room herself. -She "kept getting roaches up" in her family member's room. -The roaches were usually dead or on their "last leg". Confidential telephone interview with another resident's family member revealed: -The floors in the facility were disgusting. -She had seen blood on the floor in the day room; no one had cleaned up. -She had seen urine on the floor in the day room that was not cleaned up for 45 minutes. -Staff used a towel to clean up the urine.	{D 074}		

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{D 074}	Continued From page 10 -She had seen insects in her family member's room. Confidential interview with a staff member revealed: -Housekeeping staff were responsible for cleaning the floors. -She had seen live and dead insects on the floor. -She had never seen an exterminator. -The residents had not complained about insects because they had dementia. Confidential interview with another staff member revealed: -She had seen insects everywhere. -She had seen the exterminator spraying the facility for insects. -Housekeeping staff were responsible for keeping the floors clean. Observation of a housekeeper on 09/24/25 at 12:49pm revealed: -A resident urinated on the floor in the dayroom and down the hallway towards the SCU spa bathroom. -The housekeeper used a dry mop to smear and dry up the urine in the dayroom and hallway. -The housekeeper sprayed the floors of the dayroom and hallway with a disinfectant and used the same dry mop to dry the area. -The mop head was not changed during the cleaning process. Interview with a housekeeper on 09/24/25 at 1:23pm revealed: -He initially thought it was water spilled on the floor. -He sprayed the floor with a disinfectant. -He changed the mop head three times during the process.	{D 074}		

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{D 074}	Continued From page 11 Interview with the facility's Maintenance Director on 09/24/25 at 1:29pm revealed: -The housekeeper should have sprayed the area with a disinfectant and then wiped the area with a wet mop. -The housekeeper should have sprayed disinfectant to the area a second time, changed the mop head, and then cleaned the area. -When the mop head did not get changed, it contaminated the entire area. -It could spread germs if the area was not properly cleaned. Interview with the Maintenance Director on 09/26/25 at 10:58am revealed: -Housekeeping staff cleaned resident rooms daily. -The housekeeper was expected to clean up everything in the residents' rooms. -When the facility was sprayed by the pest control company, insects "popped up". -The housekeeper should be cleaning up the dead insects as needed. Interview with a housekeeper on 09/29/25 at 7:58am revealed: -He had seen a lot of dead centipedes in the hallways. -He usually saw 1-2 dead centipedes a day. -He had not seen any roaches in the facility. -He tried to clean the resident rooms every day. Telephone interview with the county Environmental Health Specialist on 09/29/25 at 9:13am revealed: -It had been a while since she was at the facility. -If dead insects were not being cleaned up, she would consider it a violation for general cleaning. -She was not an expert on pest control, but would	{D 074}		

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focus on the floors not being cleaned, as evidenced by harborage (in pest control, harborage referred to the locations and conditions where pests could live, thrive, and reproduce).
-She would recommend the facility follow the recommendation of the pest control company.

Telephone interview with a representative from the facility's contracted pest control company on 9/29/25 at 9:24am revealed the company had a policy in place that they could not discuss anything related to the facility and provided the surveyor with the facility's Regional Maintenance Director's telephone number.

Interview with the Special Care Unit Coordinator (SCC) on 09/26/25 at 11:15am revealed:
-The housekeeper was responsible for cleaning the floors in hallways and the day room.
-She had seen dead insects, "here and there".
-The pest control company sprayed the facility, then the insects came out and died.
-She did not know how often the residents' rooms were cleaned.
-No residents had complained to her about insects in their rooms.

Interview with the Administrator on 09/29/25 at 5:40pm revealed:
-Staff needed to do a more thorough job of cleaning.
-The facility could not prevent insects from coming into the facility.
-The facility did routine pest control.
-She was concerned the residents may have health concerns or a fear of insects if they were not cleaned up.

Attempted telephone interview with the facility's Regional Maintenance Director on 09/29/25 at

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{D 074}	Continued From page 13 9:35am was unsuccessful. Refer to the interview with the facility's Maintenance Director on 09/24/25 at 10:26am. Refer to the interview with the Administrator on 09/25/25 at 8:12am. _____ Interview with the facility's Maintenance Director on 09/24/25 at 10:26am revealed: -There were two housekeepers in the facility. -He assisted the housekeepers when they needed help. -The housekeepers were responsible for cleaning the residents' rooms daily. -The rooms were swept and mopped, and trash was removed daily. -The housekeepers were responsible for removing the trash daily. -Some residents refused to have their rooms cleaned. -When residents refused to have their rooms cleaned, the housekeepers reported it to him or the Administrator. -The refusals were not documented anywhere. -Two housekeepers worked on Monday, Wednesday, and Thursday. -One housekeeper worked on Tuesday, Friday, Saturday, and Sunday. -Deep cleaning of the residents' rooms occurred three times each week when two housekeepers worked. -Deep cleaning the rooms consisted of cleaning the bathroom and removing furniture in the room to sweep, mop, and buff the floor. -The hallways and common areas were swept and mopped daily. -No housekeeper worked at night. Interview with the Administrator on 09/25/25 at	{D 074}		

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{D 074}	Continued From page 14 8:12am revealed: -There were two housekeepers and the Maintenance Director helped as needed. -There were no housekeepers on second shift. -Housekeeping was responsible for cleaning the common areas and floors in the facility. -The hallways were swept and mopped once a week. -Light cleaning was done to the residents' rooms daily. -Trash was removed from the residents' rooms daily. -Deep cleaning in the residents' rooms was done on a rotating schedule once a week. -She had not witnessed unclean floors in the facility or residents' rooms being unclean. -Some residents complained about their trash not being removed on every shift. -She was concerned the residents' rooms were not being thoroughly cleaned.	{D 074}		
{D 118}	10A NCAC 13F .0311 (i) Other Requirements 10A NCAC 13F .0311 Other Requirements (i) In licensed facilities without live-in staff, there shall be an electrically operated call system meeting the following requirements: (1) the call system shall connect residents' bedrooms and bathrooms to a location accessible to staff; (2) residents' bedrooms shall have a resident call system activator at the resident's bed; (3) the resident call system activator shall be within reach of a resident lying on the bed; (4) the resident call system activator shall be such that it can be activated with a single action and remain on until deactivated by staff at point of origin; and	{D 118}		

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{D 118}	Continued From page 15 (5) when activated, the call system shall activate an audible and visual signal in a location accessible to staff. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, record reviews, and interviews, the facility failed to ensure the electrical call bell system in the Assisted Living (AL) and the Special Care Unit (SCU) was maintained in an operating condition with an audible and visual signal accessible by staff. The findings are: Review of the facility's current license effective 01/01/25 revealed the facility was licensed for 62 residents in AL and 24 residents in the SCU. Review of the facility's current census dated 09/23/25 revealed 38 residents resided in AL and 19 in the SCU. Observation of the facility's call bell system on 09/24/25 at 8:49am revealed: -The facility's call bell monitoring system was in the AL medication room. -There was a long hallway, which was the 100 hall, that led to the 200 hall. -The medication room was on the 200 hall which was towards the back of the facility. -The medication room was the second door on	{D 118}		

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the right of the 200 hall.
-The medication room door was closed and locked.
-The call bell monitor had a screen that would show the room number when a resident pulled their call bell.
-The monitor audibly alerted staff to know which room a call bell was pulled in both the AL and the SCU.

Interview with a personal care aide (PCA) on 09/29/25 at 8:36am revealed:
-He would not know when a resident in the SCU pulled their call bell unless someone in AL let the staff in the SCU know when a call bell had been pulled.
-Staff sometimes did not hear the call bell alarm unless someone passed the medication room in AL, where the alarm was located.
-The call bell alarms for the SCU could not be heard until staff were "about at room 108 in AL" which was halfway down the hallway.

Interview with another PCA on 09/29/25 at 11:52am revealed:
-The residents in the SCU did not use their call bells.
-If a resident in the SCU pulled their call bell, it would ring in the medication room on the AL.
-The SCU call bells could not be heard until the staff were almost to the end of the hall where the medication room was located on the AL.

Interview with a third PCA on 09/29/25 at 11:52am revealed:
-She had looked at the call bell monitor in the medication room on the AL and saw where the call bell alarm was from a resident room in the SCU.
-She would let a staff member in the SCU know

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which call bell was alarming.
-If staff were busy providing care to the residents in the AL, they may not know if a call bell had been pulled in the SCU.

Interview with a fourth PCA on 09/25/25 at 10:31am revealed:
-She could not recall how long the call bell system had not been working.
-The call bell system would work for a few days and then go back out.
-The residents used whistles to alert staff.
-The majority of the time she would hear the whistle.
-When she was on the 100 hall, she would not hear a whistle blown at the other end of the 200 hall.
-When she was on the 200 hall, she was not able to hear a whistle at the other end of the 100 or 300 halls.
-When the call bell system was working, the call bell screen in the medication room would sound and the resident's room number would show on the screen.
-When the residents blew the whistle, she would go into a few bedrooms to discover which resident blew the whistle.
-The residents complained about the call bell system not working consistently.

Confidential interview with a staff revealed:
-Staff were not able to hear the call bell if they were on the hallways closer to the dining room.
-During mealtimes all of the staff were in the dining room assisting residents.
-When a resident was in their bedroom, staff would not know they needed help until after mealtimes.
-Staff worked hard trying to hear all of the whistles but were not able to hear them all of the

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{D 118}	Continued From page 18 time. Interview with a medication aide (MA) on 09/29/25 at 11:37am revealed the SCU call bells rang in the medication room on the AL. Interview with another MA on 09/24/25 at 4:38pm revealed: -She could not recall how long the call bells had not been working. -The system was working for a while and then stopped working. -The residents complained about staff responding late to the whistles. -When the residents blew the whistle, staff would walk the halls to ask the residents who blew the whistle. Interview with a third MA on 09/24/25 at 5:04pm revealed: -She could not recall the last time the call bells stopped working. -The residents were given whistles. -She walked down the hallways and asked residents if they had blown their whistle. Interview with a fourth MA on 09/29/25 at 11:37am revealed: -Staff in the AL would not know a call bell was ringing unless they were near the medication room. -The call bell could not be heard in the dining room or the lobby. 1. Interview with a resident who resided in resident room #508 on the SCU on 09/23/25 at 3:16pm revealed: -He had to use a whistle when he needed assistance to go to the bathroom. -"When I have to go , I have to go."	{D 118}		

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{D 118}	Continued From page 19 -He had to wait as long as an hour before any staff came to his room. -He had wet himself by then, and that made him feel like "scum". -He did not like anyone to have to clean him up. -He heard his roommate calling for assistance, and the resident could not talk as loudly as he could, so he would "holler for him". -He heard his roommate calling for a "nurse" all night long. -He had called the nurses' station to ask for assistance but always got voicemail. Observation of the resident who resided in resident room #508 on the SCUon 09/23/25 from 3:34pm-3:40pm revealed: -At 3:34pm, the resident blew his whistle several times. -At 3:38pm, he blew his whistle several more times. -At 3:40pm, a personal care aide (PCA) entered the room with a box of snacks, asked the resident if he wanted a snack, and left the room. -The PCA did not ask the resident or his roommate if they blew the whistle or if they needed anything. Telephone interview with a family member of the resident who resided in resident room #508 on 09/23/25 at 6:25pm revealed one day, the resident soiled himself three times because staff did not respond to the resident when he needed assistance. Telephone interview with a hospice PCA for the resident who resided in resident room #508 on 09/25/25 at 12:53pm revealed the resident had complained to her that he pulled his call bell and blew his whistle, and no one responded, and then he wet himself and had to lie there.	{D 118}		

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{D 118}	Continued From page 20 Observation of a second resident who resided in resident room #508 on the SCU on 09/23/25 at 3:42pm revealed: -The resident could be heard saying "nurse, nurse" multiple times; his voice was soft spoken, and he could not be heard outside of the room. -There were no staff in the hallway within sight of his room. -The surveyor located a staff member on another hallway in the SCU and notified her that the resident in resident room #508 needed assistance. Interview with the second resident in room #508 on 09/25/25 at 10:46am revealed he had pulled his call bell before, and no staff ever came. Interviews with a family member of the second resident in resident room #508 on 09/25/25 at 10:46am and 12:10pm revealed: -The resident said the call bell did not work. -He said he pulled the call bell, and nobody came. -She had mentioned this to whatever staff member she saw. -Someone said the call bells did not work, but she did not recall who. Observation of resident room #508 on 09/25/25 from 10:52am to 10:59am revealed: -The call bell was pulled. -There were no staff members in the hallway or the day room. -At 10:59am, a PCA from AL entered the SCU and responded to the call bell. Interview with the PCA on 09/25/25 at 11:00am revealed: -She heard the call bell on the AL side and was checking on the resident.	{D 118}		

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{D 118}	Continued From page 21 -There was no working call bell alarm system in the SCU. -Call bells pulled in the SCU only alarmed in the AL medication room. Observation in the facility and in resident room #508 on the SCU on 09/29/25 from 8:00am-8:09am revealed: -At 8:00am, the call bell was pulled and a red light on the call bell box on the wall turned on. -No audible call bell sound could be heard near the resident's room. -At 8:02am, an audible call bell sound could be heard approximately halfway down the AL hallway. -The room on the AL where the call bell sound was heard was locked and no staff were present. -At 8:08am, the red light on the call bell box remained on in the resident's room. -At 8:09am, the monitor for the call system in the SCU medication room had a black screen and no audible call bell sound could be heard. Interview with a second PCA on 09/24/25 at 3:48pm revealed: -The call bells were not working in the SCU. -The residents had to use a whistle or bell when they needed assistance. -Sometimes she could hear the bells/whistles, and sometimes she could not. -When she was working in the SCU, she tried to walk through the SCU "quite often," like every 30-40 minutes. Interview with a third PCA on 09/24/25 at 4:00pm revealed: -The call bells were not working; she never heard a call bell in the SCU. -The residents used whistles or bells. -She could hear the whistles or bells when she	{D 118}		

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was walking around.
-She was constantly walking in the hallways in the SCU.

Interview with a medication aide (MA) on 09/24/25 at 4:06pm revealed:
-The call bells were working in the SCU.
-There was only one resident who could comprehend how to use the call bells.

Interview with the Special Care Unit Coordinator (SCC) on 09/25/25 at 11:15am revealed:
-If a resident in the SCU pulled their call bell, it would ring in the AL unit.
-There was a monitor in the SCU, but now the call bells were only alarmed on the monitor in the AL unit.
-The SCU monitor was being repaired because when the call bell was activated, it was not loading on the monitor to show a call bell had been pulled.
-The AL staff would have to let the SCU staff know a call bell was ringing.

Refer to the interview with the Resident Care Coordinator (RCC) on 09/24/25 at 5:14pm.

Refer to the interview with the Maintenance Director on 09/24/25 at 11:43am.

Refer to the interview with the Regional Information Technology (IT) representative on 09/25/25 at 9:23am.

Refer to the interview with the Administrator on 09/24/25 at 11:02am.

2. Observation of the AL medication room revealed on 09/24/25 at 8:49am revealed there was an audible beep that could be heard in the

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{D 118}	Continued From page 23 hallway near the medication room and in the medication room. Observation of a resident who resided in AL in resident room #110 on 09/23/25 from 8:36am-9:10am revealed: -The resident pulled the call bell at 8:36am. -The red light came on when the cord was pulled. -The call bell sounded and could be heard on the 100 hall; no staff were seen on the hallway. -At 9:10am, there was still no response from staff. Based on observations and interviews, the resident who resided in resident room #110 was not interviewable. Observation of resident room #308 on 09/23/25 at 8:54am revealed: -The resident was observed sitting in her recliner. -The call bell box with a string was located on the wall behind the resident's bed,. -The resident pulled the call bell string and the red light on the call light box did not come on. Interview with a resident who resided in AL in resident room #308 on 09/23/25 at 9:02am revealed: -The call bells did not work; the call bells had not worked in three weeks. -The facility would have someone work on the call bell system; the call bell system would work for a few days and the would break again. -She paid a monthly fee for lifeline so she could notify Emergency Medical Services (EMS) if she needed assistance. Observation of resident room #308 in AL on 09/24/25 from 9:26am to 10:06am revealed: -The resident who resided in the room was observed sitting in her recliner with oxygen in use.	{D 118}		

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{D 118}	Continued From page 24 -The surveyor pulled the pull-cord in the resident's bedroom. -A dietary staff brought the resident a snack at 10:04am. -No other staff had responded by 10:06am. Second observation of resident room #308 in AL on 09/24/25 from 11:46am to 12:29pm revealed: -The resident who resided in the room was observed sitting in her recliner. -The surveyor asked the resident to ring the red bell that was given to her by staff. -The surveyor left the residents' room at 12:29pm and no staff had responded. Interview with the resident who resided in AL in resident room #308 on 09/24/25 at 9:20am revealed: -The call bells did not work and had not worked for the last few weeks. -She was given a bell by staff to use when the call bell system stopped working. -When she rang her bell, staff did not always respond. -She had to wait until staff came to do rounds to get assistance. -Staff did not consistently make rounds. Interview with a PCA on 09/24/25 at 12:38pm revealed: -When he heard a resident blow a whistle, he had to walk the hallways and ask several residents if they had blown a whistle. -He made 2-hour rounds to check on residents. Refer to the interview with the RCC on 09/24/25 at 5:14pm. Refer to the interview with the Maintenance Director on 09/24/25 at 11:43am.	{D 118}		

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{D 118}	Continued From page 25 Refer to the interview with the Regional IT representative on 09/25/25 at 9:23am. Refer to the interview with the Administrator on 09/24/25 at 11:02am. Interview with the RCC on 09/24/25 at 5:14pm revealed: -The call bell system went down in the middle of August 2025 and was fixed the same week. -Three weeks ago, the system went down, and the entire system was replaced. -The system had not stopped working after it was replaced. -None of the residents had complained to her about the call bells not working. Interview with the Maintenance Director on 09/24/25 at 11:43am revealed: -The call bell system had been working since it was fixed a few months ago. -The system went out for a few days last week but was working again. -He did not know why the system stopped working. -The system was replaced about a month ago. -He was not aware why the system was replaced. -The residents complained about the system not working. Interview with a Regional IT representative on 09/25/25 at 9:23am revealed: -He took over maintenance of the facility's call bell system 3-4 months ago. -In August 2025, he replaced the entire server and, along with the Maintenance Director, checked all pull-cords to ensure they were working properly. -Some pull-cords were misconfigured and were	{D 118}		

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fixed last month.
-He recalled the Administrator calling him once after the system replacement but could not remember when.
-He was able to fix issues remotely when needed.
-Some pull-cord box batteries, which typically last three years, needed to be replaced.
-Staff could only tell a battery was not working if the pull-cord was pulled and the medication room system did not alert.
On 09/24/25, the Administrator called to report pull-cord problems.
-He suggested the repeater (signaling device) in the system may need replacement and called the Corporate Office that day to request approval for the repair.

Interview with the Administrator on 09/24/25 at 11:02am revealed:
-The call bell system was currently working properly.
-The entire system was replaced last month, August 2025.
-She requested to have the system replaced because the system kept going down.
-The last time the system went out was on 09/19/25.
-She found out that the system was not working because she heard a resident blow a whistle.
-She contacted the Regional IT representative to repair the system.
-The representative was able to repair the system remotely on 09/22/25.
-The residents were given whistles and bells to use while the system was not working.
-She was concerned that staff did not hear the call bell and that was the reason staff were not responding.
-If a resident had a fall, the resident would not be able to pull the pull-cord.

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{D 118}	Continued From page 27 -At times, the call bell system was triggered as if the bell had been pulled, even when no resident was in the room. -She was not sure why that was occurring. -She called the representative to report the issue on 09/24/25, and he thought the repeater needed to be replaced. -The representative did not give her a date to repair the repeater for the call bell system. _____ The facility failed to ensure all residents had a audible sounding device or an effective means to alert staff for assistance. Multiple residents were dependent on staff for toileting and transferring and had to wait long periods of time for staff to respond. There were occasions when staff did not respond at all including a time the call system's central audible equipment was locked up and not monitored by staff and a time staff were not in the area to hear the system while it was activated. This failure was detrimental to the health, safety, and welfare of the residents and constitutes an Unabated Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/25/25.	{D 118}		
{D 254}	10A NCAC 13F .0801 (c) Resident Assessment 10A NCAC 13F .0801 Resident Assessment (c) When a facility identifies a change in a resident's baseline condition based upon the factors listed in Parts (1)(A) through (M) of this Paragraph, the facility shall monitor the resident's condition for no more than 10 days to determine if a significant change in the resident's condition has occurred. The facility shall conduct an assessment of a resident within three days after	{D 254}		

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the facility identifies that a significant change in the resident's baseline condition has occurred. The facility shall use the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows:
(1) Significant change is one or more of the following:
(A) deterioration in two or more activities of daily living including bathing, dressing, personal hygiene, toileting, or eating;
(B) change in ability to walk or transfer, including falls if the resident experiences repeated falls, meaning more than one, on the same day, or multiple falls that occur over several days to weeks, new onset of falls not attributed to an identifiable cause, a fall with consequent change in neurological status, or physical injury;
(C) pain worsening in severity, intensity, or duration, occurring in a new location, or new onset of pain associated with trauma;
(D) change in the pattern of usual behavior, new onset of resistance to care, abrupt onset or progression of agitation or combative behavior, deterioration in affect or mood, or violent or destructive behaviors directed at self or others;
(E) no response by the resident to the intervention for an identified problem;
(F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period;
(G) when a resident has been enrolled in hospice;
(H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crater, or any pressure ulcer determined to be greater than

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{D 254}	Continued From page 29 Stage II; (I) a new diagnosis of a condition which affects the resident's physical, mental, or psychosocial well-being; (J) improved behavior, mood or functional health status to the extent that the established plan of care no longer meets the resident's needs; (K) new onset of impaired decision-making; (L) continence to incontinence or indwelling catheter; or (M) the resident's condition indicates there may be a need to use a restraint in accordance with Rule .1501 of this Subchapter and there is no current restraint order for the resident. (2) Significant change does not include the following: (A) changes that resolve with or without intervention; (B) an acute illness or episodic event. For the purposes of this Rule "acute illness" means symptoms or a condition that develops quickly and is not a part of the resident's baseline physical health or mental health status; (C) an established, predictable cyclical pattern; or (D) steady improvement under the current course of care. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure an assessment and care plan was updated following a significant change	{D 254}		

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in condition for 3 of 5 sampled residents (#4, #5, #8) including a resident who had developed a wound (#4); a resident who was no longer ambulatory and required 2 to 3 staff assistance with transferring and providing incontinence care (#5); and a resident who had weight loss (#8).

The findings are:

1. Review of Resident #4's current FL-2 dated 08/06/25 revealed:
-Diagnoses included pain in the right knee, chronic kidney disease, mild cognitive impairment, actinic keratosis, poly-osteoarthritis, and the presence of a right artificial knee joint.
-Resident #4 was semi-ambulatory.
-Resident #4 was intermittently disoriented.
-Resident #4 was incontinent of bladder and bowels.

Review of Resident #4's Resident Register revealed an admission date of 06/03/25.

Review of Resident #4's care plan dated 06/03/25 revealed:
-He required staff supervision for ambulation, transfers, bathing, dressing, and grooming.
-He required limited staff assistance with toileting.
-He was dependent on the staff for eating.
-His skin was normal.
-He was not incontinent of bowel or bladder.

Review of Resident #4's Licensed Health Professional Support (LHPS) evaluation dated 06/30/25 revealed Resident #4 had no LHPS tasks.

Review of Resident #4's triage note dated 09/04/25 revealed the staff reported to the Primary Care Provider (PCP) that Resident #4

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had a wound on the lateral aspect of his right femur.

Review of Resident #4's electronic progress note dated 08/27/25 revealed the Resident Care Coordinator (RCC) documented the medication aide (MA) told the provider of a new skin concern, a pressure wound on the right hip.

Review of Resident #4's triage note dated 09/07/25 revealed the staff reported to the PCP that Resident #4 had an open wound on his right hip; the wound had changed quickly.

Interview with a personal care aide (PCA) on 09/26/25 at 2:09pm revealed:
-She found a red area with a small wound on Resident #4's right hip on 08/27/25.
-She took a picture of the wound and sent the picture to a MA, who sent the picture to the RCC.

Interview with a MA on 09/26/25 at 1:46pm revealed:
-She knew Resident #4 had a wound.
-She took a picture of the wound on 09/04/25 and sent it to the RCC.
-She had reported the wound to the RCC on 08/27/25 when she received a picture from the PCA and again on 09/04/25 when the wound was worse.
-The RCC thought that Resident #4's skin was pressing up against something on the wheelchair, and that was how the wound started, but she did not know how the wound started.

Interview with a second MA on 09/29/25 at 9:53am revealed:
-She knew Resident #4 had a wound to his right hip.
-She let the RCC know what the wound looked

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like and that it was worse, but she did not remember the date.
-Resident #4 was admitted to the hospital a few days after she saw the wound had gotten worse.

Interview with the RCC on 09/29/25 at 12:15pm revealed:
-She knew Resident #4 had developed a wound to his right hip, but she had forgotten to update the care plan.
-She was responsible for updating Resident #4's care plan related to the wound on his right hip.

Refer to the interview with the RCC on 09/29/25 at 12:15pm.

Refer to the interview with the Administrator on 09/26/25 at 4:00pm.

2. Review of Resident #8's current FL-2 dated 10/09/24 revealed diagnoses included fractured right femur, pleural effusion, hypertensive heart disease with heart failure, osteoarthritis, aortic valve stenosis, chronic kidney disease, and gastro-esophageal reflux disease (GERD).

Review of Resident #8's Resident Register revealed an admission date of 10/14/24.

Review of the facility's discharges revealed Resident #8 was discharged on 04/06/25.

Review of Resident #8's care plan dated 10/14/24 revealed:
-She required limited assistance from staff with eating.
-She was totally dependent on staff for ambulation, transfers, toileting, bathing, dressing, and grooming.
-Resident #8 was non-ambulatory; she used a

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wheelchair.
-She was incontinent of bowel and bladder daily.
-She was oriented.

Review of Resident #8's Licensed Health Professional Service (LHPS) evaluation dated 10/30/24 revealed:
-Resident #8 used an ambulation assistive device that required physical assistance.
-Resident #8 had physical therapy and occupational therapy.
-Resident #8 required assistance with transferring.

Review of Resident #8's LHPS evaluation dated 01/20/25 revealed:
-Resident #8 used an ambulation assistive device that required physical assistance.
-Resident #8 required assistance with transferring.

Review of Resident #8's weights revealed:
-There was documentation that Resident #8's admission weight was not taken on 10/15/24.
-Resident #8's admission weight was taken on 10/18/24 at 2:51pm; her weight was 124 pounds.
-Resident #8's weight on 11/15/24 at 11:31am was 106 pounds.
-There were no other weights documented in November 2024.

Review of Resident #8's Primary Care Primary (PCP) progress note dated 12/16/24 revealed:
-There was an order for a nutritional supplement twice daily with meals for weight loss.
-Monitor weights every other week.

Interview with the Resident Care Coordinator (RCC) on 09/29/25 at 12:15pm revealed:
-She did not know that Resident #8 had a

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significant weight loss, so she did not know to update the care plan in December 2024.
-She did not look at the weights every week; she only looked at the weights once a month, because the weights were obtained on the 15th of the month, she would look at the monthly weights after the 15th.

Refer to the interview with the RCC on 09/29/25 at 12:15pm.

Refer to the interview with the Administrator on 09/26/25 at 4:00pm.

3. Review of Resident #5's FL2 dated 03/09/25 revealed:
-Diagnoses included dementia, hypertension, and chronic obstructive pulmonary disease (COPD).
-She was intermittently disoriented.
-She was semi-ambulatory.
-Level of care was Special Care Unit (SCU).

Review of Resident #5's SCU pre-admission checklist dated 02/24/25 revealed:
-Resident #5 was independent with eating.
-Resident #5 required minimal assistance from staff with bathing and dressing.
-Resident #5 required prompting from staff for bowel and bladder.
-Resident #5 walked with a walker.

Review of Resident #5's care plan dated 02/26/25 revealed:
-She required limited staff assistance with eating.
-She was independent with toileting, ambulation, and transferring.
-She required supervision from staff for bathing, dressing, and grooming.

Review of Resident #5's care plan dated 08/11/25

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revealed:
-She required limited staff assistance with eating.
-She was independent with toileting, ambulation, and transferring.
-She required supervision from staff for bathing, dressing, and grooming.

Review of Resident #5's Licensed Health Professional Support (LHPS) evaluation dated 09/16/25 revealed:
-Personal care tasks included ambulation using assistance devices that required physical assistance and transferring semi-ambulatory or non-ambulatory residents.
-The type of assistive device required for ambulation was a wheelchair.
-The type of transfer assistance was from the bed to the chair/chair to the bed.
-The type of assistance required by staff for transferring was a one-person assist.
-She leaned forward at all times.
-Resident #5 had 11 falls since the last LHPS evaluation dated 03/11/25.

Observation of Resident #5 on 09/24/25 at various times from 7:34am-4:00pm revealed:
-At 7:34am, Resident #5 had her head lying on the table in the day room.
-The resident was pushed in her wheelchair from the day room to the dining room.
-At 9:55am, Resident #5 was leaning over in her wheelchair with her head on her lap.
-At 12:47pm, there was a 5-inch by 5-inch puddle of dark urine under Resident #5's wheelchair.
-Resident #5 was pushed in her wheelchair to the bathroom.
-It took three staff members to change Resident #5's incontinence brief.
-Resident #5 had her head lying on the dining room table.

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{D 254}	Continued From page 36 -Resident #5 was fed by a staff member. -It took two staff members to pick Resident #5 up from her wheelchair and transfer her to bed. Interview with SCU Coordinator (SCC) on 09/24/25 at 12:48pm revealed: -Resident #5 was total care. -Resident #5 could not stand up and had to be transferred. Interview with a medication aide (MA) on 09/24/25 at 12:54pm revealed Resident #5 was incontinent of both bowel and bladder. Interview with a second MA on 09/24/25 at 5:04pm revealed: -Resident #5 was walking up until about July 2025, when she had a decline. -Resident #5 would refuse to stand up and would not put her feet flat on the floor when staff tried to stand her up. -Resident #5 was not walking and had been sitting "hunched over" in her wheelchair since July 2025. -Resident #5 had been a two-person transfer since July 2025. Interview with a personal care aide (PCA) on 09/25/25 at 3:48pm revealed Resident #5 was a two-person transfer. Interview with a second PCA on 09/25/25 at 9:29am revealed: -Resident #5 had declined since she was admitted to the facility. -Resident #5 had to be fed today, 09/25/25. Interview with a third PCA on 09/25/25 at 4:00pm revealed: -Resident #5 required two people to transfer.	{D 254}		

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{D 254}	Continued From page 37 -Resident #5 was a heavy wetter. Interview with a fourth PCA on 09/26/25 at 2:52pm revealed: -Resident #5 had declined a lot. -Resident #5 could not even feed herself "now", she needed to be fed. -Resident #5 was dependent on staff for bathing and dressing. Telephone interview with Resident #5's mental health provider on 09/24/25 at 11:03am revealed Resident #5 was clearly continuing to decline. Interview with the SCC on 09/25/25 at 11:15am revealed: -She was responsible for completing the care plans for residents in the SCU. -She completed a general care plan for the residents and then a second care plan specific to residents in the SCU. -If a resident had a significant change, she would complete a new care plan. -Resident #5 had been the way she was now for months. -For months, Resident #5 had required staff assistance with feeding and transfers. -Staff members were verbally told about changes in a resident's care plan at shift change or through the work group chat. Interview with the SCC on 09/29/25 at 1:59pm revealed: -A care plan meeting was held on 09/22/25 with Resident #5's family members and primary care provider (PCP). -Resident #5 was dependent on staff for bathing and dressing. -Resident #5 was a 1-2 person assist. -She had not entered Resident #5's changes into	{D 254}		

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{D 254}	Continued From page 38 a new care plan. Interview with the Administrator on 09/29/25 at 5:40pm revealed: -The SCC was responsible for updating Resident #5's care plan. -The purpose of updating the care plan was to make sure staff were assisting the resident based on her needs identified and those needs were documented on the care plan. Refer to the interview with the RCC on 09/29/25 at 12:15pm. Refer to the interview with the Administrator on 09/26/25 at 4:00pm. _____ Interview with the RCC on 09/29/25 at 12:15pm revealed: -She and the SCC were responsible for updating the care plans within one week of a significant change. -She thought the care plan should be updated in 7 days; she did not realize she had 10 days to update the care plan. -Care plans should be updated when a significant change occurred with a resident. Interview with the Administrator on 09/26/25 at 4:00pm revealed: -The RCC and Special Care Unit Coordinator (SCC) were responsible for updating the care plans. -She expected the RCC and SCC to update care plans with significant change, a decline, if they obtained a new assistive device, if they developed a wound, or had significant weight loss. -She expected the care plan to be updated in 14 to 15 days.	{D 254}		

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D 259	10A NCAC 13F .0802 (a) (c) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (a) The facility shall develop and implement a care plan for each resident based on the resident's assessment completed in accordance with Rule .0801 of this Section. The care plan shall be resident-centered and include the resident's preferences related to the provision of care and services. A copy of each resident's current care plan shall be maintained in a location in the facility where it can be accessed by facility staff who are responsible for the implementation of the care plan. (c) The care plan shall include the following: (1) a description of services, supervision, tasks, and level of assistance to be provided to address the resident's needs identified in the resident's assessment in Rule .0801 of this Section; (2) frequency of the services or tasks to be performed; (3) revisions of tasks and frequency based on reassessments in accordance with Rule .0801 of this Section; (4) licensed health professional tasks required according to Rule .0903 of this Subchapter; (5) a dated signature of the assessor upon completion; and (6) a dated signature of the resident's physician or physician extender as defined in Rule .0102 of this Subchapter within 15 days of completion of the care plan certifying the resident is under this physician's care and has a medical diagnosis with associated physical or mental limitations warranting the provision of the personal care services in the above care plan in accordance with G.S. 131D-2.15. This shall not apply to residents assessed through the Medicaid State Plan Personal Care Services Assessment for the	D 259		

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D 259	Continued From page 40 portion of the assessment covering tasks needed for each activity of daily living of this Rule for which care planning and signing are directed by Medicaid. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure 4 of 7 sampled residents (#6, #7, #8, and #10) had a completed care plan that was signed by a physician. The findings are: 1. Review of Resident #6's current FL2 dated 08/06/25 revealed: -Diagnoses included chronic obstructive pulmonary disease, gastroesophageal reflux, hyperlipidemia, and hypertension. -The resident was ambulatory. Review of Resident #6's Resident Register revealed an admission date of 08/28/24. Review of Resident #6's care plan dated 09/27/24 revealed: -Resident #6 was independent with eating, toileting, ambulation, bathing, dressing, grooming, and transferring. -The care plan was not signed by Resident #6's Primary Care Provider (PCP) within 15 days of the assessment. Interview with the Resident Care Coordinator (RCC) on 09/25/25 at 11:42am revealed she was aware Resident #6's care plan had not been signed by the PCP within 15 days of the	D 259		

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assessment.

Refer to the interview with the RCC on 09/25/25 at 11:42am.

Refer to the interview with the Administrator on 09/26/25 at 8:10am.

2. Review of Resident #7's current FL2 dated 04/15/25 revealed:
-Diagnoses included diabetes mellitus, hypertension, hyperlipidemia, and osteoarthritis.
-Resident #7 was semi-ambulatory.

Review of Resident #7's Resident Register revealed an admission date of 05/07/25.

Review of Resident #7's care plan dated 05/27/25 revealed:
-Resident #7 was independent with eating, toileting, ambulation, bathing, dressing, grooming, and transferring.
-The care plan was not signed by Resident #6's Primary Care Provider (PCP) within 15 days of the assessment.

Interview with the RCC on 09/25/25 at 11:42am revealed she was aware Resident #7's care plan had not been signed by the PCP within 15 days of the assessment.

Refer to the interview with the RCC on 09/25/25 at 11:42am.

Refer to the interview with the Administrator on 09/26/25 at 8:10am.

3. Review of Resident #8's current FL-2 dated 10/14/24 revealed:
-Diagnoses included fractured right femur, pleural

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effusion, hypertensive heart disease with heart failure, osteoarthritis, aortic valve stenosis, chronic kidney disease, and gastroesophageal reflux disease (GERD).
-She was semi-ambulatory.
-She was incontinent of bladder at times.

Review of Resident #8's Resident Register revealed an admission date of 10/14/24.

Review of Resident #8's care plan dated 10/14/24 revealed:
-She required limited assistance from staffing with eating.
-She was totally dependent on staff assistance or ambulation, transfers, toileting, bathing, dressing and grooming.
-Resident #8 was non-ambulatory; she used a wheelchair.
-She was incontinent of bowel and bladder daily.
-The care plan was not signed by Resident #8's Primary Care Provider (PCP) within 15 days of the assessment.

Interview with the Resident Care Coordinator (RCC) on 09/25/25 at 11:42am revealed:
-She was aware Resident #8's care plan had not been signed by the PCP within 15 days of the assessment.
-She did not know she needed to have the care plan signed but the PCP in October 2024.

Refer to the interview with the RCC on 09/25/25 at 11:42am.

Refer to the interview with the Administrator on 09/26/25 at 8:10am.

4. Review of Resident #10's current FL-2 dated 10/09/24 revealed:

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D 259	Continued From page 43 -Diagnoses included pleural effusion, hypertensive heart disease, atrial fibrillation, chronic kidney disease, osteoarthritis, hyperlipidemia, gastro-esophageal reflux disease (GERD), and anemia. -She was intermittently disoriented. -She required assistance with bathing and dressing. -She was semi-ambulatory. -She was incontinent of bladder and bowel. Review of Resident #10's Resident Register revealed and admission date of 10/14/24. Review of Resident #10's care plan dated 10/15/24 revealed: -She required limited staff assistance with eating and toileting. -She required extensive staff assistance with ambulation, transfers, bathing, dressing and toileting. -She had occasional bladder and bowel incontinence. -She used a wheelchair for ambulation. -The care plan was not signed by Resident #10's Primary Care Provider (PCP) within 15 days of the assessment. Review of Resident #10's care plan dated 12/02/24 revealed: -She was totally dependent with eating, ambulation, transferring, bathing, dressing, and grooming. -She had daily bladder and bowel incontinence. -She was non-ambulatory and used a wheelchair. -The care plan was not signed by Resident #10's PCP within 15 days of the assessment. Review of Resident #10's care plan dated 03/18/25 revealed:	D 259		

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-She was totally dependent with eating, ambulation, transferring, bathing, dressing, and grooming.
-She had daily bladder and bowel incontinence.
-She was non-ambulatory and used a wheelchair.
-She had a pressure injury in the middle of her back.
-The care plan was not signed by Resident #10's Primary Care PCP within 15 days of the assessment.

Review of the hospice nursing note dated 03/24/25 revealed:
-On 03/24/25, the on-call hospice nurse was paged to the facility.
-Upon arrival Resident #10 was found without a pulse or respirations.
-Time of death pronounced at 10:59pm on 03/24/25.

Interview with the Resident Care Coordinator (RCC) on 09/25/25 at 11:42am revealed:
-She was aware Resident #10's care plan had not been signed by the PCP within 15 days of the assessment.
-She did not know she needed to have the care plan signed but the PCP in October 2024.

Refer to the interview with the RCC on 09/25/25 at 11:42am.

Refer to the interview with the Administrator on 09/26/25 at 8:10am.

_____
Interview with the RCC on 09/25/25 at 11:42am revealed:
-She was responsible for ensuring the care plans were signed by the PCP within 15 days of the assessment.
-She had not been properly trained on how care

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D 259	Continued From page 45 plans were to be completed. -She was trained on how to complete care plans in May 2025. -Any care plans completed after May 2025 should have been completed correctly. Interview with the Administrator on 09/26/25 at 8:10am revealed: -The RCC was responsible for ensuring resident care plans were completed and signed. -She was not aware residents' care plans were not signed by the physician.	D 259		
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: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide personal care assistance for 4 of 8 sampled residents (#4, #5, #10, and #15), including a resident who required limited assistance with incontinence care and developed a pressure wound (#4); another resident who required total care with toileting, bathing, dressing and mobility and developed a pressure wound (#10, #15); and two residents who required staff assistance with incontinent care and repositioning (#5).	D 269		

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D 269	Continued From page 46 The findings are: 1. Review of Resident #5's FL2 dated 03/09/25 revealed: -Diagnoses included dementia, hypertension, and chronic obstructive pulmonary disease (COPD). -She was intermittently disoriented. -She required assistance from staff with bathing and dressing. -She was semi-ambulatory. -She was incontinent of bowel and bladder. -Level of care was Special Care Unit (SCU). Review of Resident #5's Resident Register revealed an admission date of 02/25/25. Review of Resident #5's SCU pre-admission checklist dated 02/24/25 revealed: -Resident #5 was independent with eating. -Resident #5 required minimal assistance from staff with bathing and dressing. -Resident #5 required prompting from staff for bowel and bladder. -Resident #5 walked with a walker. Review of Resident #5's care plan dated 02/26/25 revealed: -She required limited staff assistance with eating. -She was independent with toileting, ambulation, and transferring. -She required supervision from staff for bathing, dressing, and grooming. Review of Resident #5's care plan dated 08/11/25 revealed: -She required limited staff assistance with eating. -She was independent with toileting, ambulation, and transferring. -She required supervision from staff for bathing, dressing, and grooming.	D 269		

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D 269	Continued From page 47 Review of Resident #5's Licensed Health Professional Support (LHPS) evaluation dated 09/16/25 revealed: -Personal care tasks included ambulation using assistance devices that required physical assistance and transferring semi-ambulatory or non-ambulatory residents. -The type of assistive device required for ambulation was a wheelchair. -The type of transfer assistance was from the bed to the chair/chair to the bed. -The type of assistance required by staff for transferring was a one-person assist. -She leaned forward at all times. -Resident #5 had 11 falls since the last LHPS evaluation dated 03/11/25. Confidential interview with a resident's family member revealed she had seen urine under Resident #5's wheelchair; it was a common occurrence. Confidential interview with another resident's family member revealed he saw urine under Resident #5's wheelchair "plenty of times". Confidential interview with a staff member revealed Resident #5 was "dead weight" and could not be transferred or changed without two staff members. Confidential interview with staff revealed: -Resident #5 was total care and needed to be in a skilled nursing facility (SNF). -Resident #5 had "gone downhill" over the last 1-2 months. -Resident #5 was a two-person transfer. -Sometimes Resident #5 was not soiled when she checked her, but at other times, "when she	D 269		

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D 269	Continued From page 48 goes, she goes". Telephone interview with a resident's family member on 09/24/25 at 5:54pm revealed: -She was concerned about the residents' lack of basic care, like not taking the residents to the bathroom very often. -She observed the residents sitting in the SCU day room, going to the dining room, and going back into the day room, and never being taken to the bathroom. -She had seen urine under Resident #5's wheelchair before. -She told a staff member when she saw the urine, and sometimes it took a while to find someone to even tell. Interview with a personal care aide (PCA) on 09/24/25 at 3:48pm revealed: -Resident #5 was a two-person transfer. -Resident #5 was supposed to be changed every two hours. -Resident #5 was never "super soiled" when she changed her. Interview with a second PCA on 09/24/25 at 4:00pm revealed: -Resident #5 required two people to transfer. -Resident #5 was not always soiled when she checked her. -Resident #5 should be changed every two hours. Telephone interview with Resident #5's mental health provider on 09/24/25 at 11:03am revealed: -Resident #5 was clearly continuing to decline. -Resident #5 needed to be changed when her incontinence brief was soiled because it increased her risk of skin breakdown. -Because of Resident #5's level of need, staff would be responsible for changing the resident.	D 269		

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D 269	Continued From page 49 -All Resident #5 was capable of doing was "what you see", bending over and leaning forward. Telephone interview with Resident #5's Occupational Therapist (OT) on 09/29/25 at 4:01pm revealed: -Resident #5 had recently been discharged from OT services, but he was not sure of the date. -He had done training with the staff to encourage Resident #5 to lean back in her wheelchair to keep her from leaning forward, as it could cause her to stretch out her back muscles, which could cause discomfort. -Resident #5 should be repositioned every 30 minutes to maintain her skin integrity. -Ideally, Resident #5 should lie down some during the day on her side. -Staff could also try to get Resident #5 to stand up; just one minute would be beneficial. Telephone interview with the facility's Clinical Nurse Consultant on 09/29/25 at 2:39pm revealed: -She completed Resident #5's LHPS assessment on 09/16/25. -Resident #5 was seated in her wheelchair and was leaning over. -She observed Resident #5 being toileted and it took 2 PCAs and herself to provide incontinence care. -The PCAs reported that sometimes it took one PCA, sometimes two, and other times three PCAs to provide incontinence care for Resident #5. -Skin integrity was the primary concern for Resident #5, as sitting for extended periods without toileting increased the resident's risk of developing wounds. Observation of Resident #5 on 09/24/25 from	D 269		

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7:34am-12:47pm revealed:
-At 7:34am, Resident #5 had her head lying on the table in the day room.
-The resident was pushed in her wheelchair from the day room to the dining room.
-At 8:09am, Resident #5 was transported from the dining room back to the day room.
-At 9:13am, Resident #5 remained in the day room with her head on the table.
-At 9:48am, a staff member took Resident #5 into the podiatrist room in the Assisted Living (AL) unit and parked her wheelchair in the middle of the floor; she was leaning over in her wheelchair with her head on her lap.
-At 9:55am, 10:12am, 10:25am Resident #5 was leaning over in her wheelchair with her head on her lap.
-At 10:36am, Resident #5 was receiving foot care from the podiatrist.
-At 10:44am, Resident #5 was brought from the podiatrist room to the day room, was pushed up to the table, and her wheelchair was locked.
-At 10:54am, a staff member placed a sweater on Resident #5.
-At 12:47pm, there was a 5-inch by 5-inch puddle of dark urine under Resident #5's wheelchair.

Observation of the SCU spa bathroom on 09/24/25 at 12:51pm revealed:
-Two staff members picked Resident #5 up under her arms and were holding the resident up while one of the staff members attempted to use her other hand to pull the resident's pants down.
-Resident #5's pants were visibly soiled from her buttocks to the waist of the pants.
-A third staff member came into the room to assist with the resident.
-While Resident #5 was being held up by 2 staff members, the third staff member removed Resident #5's incontinence brief; the incontinence

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brief's liner was saturated with dark urine from one end of the liner to the other end and contained stool as well.

Interview with the SCU Coordinator (SCC) on 09/24/25 at 12:48pm revealed:
-Resident #5 was total care.
-Resident #5 could not stand up and had to be transferred.

Interview with the medication aide (MA) on 09/24/25 at 12:54pm revealed Resident #5 was incontinent of both bowel and bladder.

Interview with another MA on 09/24/25 at 5:04pm revealed:
-PCAs were supposed to check the residents every 2 hours to see if the residents needed to be toileted and/or changed.
-She helped with toileting if she needed to.
-Resident #5 was walking up until about July 2025 when she had a decline.
-Resident #5 would refuse to stand up and would not put her feet flat on the floor when staff tried to stand her up.
-Resident #5 was not walking and had been sitting "hunched over" in her wheelchair since July 2025.
-Resident #5 had been a two-person transfer since July 2025.
-She thought the reason Resident #5 was not being toileted by staff today, 09/24/25, was due to a lack of communication between the PCAs.
-She was concerned Resident #5 was not being toileted, and she talked to both PCAs after the incident.
-She was concerned Resident #5 was not being toileted because it increased her risk for skin breakdown, because the resident was not mobile.
-She did rounds in the SCU to make sure the

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residents had been changed.
-She did not notice Resident #5 had not been changed on 09/24/25; it did not cross her mind.

Second interview with the SCC on 09/24/25 at 5:31pm revealed:
-She took Resident #5 to the podiatrist's room today, 09/24/25, and while the resident was waiting for the podiatrist, she took the resident to the bathroom.
-Resident #5 had been in the podiatrist room about 20-30 minutes when she took the resident to the bathroom.
-She toileted Resident #5 by herself in the AL bathroom.

Observation of Resident #5 on 09/24/25 from 8:14am-12:08pm revealed:
-At 8:10am, Resident #5 was sitting at the dining room table with her head lying on the edge of the table.
-At 9:11am, Resident #5 was observed with her head lying on the table in the day room.
-At 9:49am, a PCA took Resident #5 to the spa room; she was gone less than 5 minutes.
-At 11:31am, there was a 7-inch by 7-inch puddle of dark colored urine under Resident #5's wheelchair.
-At 11:47am, Resident #5 remained at the table with the puddle of urine under her wheelchair.
-At 11:54am, staff took Resident #5 to the spa room.
-At 11:59am, the PCA left the spa room and went down the hall, and within a minute, the PCA and the SCC entered the spa room with a pair of pants and a brief.
-At 12:01pm, the SCC left the spa room.
-At 12:03pm, the Administrator entered the spa room.
-At 12:08pm, Resident #5 was brought back into

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D 269	Continued From page 53 the day room. Interview with the Administrator on 09/24/25 at 12:04pm revealed the SCC wanted her to see how soiled Resident #5's brief was. Interview with the SCC on 09/24/25 at 12:12pm revealed: -Resident #5 was not soiled when she was taken into the spa room. -Resident #5's incontinence brief and her pants were dry, and she called the Administrator in the room to show her. -Resident #5's wheelchair seat was not soiled. -She had not changed Resident #5 today, 09/24/25. -There was a drip on a piece of metal on Resident #5's wheelchair, but the wheelchair seat was not soiled. Interview with the PCA on 09/24/25 at 9:29am and 12:16pm revealed: -Resident #5 was a two-person transfer. -Resident #5 had been a two-person transfer since last month. -The first shift staff usually got Resident #5 out of bed. -She changed Resident #5's incontinence brief today, 09/24/25, around 7:00am-7:15am. -When she took Resident #5 to be toileted this morning (observed at 9:49am) the resident was not soiled, so she did not need to change her. Observation of Resident #5 on 09/24/25 at 2:48pm revealed: -Two staff members took Resident #5 to her room for her to lie down. -It took two staff members to pick Resident #5 up from her wheelchair and transfer her to bed. -Resident #5's pants were soiled from her	D 269		

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buttocks up to the top of the incontinence brief.
-The incontinence brief contained dark urine at the back part of the liner; the inside of the liner was torn.

Observation of Resident #5 on 09/29/25 at various times from 7:43am-2:13pm revealed Resident #5 was sitting in the day room and/or the dining room in her wheelchair.

Observation of Resident #5 on 09/29/25 at 2:13pm revealed:
-The PCA pushed Resident #5 from the day room to the SCU spa bathroom.
-The resident refused to let him provide her with any type of care.
-A female PCA entered the room and began to provide Resident #5's incontinence care.

Interview with the PCA on 09/29/25 at 2:13pm revealed:
-When he got Resident #5 out of bed today, 09/29/25, her incontinence brief was dry.
-He had not changed Resident #5's incontinence brief today, 09/29/25.
-He was told to give Resident #5 a shower, even though he knew she was going to refuse because he was a man.

Observation of Resident #5's incontinence brief on 09/29/25 at 2:22pm revealed brown stool was smeared on the resident's brief on the left side along the edge of the brief about 3 inches, and 2 smears of stool in the brief, one about one inch and the other about 2 inches.

Based on observations, interviews, and record reviews, it was determined Resident #5 was not interviewable.

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D 269	Continued From page 55 Attempted telephone interview with Resident #5's PCP on 09/25/25 at 8:31am and 09/29 25 at 1:37pm were unsuccessful. Refer to the interview with a resident on 09/23/25 at 8:20am. Refer to the interview with a PCA on 09/26/25 at 2:09pm. Refer to the interview with a MA on 09/26/25 at 1:46pm . Refer to the interview second interview with the RCC on 09/29/25 at 5:42pm. Refer to the interview with the Administrator on 09/24/25 at 5:00pm. 2. Review of Resident #4's current FL-2 dated 08/06/25 revealed: -Diagnoses included pain in the right knee, chronic kidney disease, mild cognitive impairment, actinic keratosis, poly-osteoarthritis, and the presence of a right artificial knee joint. -He was intermittently disoriented. -He was incontinent of bowel and bladder. -His level of care was Assisted Living (AL). Review of Resident #4's Resident Register revealed an admission date of 06/03/25. Review of the facility's current census dated 09/23/25 revealed Resident #4 was admitted to the hospital on 09/17/25. Review of Resident #4's care plan dated 06/03/25 revealed: -He required staff supervision for ambulation, transfers, bathing, dressing, and grooming.	D 269		

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-He required limited staff assistance with toileting.
-He was dependent on staff for eating.
-His skin was normal.
-He was not incontinent of bowel or bladder.

Review of Resident #4's Licensed Health Professional Support (LHPS) evaluation dated 06/30/25 revealed Resident #4 had no LHPS tasks.

Review of Resident #4's shower skin assessment sheets revealed:
-On 08/28/25, there was documentation of redness noted on his right hip.
-On 09/04/25, there was documentation of a pressure sore on his right hip.
-On 09/07/25, 09/12/25, and 09/16/25, there was documentation there was no redness or pressure sore and no new skin concerns.
-On 09/17/25, there was documentation of a pressure wound, and the Primary Care Provider (PCP) was aware and had no skin concerns.

Review of Resident #4's electronic progress note dated 08/24/25 at 5:20am revealed:
-The medication aide (MA) documented that Resident #4 had an open wound on his right hip the size of a dime with redness around the area.
-There was a corrected documentation entered on 08/24/25 by the Administrator that read, Resident #4 had a red area on his right hip the size of a dime; the skin was not opened.
-The red area without skin breakdown was verified by the Resident Care Coordinator (RCC) and the Administrator.

Review of two photographs of Resident #4's right hip revealed:
-On 08/27/25 at 7:55am, there was a 1-inch by 2-inch red area on Resident #4's right hip.

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-There were two small openings within the red area; both were less than the size of a dime.
-On 09/04/25, there was a second picture of a 1-inch by 2-inch reddened area, and the skin was opened 1/2 inch by 2 inches with a dark area that extended about 1 inch from the broken skin on Resident #4's right hip.

Review of Resident #4's triage note dated 09/04/25 revealed:
-The staff reported Resident #4 had a wound on the lateral aspect of his right femur.
-The PCP requested pictures.
-The staff sent the picture taken on 09/04/25 to the PCP.
-The PCP said she would order a cream, wound care, and Home Health (HH).
-The order read: clean wound to the right hip with soap and water, and cover with non-stick dressing every other day for 10 days; have HH evaluate and treat the wound and teach wound management to the staff.
-There was no order for a cream dated 09/04/25.

Review of Resident #4's electronic progress note dated 09/04/25 revealed:
-The RCC documented the MA told the provider of a new skin concern, a pressure wound to the right hip.
-Treatment orders were placed, and HH was ordered.

Review of Resident #4's triage note dated 09/07/25 revealed:
-The staff reported Resident #4 had an open wound on his right hip; the wound had changed quickly.
-The PCP requested a picture of the wound.
-The PCP ordered to clean the wound with normal saline, apply Mupirocin 2% ointment

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(used to treat bacterial skin infections) twice daily, and cover with a dressing.
-The PCP ordered Cephalexin 500mg (an antibiotic used to treat wound infections) every 6 hours for 7 days.

Telephone interview with a representative from the facility's contracted pharmacy on 09/23/25 at 3:30pm revealed:
-The pharmacy had an order for Mupirocin 2% ointment twice daily, and cover with a dressing dated 09/07/25.
-The pharmacy dispensed a 22gm tube of Mupirocin 2% on 09/07/25.

Review of the PCP's orders for Resident #4 dated 09/08/25 revealed:
-There was an order for HH to evaluate and treat the right hip wound and teach wound management to the staff.
-Hold amoxicillin 500mg (an antibiotic used to treat infections) for chronic right knee infection x 7 days while taking Cephalexin.

Review of Resident #4's electronic progress note dated 09/09/25 revealed:
-The RCC documented she spoke with the PCP about the condition of the wound on the right hip.
-The RCC inquired if the wound could still be managed by the AL staff.
-The PCP reassured the RCC that the wound could be treated in the facility with HH involved.

Review of Resident #4's electronic progress note dated 09/09/25 revealed:
-The RCC documented that she spoke with a representative from the HH agency about Resident #4's wound care.
-The representative said the HH agency was waiting on insurance authorization and would

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D 269	Continued From page 59 possibly be out today, 09/09/25. Review of Resident #4's HH evaluation dated 09/10/25 revealed: -The Registered Nurse (RN) completed the evaluation for Resident #4 regarding wound care. -The right hip wound was assessed and noted to have drainage with slough. -The area was cleaned with saline, but not covered. -The RN educated the staff to reposition Resident #4 when possible. -The staff verbalized understanding of the education provided. -Wound care orders were requested from the PCP. -HH would discuss wound care orders with the HH physician. Review of Resident #4's triage note dated 09/11/25 revealed: -The staff reported that Resident #4's pressure wound on the right hip was changing; it was getting deeper and changing colors. -The PCP asked if the wound care team followed Resident #4 -The staff responded that HH did follow Resident #4. -The PCP asked when was the wound care team's next visit. -The staff responded they did not know when HH would visit again. -The PCP asked how deep the wound was and if it was being packed. -The staff responded the wound was pretty deep, there was no packing of the wound, only a dressing over it, and the MA could not pack a wound. -The PCP asked if the wound care team would be in the facility tomorrow?	D 269		

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-The staff responded she did not know.
-The PCP asked the staff to find out if the wound care team would be in the facility tomorrow.
-The staff reported she would find out.
-The PCP requested a follow-up about the wound care team, and no one responded.
-Another (NP) Nurse Practitioner ordered a stat (to do immediately) x-ray of the right hip and femur to rule out osteomyelitis, a stat complete blood count (CBC) with differential related to the wound.
-Notify the PCP if the wound care team could not come to the facility tomorrow, 09/12/25, to evaluate Resident #4.
-Encourage the staff to provide pressure off-loading to the right hip.

Review of Resident #4's triage note dated 09/12/25 revealed the x-ray did not show evidence of fractures or osteomyelitis.

Review of Resident #4's electronic progress note dated 09/12/25 revealed:
-The MA documented that Resident #4 was sent to the local hospital Emergency Department (ED).
-No reason for transport was documented.

Review of Resident #4's Emergency Medical Services (EMS) report dated 09/12/25 revealed:
-The call was received by EMS at 12:23pm.
-The staff wanted Resident #4 transported to the ED for further evaluation of a right hip wound.
-Resident #4 was being treated with antibiotics in the facility.
-Resident #4 was transported to the local hospital ED related to a wound on his right hip; the wound had been present since August 2025.

Review of the after-care instructions from the ED visit on 09/12/25 revealed:

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-Resident #4 was diagnosed with a decubitus ulcer.
-A decubitus ulcer occurred when there was unrelieved, constant pressure on an area of the body.
-Pressure ulcers often formed over bones; the bones squeezed the skin against the outside surface, such as a mattress or wheelchair.

Review of Resident #4's triage note dated 09/12/25 revealed:
-The MA reported, that Resident #4 had returned from the ED with a prescription for Doxycycline 100mg (used to treat bacterial infections) and requested the prescription for Doxycycline be sent to the local pharmacy so it can be picked up and started the night of 09/12/25.
-The PCP responded that she would send the order for Doxycycline 100mg twice a day for 1 week to the local pharmacy.

Telephone interview with a representative from the local pharmacy on 09/29/25 at 9:04am revealed:
-The pharmacy received an order for Doxycycline 100mg twice daily for 7 days, dated 09/12/25 for Resident #4.
-The pharmacy dispensed 14 Doxycycline 100mg capsules on 09/13/25.
-The prescription was picked up on 09/13/25 at 3:56pm; he could not tell who picked the medication up from the pharmacy.

Review of the HH Licensed Practical Nurses (LPN) notes dated 09/17/25 revealed:
-The right hip wound was assessed and measurements taken.
-The wound measured 5cm x 3cm x 0.1cm; the depth description was necrosis.
-The wound was unstageable with necrosis

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obscuring the wound bed.
-Wound care was provided as follows: the right hip wound was cleansed with a wound cleanser, patted dry, a silver dressing was applied, and covered with a foam dressing.
-The HH nurse would assess the wound weekly, and the facility LPN would perform the dressing change twice a week.

Telephone interview with Resident #4's Power of Attorney (POA) on 09/23/25 at 12:57pm revealed:
-The staff got Resident #4 out of bed and into a wheelchair.
-He asked the RCC what she thought caused the wound, and the RCC said she thought Resident #4's skin rubbed the side of the wheelchair and caused the wound on his right hip.
-He asked the staff to place a towel or pad between Resident #4 and the wheelchair when Resident #4 was up in the wheelchair, but he never saw Resident #4 with a towel or pad in the wheelchair to protect Resident #4's skin.
-Every time he saw Resident #4, he was in the wheelchair with no towel or pad in place.
-He did not know when the wound on his right hip developed, but he knew the MAs would place an ointment on the right hip wound, but the wound continued to get worse.
-Resident #4 was transported to the ED on 09/12/25 because of the wound to his right hip.
-Resident #4 received an order for an antibiotic.
-The RCC told him the wound continued to get worse and was unstageable, and Resident #4 would have to go to a skilled nursing facility (SNF) until the wound was healed, and then Resident #4 could return to the facility.
-He did not see Resident #4's wound, but he was told by the RCC that the wound had a dark center.
-Resident #4 was admitted to the local hospital on

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D 269	Continued From page 63 09/17/25. Interview with a personal care aide (PCA) on 09/29/25 at 7:48am revealed: -Resident #4 had a small, round wound on his right hip that got bigger. -It was about the size of a dime when she saw the wound the first time, but the wound kept getting bigger. -She told a nurse that Resident #4's wound was getting worse, but she did not remember who she told. -About 2 weeks later, after she told a nurse that Resident #4's wound was getting worse, Resident #4 went to the hospital because of his wound. -Resident #4's wound had gotten "really bad". -She did not know how Resident #4 got the wound on his right hip. -She did not think the wound was caused by the wheelchair because, after meals, she would take Resident #4 to the living room and transfer him to a chair in the living room. -She did not leave Resident #4 in the wheelchair all the time. -She checked on Resident #4 every 2 hours and changed him when he was soiled. -She would roll up a pad and place it under his right hip when he was in the wheelchair to help relieve pressure, but she did that because that was what she had been taught in her training. -She did not receive any instructions from management regarding the wound and how to care for Resident #4 while he had a wound. Interview with a second PCA on 09/26/25 at 2:09pm revealed: -She would find him with a soiled brief and clothes some mornings. -Resident #4 laid on his right side most of the time; he favored his right side.	D 269		

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-She found a red area with a small wound on 08/27/25.
-She took a picture of the wound, sent the picture to a MA, who sent the picture to the RCC.
-She was not given any specific instructions on how to care for Resident #4's wound on his right hip.
-Resident #4 could stand and pivot with the assistance of one person.
-She would transfer Resident #4 to the wheelchair.
-Resident #4 would stay in his wheelchair most of the day.
-She did not think Resident #4 got the wound on his right hip from rubbing on the wheelchair.
-Resident #4's skin did not touch the side of the wheelchair; there was probably an inch on each side of the resident to the side of the wheelchair.

Interview with a third PCA on 09/29/25 at 3:31pm revealed:
-She did not know about Resident #4's wound on his right hip until after he returned from the ED visit on 09/12/25.
-No one had told her Resident #4 had a wound on his right hip prior to Resident #4 going to the ED on 09/12/25.
-She was instructed by the MA after Resident #4's ED visit to let her know when Resident #4's soiled brief was changed so she could place a cream on Resident #4's wound.
-Within two to three days, the wound got darker, it had an odor, and yellowish drainage.
-Resident #4 lay on his right side a lot, and that was the side the wound was on.
-She did not know why Resident #4 was sent to the hospital on 09/17/25.
-Resident #4 soiled the dressing over the wound and his clothes due to incontinence.
-No one instructed her to pad Resident #4's

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wheelchair while sitting in the wheelchair.
-His skin did not rub the side of the wheelchair; there was room between the resident and the side of the wheelchair.

Interview with a MA on 09/26/25 at 1:46pm revealed:
-She knew Resident #4 had a wound.
-The PCP had ordered a cream to put on the wound daily and an antibiotic for infection.
-She sent Resident #4 to the ED on 09/12/25 because the wound looked terrible.
-She took a picture of the wound on 09/04/25 and sent it to the RCC.
-She had reported the wound to the RCC on 08/27/25 when she received a picture from the PCA and again on 09/04/25 when the wound was worse.
-The RCC thought that Resident #4's skin was pressing up against something on the wheelchair, and that was how the wound started, but she did not know how the wound started.
-She did not receive any guidance or instructions from the RCC in managing Resident #4's wound.

Interview with a second MA on 09/29/25 at 9:53am revealed:
-She knew Resident #4 had a wound to his right hip.
-There was an order to cleanse the wound with wound cleanser, apply a medicated ointment, and cover with a non-stick dressing.
-The dressing was always on when she changed Resident #4's dressing to his right hip.
-The last time she saw Resident #4's right hip wound, she thought "it had too much pressure on it"; the wound looked like it had sunk in.
-She let the RCC know what the wound looked like and that it was worse, but she did not remember the date.

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-Resident #4 was admitted to the hospital a few days after she saw the wound had gotten worse.
-She did not notice any odor or drainage of the wound.

Interview with a third MA on 09/29/25 at 3:10pm revealed:
-Resident #4 could stand with the assistance of his walker, then he could pivot and sit in his wheelchair.
-She was aware Resident #4 had a wound on his right hip; she would place the cream that the PCP ordered onto the wound.
-When she treated the wound, it was about the size of a 50-cent piece, and the skin was pinkish.
-She had not worked with Resident #4 in weeks.
-She did not know how Resident #4 got the wound.
Telephone interview with a representative from HH agency on 09/29/25 at 8:32am revealed:
-Home Health received a referral for Resident #4 for wound care to his right hip on 09/09/25.
-A RN saw Resident #4 on 09/10/25 for his initial evaluation.
-The RN placed a dry dressing on Resident #4's right hip wound until orders were obtained from Resident #4's PCP.
-HH reached out to the PCP by phone and fax twice to get an order for wound care after the initial assessment, with no success.
-The RCC was informed that HH had attempted to get an order for Resident #4's wound care from the PCP.
-On 09/16/25, the RCC notified HH and wanted to know when another visit was scheduled for Resident #4.
-The RCC was informed that HH had attempted twice to get an order for treatment, but the PCP had not responded to the request for wound care orders.

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-The RCC stated she would send an order for wound care for Resident #4 shortly.
-On 09/16/25, HH received an order for Resident #4 to cleanse the right hip wound with wound cleanser, pat dry, apply an alginate dressing (a dressing used to manage moderate to heavy drainage wounds, absorbing large amounts of fluid to prevent maceration of the skin, and helping with debridement by promoting removal of dead tissue), and cover with a padded dressing three times a week.
-The RCC was shown how to change the dressing and was responsible for changing the dressing twice weekly, and the HH nurse would assess and change the dressing weekly.

Interview with a representative from Resident #4's PCP office on 09/29/25 at 10:00am revealed:
-There was documentation on 09/04/25 that the PCP was notified of a wound to Resident #4's right hip; this was the first documentation of the PCP being notified of a wound.
-Resident #4 had an order to clean the wound with soap and water every other day for 10 days.
-Notify HH to evaluate and treat Resident #4's right hip wound.
-On 09/07/25, the PCP ordered Mupirocin 2% ointment twice daily, cover with a dressing, and administer Cephalexin every 6 hours for 7 days.
-On 09/11/25, the PCP was notified that the wound was getting deeper and changing colors.
-The PCP ordered an x-ray of Resident #4's right hip, which was negative.
-The PCP instructed the staff to notify HH and see if they could make a visit on 09/12/25.
-On 09/12/25, Resident #4 was sent to the ED because of the worsening wound.
-Resident #4 was ordered Doxycycline 100mg twice daily for one week in the ED.
-On 09/17/25, Resident #4 was seen by a nurse

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from HH and informed the PCP that Resident #4's right hip wound was unstageable and needed a skilled nursing facility to manage the wound.
-The PCP had discussed with the staff about repositioning Resident #4, keeping him clean and dry.
-Resident #4 was in his wheelchair each week when the PCP visited, and there was no pillow/padding to support his right hip.

Interview with the RCC on 09/29/25 at 10:00am revealed:
-Resident #4 was admitted to the local hospital on 09/17/25 because of the wound on his right hip.
-The wound on his right hip was caused by the resident's right hip rubbing against the side of the wheelchair.
-She thought a MA told her that Resident #4 had a wound on his right hip on 09/04/25.
-On 09/04/25, the PCP was notified, and an order was obtained to cleanse the wound with soap and water and cover it with a dressing.
-She did not know why the PCP did not order a cream for the wound, as the PCP had stated.
-On 09/09/25, Mupirocin ointment was ordered twice daily, and to notify HH to evaluate the wound.
-She notified HH, and they were to come see Resident #4 within the week.
-On 09/12/25, Resident #4's wound was larger than a quarter, pinkish in color, and 0.2cm deep.
-She did not remember if Resident #4's wound was draining or if there was an odor.
-She notified the PCP to have Resident #4 sent to the ED.
-She instructed the PCAs to place a towel between Resident #4's skin and the wheelchair when Resident #4 sat in his wheelchair.
-Resident #4 was sent to the ED related to the

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wound and returned with an order for Doxycycline.
-On 09/17/25, Resident #4 returned to the ED because of his wound and was admitted to the hospital.
-Resident #4 was transferred to a SNF from the hospital for wound care.
-Resident #4's wound dressing would get soiled daily because Resident #4 wore briefs and was incontinent of urine.
-The PCAs would change Resident #4's soiled brief, and the MAs would change Resident #4's dressing on his right hip wound.
-She saw Resident #4's wound on 09/17/25 before he was sent to the hospital; the center was tannish, surrounded by pink tissue.

Second interview with the RCC on 09/29/25 at 5:42pm revealed:
-She found out about Resident #4's wound on 09/04/25; it was documented on the shower assessment, and staff told her.
-She was not notified of the wound on 08/27/25, and she was not shown a picture of the wound.
-She spoke to HH; services were delayed because they were awaiting insurance approval.
-HH started on 09/10/25.

Interview with the Administrator on 09/26/25 at 4:00pm revealed:
-She knew Resident #4 had developed a wound:
-She was told on 09/04/25 that Resident #4's right hip was getting red and appeared raw, and that an ointment was ordered for his right hip.
-The RCC had come to her on 09/12/25 and told her Resident #4 had a stage II wound to his right hip.
-She told the RCC to get in touch with the PCP.
-The PCP had Resident #4 sent to the ED.
-Resident #4 returned to the facility with a new

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antibiotic order; the ED physician said the wound was a stage III.
-She saw the wound on 09/17/25, the day he went to the ED and was admitted to the hospital.
-The wound looked like it was scabbed over.
-She asked the HH nurse, and she said the wound was unstageable.
-She was not aware that the wound was first noticed on 08/27/25 and that a picture had been taken and shown to the RCC.
-She did recall documentation in the electronic progress notes of a wound on Resident #4's right hip, but there was no wound, only redness, and she could not remember the date.
-She had no idea how Resident #4 got the wound on his right hip.

Telephone interview with Resident #4's Power of Attorney (POA) on 09/29/25 at 7:41pm revealed:
-Resident #4 was admitted to a SNF on 09/24/25 for wound care.
-Resident #4 expired on 09/25/25 at the SNF.
-Resident #4's death certificate read he died of sepsis.

Attempted telephone interview with the RN from Home Health on 09/29/25 at 8:52am was unsuccessful.

Attempted telephone interview with the LPN from Home Health on 09/29/25 at 8:53am was unsuccessful.

Refer to the interview with a resident on 09/23/25 at 8:20am.

Refer to the interview with a PCA on 09/26/25 at 2:09pm.

Refer to the interview with a MA on 09/26/25 at

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D 269	Continued From page 71 1:46am . Refer to the interview with the RCC on 09/29/25 at 5:42pm. Refer to the interview with the Administrator on 09/24/25 at 5:00pm. 3. Review of Resident #15's current FL2 dated 03/11/25 revealed: -Diagnoses included vascular dementia, atherosclerotic heart disease, hypertension, and atrial fibrillation. -The resident was incontinent of bowel and bladder. -The resident required assistance with bathing and dressing. Review of Resident #15's Hospice Plan of Care dated 04/12/25 revealed: -Resident #15 required total assistance from staff with toileting, bathing, and dressing. -Resident #15 required moderate assistance from staff to transfer from bed to wheelchair. -The resident had a history of falls and was a high fall risk. -The resident had a right femur fracture two years ago. -Resident #15 was at risk for skin breakdown due to bowel and bladder incontinence. -A goal for staff was to verbalize understanding of factors influencing skin integrity and demonstrating measures to implement prevention of skin breakdown. Review of the facility's progress notes from 08/07/25 to 08/19/25 for Resident #15 revealed: -There was a progress note dated 08/07/25 at 2:49pm from the Resident Care Coordinator (RCC) to the hospice provider, redness to the	D 269		

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D 269	Continued From page 72 sacrum was seen during a skin assessment on 08/07/25. -On 08/19/25 at 12:33pm, the hospice provider advised the facility to use off-loading techniques to prevent skin breakdown on the buttocks/sacrum. -On 09/25/25 at 1:35pm, the hospice provider completed a skin assessment and observed a pressure injury on the resident's sacrum; wound assessment visit was set up. -On 09/26/25 at 3:33pm, an order from the hospice provider was received by the facility for a barrier cream. Observation of Resident #15 on 09/26/25 at 12:51pm revealed she was lying in bed with the head of the bed elevated, eating lunch. Review of a photo of Resident #15's sacrum on 09/29/25 at 5:15pm revealed: -The photo was timed stamped on 09/22/25 at 8:56pm. -The resident had a sore on her right buttock that measured 1 and 1/2 inches. -The area was red with the top layer of skin broken surrounded by pink tissue extending toward the right about 2 inches. -There was a 1/4-inch scabbed area at the top of the broken area. -There were two dime sized broken areas on her left buttock. Telephone interview with Resident #15's family member on 09/29/25 at 9:19am revealed: -He visited the resident on the morning of 08/07/25 between the hours of 7:30am and 9:00am. -Shortly after the visit he received a letter stating the visiting hours had been changed to 9:00am to 6:00pm.	D 269		

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D 269	Continued From page 73 -When he walked into the resident's room, it smelled strongly of urine and feces. -He checked the resident's bed and her brief and bedding were heavily soiled. -There was a pile of soiled linens in a chair in the room that consisted of about 3 sets of bedding including 3 comforters. -It appeared that the resident was not being properly cared for. -He visited the resident every other week and the room smelled of an odor, but it had never been as bad as it was during the visit on 08/07/25. -After leaving the facility he called the facility and left a voicemail message for the RCC on 08/07/25. -The RCC called him on 08/07/25 around 6:00pm and he told the RCC that he was concerned about the care Resident #15 was receiving. -He told the RCC about the resident being heavily soiled, the dirty linens in the chair, and the odor in the resident's room. -He was also concerned about the care of the resident's skin. -The RCC told him that she was going to contact the Home Health Provider to complete a skin assessment, the linen had been changed, and the room had been cleaned. -The facility did not make him aware that the resident had a wound on the sacrum. -He wanted to be made aware of any changes to the resident's condition. Interview with a personal care aide (PCA) on 09/29/25 at 12:57pm revealed: -She completed skin assessments on the resident and did not see any changes to the resident's skin. -Skin assessments were completed twice a week on shower days. -Hospice usually showered the resident but staff	D 269		

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still completed the skin assessments.
-If she noticed a change she would have documented the change on the skin assessment and would have told a medication aide (MA).
-Last week she changed the resident's brief and did not notice any redness on the resident's sacrum.
-She noticed the wound last night, 09/28/25, when she changed the resident.
-She asked a MA about the wound and was told to apply zinc oxide paste to the resident's sacrum during all incontinence care.
-No one told her at the beginning of her shift that the resident had a wound on her sacrum.
-The resident was incontinent of bowel and bladder.
-She changed the resident's brief 1-2 times when she worked.
-She repositioned the resident last night 09/28/25, to get the resident off of her backside.
-The resident stayed in bed more than any of the other residents in the facility.
-The resident always laid in bed on her backside.
-Sometimes the resident was seen lying on her back, slightly on her right side.
-She did not get the resident out of bed when she worked because the resident preferred to stay in bed.
-The resident required assistance with transferring.

Interview with a second PCA on 09/29/25 at 3:31pm revealed:
-Last week 09/22/25, when she gave Resident #15 a shower she noticed an open sore on the resident's bottom.
-She took a picture of the area and sent the photo to a MA.
-She asked the MA what she was supposed to do and was not told to do anything different with the

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resident.
-She did not complete a skin assessment on that day because she sent the photo of the wound to a MA.
-On 09/24/25, she sent a photo to another MA and was not told to do anything different to the wound.
-The resident required assistance with transferring out of bed.
-The resident was incontinent of bowel and bladder.
-She changed the resident's brief every 2 hours.
-She completed skin assessments twice a week on the resident's shower days.
-She documented changes to the resident's skin on the skin assessments and told a MA.

Interview with a MA on 09/29/25 at 3:11pm revealed:
-Resident #15 was incontinent of bowel and bladder.
-The resident required total assistance from staff with incontinence care.
-The resident required assistance with transferring from the bed to the wheelchair.
-She was not aware of how often the staff made rounds.
-It depended on who worked as to how often the staff would make rounds.
-She had to encourage the PCAs to make rounds.
-The PCAs should have made 2-hour rounds to check on the residents.
-The PCAs should have changed the resident's brief every 2 hours.
-When she came into work on 09/27/25, she saw a new order on the electronic medication administration record (eMAR) to apply zinc cream to the resident's bottom.
-No one made her aware at the beginning of her

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shift that the resident had a wound.
-The PCAs were responsible for completing skin assessment twice a week on the resident's shower days.
-The PCAs were responsible for documenting changes to a resident's skin on the skin assessment.
-The PCAs would see a change but were not documenting changes on the skin assessments.
-Some of the PCAs would tell a MA of a change they had seen to a resident's skin but would not document the change on the skin assessments.
-The PCAs did not want to look at a resident's private area and would not know there were changes to the skin in those areas.
-She constantly told the PCAs to do a complete skin assessment and to document changes so the MAs would know of any changes.

Confidential interview with a staff revealed:
-The PCAs were not providing incontinence care to the residents in a timely manner.
-She had to tell some of the PCAs to make rounds and check on the residents.
-The PCAs gathered in the medication room or in one of the television rooms to talk or get on their cellphones.
-She complained to management about not having enough staff.
-Management was always saying it was not in the budget to hire more staff.

Telephone interview with a nurse at Resident #15's Home Health Provider on 09/29/25 at 11:06am revealed:
-Resident #15 began hospice care on 04/12/25.
-The resident was totally incontinent of bowel and bladder.
-Staff should be checking on the resident every two hours.

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D 269	Continued From page 77 -The resident was at high risk for skin breakdown due to incontinence and mobility issues. -The facility was completing skin assessments and should have noticed the redness on the sacrum. -The resident's sacrum wound was at stage 2. -The wound was caused by the resident not being changed frequently, not being repositioned, and the resident lying on her backside too long. -She told the facility to apply the zinc oxide paste to the sacrum during each brief change. -Incontinence care should be completed every 2 hours, a barrier cream applied to the sacrum, and the resident should be repositioned at that time. -The resident did refuse incontinence care but she expected the facility staff to provide incontinence care to prevent further skin breakdown. -She observed the resident eating while lying flat in the bed with food lying in her lap. -The resident should have been repositioned with her head raised while being served a meal. -The resident was not able to sit herself up in the be; she required assistance from staff. -The resident was ordered an over the bed tray to use during meals and she expected the facility to serve meals on the tray so the resident was eating upright. -The resident had been eating 50% of her meals and was down to eating 25% of her meals. Interview with the RCC on 09/29/25 at 10:22am revealed: -The PCAs were responsible for conducting skin assessments. -The Home Health Nurse bathed Resident #15 but the PCAs still completed the skin assessment. -The PCAs were supposed to document changes to Resident #15's skin on the skin assessment.	D 269		

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-After the skin assessments were completed, she reviewed all skin assessments.
-She expected the PCAs to document changes on the skin assessments.
-If there was a documented change on the skin assessment for Resident #15, she would have made the Home Health Nurse aware.

Second interview with the RCC on 09/29/25 at 2:15pm revealed:
-There were no set times for staff to make rounds.
-She was not aware of how often the resident's brief was being changed.
-The resident was incontinent of bladder and bowel.
-She required total incontinence assistance from staff.
-The resident was normally lying in her bed on her backside throughout the day.
-The resident did not like getting out of her bed or leaving her room.
-Staff encouraged the resident to get out of bed.
-She was not aware if the staff were repositioning the resident in bed.

Interview with the Administrator on 09/29/25 at 3:56pm revealed:
-The facility did not have a policy on how often rounds were to be made.
-Skin assessments were to be completed when the resident received a bath.
-The RCC was responsible for reviewing all skin assessments prior to closing out the skin assessment.
-The RCC told her about Resident #15's wound on 09/25/25.
-The RCC saw the wound when she completed a skin assessment with the hospice nurse.
-The RCC noticed an open wound on the

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resident's sacrum.
-She was not aware of the size or stage of the wound.
-She was aware there was a problem with the PCAs not properly documenting skin changes on the skin assessments.
-She was concerned with the lack of communication between her staff.
-She expected staff to make her aware of any changes to a resident's skin.

Based on observations, interviews, and record reviews it was determined Resident #15 was not interviewable.

Refer to the interview with a resident on 09/23/25 at 8:20am.

Refer to the interview with a PCA on 09/26/25 at 2:09pm.

Refer to the interview with a MA on 09/26/25 at 1:46pm .

Refer to the interview interview with the RCC on 09/29/25 at 5:42pm.

Refer to the interview with the Administrator on 09/24/25 at 5:00pm.

4. Review of Resident #10's current FL-2 dated 10/09/24 revealed:
-Diagnoses included pleural effusion, hypertensive heart disease, atrial fibrillation, chronic kidney disease, osteoarthritis, hyperlipidemia, gastroesophageal reflux disease (GERD), and anemia.
-She was intermittently disoriented.
-She required assistance with bathing and dressing.

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D 269	Continued From page 80 -She was semi-ambulatory. -She was incontinent of bladder and bowel. Review of Resident #10's Resident Register revealed: -She was admitted on 10/14/24. -She required assistance with toileting, skin care, and transferring. Review of Resident #10's care plan dated 10/15/24 revealed: -She required limited staff assistance with eating and toileting. -She required extensive staff assistance with ambulation, transfers, bathing, dressing, and toileting. -She had occasional bladder and bowel incontinence. -She used a wheelchair for ambulation. Review of Resident #10's care plan dated 12/02/24 revealed: -She was totally dependent on staff for eating, ambulation, transferring, bathing, dressing, and grooming. -She had daily bladder and bowel incontinence. -She was non-ambulatory and used a wheelchair. Review of Resident #10's care plan dated 03/18/25 revealed: -She was totally dependent on staff for eating, ambulation, transferring, bathing, dressing, and grooming. -She had daily bladder and bowel incontinence. -She was non-ambulatory and used a wheelchair. -She had a pressure injury in the middle of her back. Review of Resident #10's Licensed Health Professional Support (LHPS) evaluation dated	D 269		

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10/30/24 revealed:
-She had oxygen that needed monitoring.
-She required assistance with ambulation devices.
-Physical therapy and occupational therapy were ordered.
-She required assistance with transferring.

Review of Resident #10's LHPS evaluation dated 12/18/24 revealed:
-She had oxygen that needed monitoring.
-She required assistance with ambulation devices.
-She required assistance with transferring.

Review of Resident #10's LHPS evaluation dated 03/11/25 revealed:
-She had oxygen that needed monitoring.
-She required assistance with ambulation devices.
-She required assistance with transferring.
-She had an order for suppositories as needed.
-There was no documentation of skin breakdown or redness; the skin assessment was blank.

Review of Resident #10's shower skin assessment sheets revealed:
-On 03/04/25, 03/13/25, and 03/17/25 there was documentation there was no redness or pressure wound noted, and there were no skin concerns.
-On 03/18/25, the bath was provided by the hospice personal care aide (PCA).
-On 03/21/25, there was documentation there was no redness or no pressure wound noted, and there were no skin concerns.

Review of the hospice nursing note dated 03/24/25 revealed:
-On 03/24/25, the on-call hospice nurse was paged to the facility.

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-Upon arrival Resident #10 was found without a pulse or respirations.
-Time of death pronounced at 10:59pm on 03/24/25.

Review of Resident #10's hospice nurse's notes revealed:
-On 03/11/25, Resident #10 had a new stage II wound on her right side, middle back; there was no drainage.
-The wound was cleaned, and a foam bandage was applied.
-On 03/12/25, Resident #10 had an unstageable wound to the left side of her middle back that measured 3cm x 2cm x 0.5cm.
-The wound was cleaned and dried, and a foam dressing was applied.
-There was also a dark purple/red area to the spinal area on the lower back that measured 3cm x 1cm.
-Staff were instructed to turn and reposition Resident #10 every 2 hours.
-On 03/15/25, the wound on Resident #10's back had yellowish brown drainage with no odor; the wound was unstageable.
-On 03/19/25, the wound dressing had been changed by the facility staff prior to the hospice nurse arriving; the family requested not to disturb Resident #10 since she was resting.
-On 03/21/25, the Power of Attorney (POA) requested that Resident #10 not be disturbed for wound care today since she was resting.
-On 03/24/25, the on-call nurse arrived at the facility to find Resident #10 without a pulse or respirations.
-Death was pronounced on 03/24/25 at 10:59pm.

Telephone interview with Resident #10's POA on 09/24/25 at 8:50am revealed:
-Resident #10 laid on her back 6 to 7 hours a day

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and developed a wound on her back.
-Resident #10 wore briefs because she was incontinent of bladder and bowel.
-Resident #10 would be soiled when she visited.
-One Sunday, she had asked a personal care aide (PCA) to assist her with bathing Resident #10 because she had body odor and needed a bath; the PCA stated baths were not given on Sundays.
-The PCAs would tell her they were not allowed to bathe Resident #10 because she was a hospice patient.
-One day in March 2025, she noticed a wound on Resident #10's back.
-The wound was about the size of an apple, the tissue was brown, and there was drainage and an odor.
-Resident #10 developed a wound because the staff did not change her and turn her frequently enough.
-As Resident #10 continued to decline, the previous Administrator notified her and told her to take Resident #10 home until she passed; she did not remember the day she was notified.

Interview with a PCA on 09/26/25 at 2:09pm revealed:
-Resident #10 required total care from staff months before she expired in March 2025.
-Resident #10 was on the shower schedule for three days a week.
-She did not see a wound on Resident #10 when she bathed and dressed her.
-She did not see a wound on Resident #10 when she changed her brief and turned and repositioned her.

Telephone interview with the hospice aide on 09/25/25 at 6:22pm revealed:
-She visited Resident #10 twice a week; as

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Resident #10 continued to decline, she visited three times a week, and in the last couple of weeks, she visited daily.
-She saw Resident #10 at 7:30am; she would get her ready for breakfast on the days she saw her.
-She saw Resident #10 two or three times a week for personal care.
-She found the wound of Resident #10's back and reported it the the HH nurse, who was in the facility.
-Resident #10 was soiled most mornings when she saw her.
-Sometimes Resident #10's clothes and sheets would be soiled in addition to her brief.
-She found Resident #10 lying on the right side of her back; she favored her right side.
-She would reposition Resident #10 off her right side after she finished Resident #10's bath.
-The hospice nurse met her at the facility some mornings.
-The hospice nurse told the staff to keep Resident #10 off the wound and to change her brief frequently and keep Resident #10 dry.
-She had spoken to the RCC after bathing Resident #10 to update her on what the wound looked like and asked the RCC to see that she was kept dry and repositioned.

Interview with a medication aide (MA) on 09/26/25 at 1:46pm revealed:
-She was not aware Resident #10 had a wound.
-She had worked with Resident #10 some, but could not remember when.
-The PCAs should do rounds every 2 hours to turn, reposition, and change soiled briefs.
-The first shift PCAs complained to her that residents were left wet from the 3rd shift.
-She reported to the RCC that the first shift PCAs were complaining about the residents being left soiled from the third shift.

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-The RCC said the 1st shift PCA should be making rounds with the 3rd shift PCA before they left their shift.
-She did not see any improvement; the PCAs still complained about residents being soiled .

Interview with a second MA on 09/26/25 at 12:33pm revealed:
-She did not know Resident #10 had a wound on her back.
-She worked with Resident #10 the week she passed away.
-The PCAs checked on Resident #10 every 2 hours and changed her brief when she was soiled.

Telephone interview with the hospice licensed practical nurse (LPN) on 09/25/25 at 11:02am revealed:
-She saw Resident #10 weekly when the hospice aide was providing care.
-She noticed the wound on Resident #10's back when she and the aide turned Resident #10.
-She notified the hospice Registered Nurse (RN).

Telephone interview with the hospice RN on 09/25/25 at 11:11am revealed:
-She cared for Resident #10 along with the hospice LPN.
-She obtained the orders for the wound care for Resident #10's back.
-She trained the Resident Care Coordinator (RCC), who was also an LPN, on how to do the dressing change.
-She instructed the RCC to replace the dressing if it became soiled or came off.
-She found the dressing off on several occasions when she visited.
-She also reinforced with the RCC how important it was for the PCAs to keeping Resident #10

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turned, repositioned, and dry.
-She found Resident #10 wet on several occasions when she visited.
-Resident #10 could not turn herself for the last 3 to 4 weeks of her life.
-Staff would have to turn and reposition her.

Interview with the RCC on 09/29/25 at 10:00am revealed:
-She thought the hospice aide told her that Resident #10 had a wound on her back, but she could not remember the date they spoke.
-She remembered the hospice RN speaking to her about the wound on Resident #10's back, but she did not remember what they discussed.
-She remembered a wound on Resident #10's back.
-She did not change the dressing to Resident #10's wound; the hospice RN dressed the wound.
-The RN was coming daily the last few weeks of Resident #10's life.

Interview with the Administrator on 09/26/25 at 4:00pm revealed she was not working at this facility when Resident #10 developed the wound and expired in the facility with hospice care.

_____
Interview with the RCC on 09/29/25 at 5:42pm revealed:
-She did not have concerns about wounds in the facility because the staff knew how to care for them.
-The staff would provide off-loading support with pillows, turn and reposition, and keep the residents dry.

Interview with the Administrator on 09/26/25 at 4:00pm revealed:
-She was concerned about wounds developing in the facility.

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D 269	Continued From page 87 -She told the RCC and SCC)that she wanted to know about any skin breakdown because she wanted to see it for herself. -The staff could not always prevent wounds. -The PCA could reposition a resident to off-load pressure, but the resident may return to a position that was more comfortable. -It was important for the residents to have incontinence care and for staff to provide off-loading of wounds. Attempted telephone interview with a second MA on 09/29/25 at 3:38pm was unsuccessful. Attempted telephone interview with a third MA on 09/29/25 at 3:42pm was unsuccessful. Refer to the interview with a resident on 09/23/25 at 8:20am. Refer to the interview with a PCA on 09/26/25 at 2:09pm. Refer to the interview with a MA on 09/26/25 at 1:46pm . Refer to the interview interview with the RCC on 09/29/25 at 5:42pm. Refer to the interview with the Administrator on 09/24/25 at 5:00pm. _____ Interview with a resident on 09/23/25 at 8:20am revealed the staff were stressed; they could not do everything that was needed for the residents. Interview with a PCA on 09/26/25 at 2:09pm revealed: -There had been times when she came to work	D 269		

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and found multiple residents with soiled briefs.
-Sometimes a resident's brief was so wet that the resident's clothes would be wet too.
-She had complained to the MA and to the RCC about residents being soiled at the beginning of the shift, but nothing was done.

Interview with a MA on 09/26/25 at 1:46pm revealed:
-The PCAs should make rounds on residents every 2 hours.
-The PCAs had reported to her that some residents were soiled when they came to work.
-She had spoken to the RCC about residents being left soiled.
-The RCC said the PCAs should make rounds at shift change to ensure all residents were clean at shift change.

A second interview with the RCC on 09/29/25 at 5:42pm revealed:
-The staff would provide off-loading support with pillows, turn and reposition, and keep the residents dry.
-She saw that the staff provided the care the residents needed.

Interview with the Administrator on 09/24/25 at 5:00pm revealed:
-Staff should be toileting the residents every 2 hours.
-The staff did not document when a resident was toileted.
-There was no staff assignment for who was responsible for toileting the residents; the staff worked that out amongst themselves.
-She was concerned that if a resident was not being toileted, there was a lack of care, and sitting in a soiled brief could cause skin breakdown and infections.

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D 269	Continued From page 89 The facility failed to provide personal care assistance for 4 of 8 sampled residents (#4, #5, #10, #15) including a resident who was a risk for skin breakdown related to incontinence and decreased mobility, who developed a reddened area on his right hip that progressed to a stage II wound, and the wound further progressed and became unstageable. The resident was hospitalized with a diagnosis of sepsis on 09/17/25 (#4). A second resident was dependent on staff for incontinence care and was observed sitting for long periods of time without being repositioned, and she was found with a saturated incontinence brief, soiled pants, and urine on the floor beneath her wheelchair. A third resident, who was at risk for skin breakdown and was totally dependent on staff for all needs, developed a stage II wound on the right side of her back, and the wound became unstageable (#10). This failure resulted in serious physical harm and neglect which constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/25/25 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 29, 2025.	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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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to provide supervision according to the resident's assessed needs for 1 of 8 sampled residents (#5) who resided in the special care unit (SCU) and had multiple falls; and multiple residents who were left unsupervised in the SCU day room.

1. Review of Resident #5's current FL2 dated 03/09/25 revealed:
-Diagnoses included dementia, hypertension, and chronic obstructive pulmonary disease (COPD).
-She was intermittently disoriented.
-She required assistance from staff with bathing and dressing.
-She was semi-ambulatory.
-She was incontinent of bowel and bladder.
-Level of care was SCU.

Review of Resident #5's care plan dated 08/11/25 revealed:
-She required limited staff assistance with eating.
-She was independent with toileting, ambulation, and transferring.
-She required supervision from staff for bathing, dressing, and grooming.

Review of Resident #5's Licensed Health Professional Support (LHPS) evaluation dated 09/16/25 revealed:
-Personal care tasks included ambulation using assistance devices that required physical

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assistance and transferring semi-ambulatory or non-ambulatory residents.
-The type of assistive device required for ambulation was a wheelchair.
-The type of transfer assistance was from the bed to the chair/chair to the bed.
-The type of assistance required by staff for transferring was a one-person assist.
-She leaned forward in her wheelchair at all times.
-Resident #5 had 11 falls since the last LHPS evaluation dated 03/11/25.

a. Review of Resident #5's incident and accident report dated 03/14/25 revealed:
-Resident #5 had a fall in the day room at 1:00pm.
-The fall was not witnessed by staff.
-She complained of pain in her left ankle.
-She was not sent to the emergency department (ED) for an evaluation.
-She had increased agitation after the fall.
-Swelling was observed on the left ankle.
-The fall prevention program was initiated.

Review of Resident #5's fall risk intervention care plan dated 03/14/25 revealed:
-Resident #5 had a fall in the day room.
-On 03/14/25, the fall risk banner was added to the facility's computer system to alert staff that fall risk interventions were in place.
-The intervention checked was to ensure the resident was wearing appropriate footwear.

b. Review of Resident #5's incident and accident report dated 06/06/25 revealed:
-Resident #5 had a fall in the day room at 10:45pm.
-The fall was not witnessed by staff.
-The resident was sitting on her buttocks on the

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floor.
-The resident had no complaints.
-The fall prevention program was initiated.
-There was documentation to take the resident on walks during high-risk times when she preferred not to be seated.

Review of Resident #5's fall risk intervention care plan dated 06/06/25 revealed:
-Resident #5 had a fall in the day room.
-On 06/07/25, a fall risk banner was added to the facility's computer system to alert staff that fall risk interventions were in place.
-There was a section for the types of interventions, but no interventions were checked in the prepopulated list.
-There were no other interventions documented.

c. Review of Resident #5's incident and accident reports revealed no incident report dated 06/27/25.

Review of Resident #5's fall risk intervention care plan dated 06/27/25 revealed:
-Resident #5 had a fall in her room.
-On 06/27/25, the fall risk banner was added to the facility's computer system to alert staff that fall risk interventions were in place.
-The intervention checked was appropriate footwear.

d. Review of Resident #5's incident and accident report dated 07/07/25 revealed:
-Resident #5 had a fall in the day room at 10:45pm.
-The fall was not witnessed by staff.
-The resident was on the floor.
-The resident had no complaints.
-She fell out of the chair, leaning forward.
-The fall prevention program was initiated.

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-There was documentation to encourage downtime for Resident #5.

Review of Resident #5's fall risk intervention care plan dated 07/07/25 revealed:
-Resident #5 had a fall in the day room.
-Possible cause was documented as a recent change in mobility.
-On 07/08/25, a fall risk banner was added to the facility's computer system to alert staff that fall risk interventions were in place.
-There was a section for the types of interventions, but no interventions were checked in the prepopulated
list or any other interventions documented.
-A second intervention section had documentation the resident's needs would be discussed with the family.
-On 07/08/25, a care plan meeting was held with the family to discuss planned intervention and to educate regarding safety issues.
-There was no documentation as to what the planned interventions were.

e. Review of Resident #5's incident and accident report dated 07/29/25 revealed:
-Resident #5 had a fall in her room at 10:57pm.
-The fall was not witnessed by staff.
-The resident was trying to get off the floor.
-She complained of pain.
-She had a bump and a small cut above her right eye.
-The area was cleaned, applied triple antibiotic ointment, and covered.
-The resident's family member refused for the resident to be sent to the ED to be evaluated.
-The fall prevention program was initiated.

Review of Resident #5's fall risk intervention care plan dated 07/29/25 revealed:

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-Resident #5 had a fall in her room.
-On 07/08/25, a fall risk banner was added to the facility's computer system to alert staff that fall risk interventions were in place.
-There was a section for the types of interventions, but no interventions were checked in the prepopulated list, nor were any other interventions documented.
-A second intervention section had documentation to ensure adequate lighting.
-On 07/27/25, a care plan meeting was held with the family to discuss planned intervention and to educate regarding safety issues.
-There was no documentation as to what the planned interventions were.

f. Review of Resident #5's incident and accident report dated 08/12/25 revealed:
-Resident #5 had a fall in her room at 10:45pm.
-The fall was not witnessed by staff.
-The resident was lying on the floor.
-The resident had no complaints.
-The fall prevention program was initiated.
-There was documentation to ensure proper lighting, and the resident was fully positioned on the bed.

Review of Resident #5's fall risk intervention care plan dated 08/13/25 revealed:
-Resident #5 had a fall in her room.
-On 08/13/25, the fall risk banner was added to the facility's computer system to alert staff that fall risk interventions were in place.
-There was a section for the types of interventions, but no interventions were checked in the prepopulated list, nor were any other interventions documented.
-A second intervention section had documentation to ensure adequate lighting.
-On 08/13/25, a care plan meeting was held with

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the family to discuss planned intervention and to educate regarding safety issues.
-There was no documentation as to what the planned interventions were.

g. Review of Resident #5's incident and accident report dated 08/18/25 revealed:
-Resident #5 had a fall in the day room at 9:45am.
-The fall was not witnessed by staff.
-The resident was lying on the floor.
-The resident had no complaints.
-The fall prevention program was initiated.
-There was documentation for staff to offer downtime when the resident appeared to sleep throughout the day.

Review of Resident #5's fall risk intervention care plan dated 08/18/25 revealed:
-Resident #5 had a fall in the day room.
-On 08/16/25, the fall risk banner was added to the facility's computer system to alert staff that fall risk interventions were in place.
-There was a section for the types of interventions, but no interventions were checked in the prepopulated list, nor were any other interventions were documented.
-A second intervention section had documentation to offer the resident downtime.
-On 08/16/25, a care plan meeting was held with the family to discuss planned intervention and to educate regarding safety issues.
-There was no documentation as to what the planned interventions were.

h. Review of Resident #5's incident and accident report dated 09/09/25 revealed:
-Resident #5 had a fall in her room at 1:50am.
-The fall was not witnessed by staff.
-The resident was lying on the floor.

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-The resident complained of right shoulder pain.
-She was sent to the ED for an evaluation; she returned with no new orders.
-The fall prevention program was initiated.

Review of Resident #5's fall risk intervention care plan dated 09/09/25 revealed:
-Resident #5 had a fall in her room.
-The possible cause was documented as a recent change in mobility.
-On 09/09/25, the fall risk banner was added to the facility's computer system to alert staff that fall risk interventions were in place.
-There was a section for the types of interventions, but no interventions were checked in the prepopulated list, nor were any other interventions documented.
-A second intervention section had documentation that a private duty sitter would be discussed with the family.
-On 09/09/25 a care plan meeting was held with the family to discuss planned intervention and to educate regarding safety issues.
-There was no documentation as to what the planned interventions were.

i. Review of Resident #5's incident and accident report dated 09/18/25 revealed:
-Resident #5 had a fall in the dayroom at 12:50pm.
-The fall was not witnessed by staff.
-The resident was lying on the floor with a large knot on her forehead.
-The resident complained of pain.
-She was sent to the ED for an evaluation.
-The fall prevention program was initiated.

Review of Resident #5's emergency medical services (EMS) report dated 09/18/25 at 1:10pm revealed:

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D 270	Continued From page 97 -A call was received for a fall. -Resident #5 was sitting in a wheelchair slumped over at the hips; staff stated this was normal for the resident. -Staff stated they did not witness the fall however there was another resident's family member who did witness the fall and reported Resident #5 fell out of her wheelchair. -Resident #5 had a hematoma on the forehead above the left eye. -Resident #5 could not ambulate or self-maneuver at all per staff. -Resident #5 was transferred to a local ED to be evaluated. Review of Resident #5's fall risk intervention care plan dated 09/22/25 revealed: -Resident #5 had a fall in the day room. -The possible cause was documented as a recent change in cognitive status. -On 09/18/25, a fall risk banner was added to the facility's computer system to alert staff that fall risk interventions were in place. -There was a section for the types of interventions, but no interventions were checked in the prepopulated list, nor were any other interventions documented. -A second intervention section had documentation that a private duty sitter would be discussed with the family. -On 09/18/25, a care plan meeting was held with the family to discuss planned intervention and to educate regarding safety issues. -There was no documentation as to what the planned interventions were. Interview with another resident's family member on 09/24/25 at 10:07am revealed: -She was in the day room on 09/18/25, and there were no staff members in the room.	D 270		

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-A male personal care aide (PCA) pushed Resident #5 up to the table, but not all the way to the table, and the PCA left the room.
-Resident #5 fell and hit her head on the table and then hit the floor.
-She ran out of the day room, calling for assistance.
-One PCA responded that she was in the bathroom.
-The male PCA came from outside.
-The Special Care Unit Coordinator (SCC) came from her office.

Telephone interview with second resident's family member on 09/24/25 at 6:47pm revealed:
-He was visiting his family member on 09/18/25 in the day room.
-There were other residents and family members present.
-Resident #5 fell over and hit her head on the table, and then she hit the floor.
-Another family member went and got the staff.
-There had been no staff in the room for 15-20 minutes.

Interview with the PCA on 09/29/25 at 8:36am revealed:
-He had finished providing Resident #5 incontinence care and took her back to the day room.
-He pushed Resident #5 all the way to the table and locked her wheelchair brakes.
-He left the room to assist another resident.
-He was not told to do anything different with Resident #5 after her falls.

Interview with a second PCA on 09/25/25 at 2:52pm revealed:
-She was told to keep an eye on Resident #5 more often, like every 2 hours.

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-She thought checking on Resident #5 every 2 hours was probably enough because she slept most of the time.

Interview with a medication aide (MA) on 09/24/25 at 4:06pm revealed:
-Staff were not obligated to sit in the day room 24/7.
-If staff were busy, no staff would be in the day room.
-There were 2-3 residents who might forget their walker.
-Staff could not prevent every fall.

Interview with another MA on 09/25/25 at 10:26am revealed:
-Resident #5 needed to be somewhere she could be watched at all times.
-Staff knew they had to watch Resident #5 to keep her safe.

Confidential interview with a staff member revealed:
-No one had told her to do anything different with Resident #5 after her falls.
-She was concerned Resident #5 needed more supervision.

Interview with the SCC on 09/25/25 at 11:15am revealed:
-There had been a lot of different fall prevention measures implemented after each of Resident #5's falls.
-For falls in her room, ensuring proper lighting was put in place along with adding a bed alarm.
-Instead of Resident #5 being in her room, her family preferred her to be in the day room.
-Staff made sure at least one of her wheelchair wheels was locked.
-Physical therapy (PT) saw Resident #5, but she

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could not participate.
-A care plan meeting was held with the family.
-Palliative care was discussed with the family.
-The family thought Resident #5 was leaning over because she was in pain, so her pain medication was scheduled instead of as needed (PRN).
-Resident #5's mental health medications were changed.
-Supervision of Resident #5 increased, but she did not recall the frequency.
-Staff members were verbally told about changes in a resident's care plan at shift change or through the work group chat.

Interview with the SCC on 09/29/25 at 1:59pm revealed:
-Private duty sitters were discussed with Resident #5's family members due to the multiple falls and determining if the resident needed a sitter or if the resident had a general decline.
-She thought Resident #5 could benefit from a sitter to provide 1:1 care to prevent falls.

Interview with the Administrator on 09/29/25 at 4:40pm revealed:
-The family did not want Resident #5 in her bed all day.
-The family told the SCC they could not afford sitters to provide 1:1 care for Resident #5.
-The sitters may have been suggested to prevent falls, but she was not sure.

Telephone interview with Resident #5's family member on 09/24/25 at 5:42pm revealed:
-Resident #5 had good days and bad days.
-Resident #5 was sitting up "right now," but some days she would be "slumped over".
-The facility staff had increased rounds on Resident #5 to at least every 2 hours, sometimes more often.

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-The staff kept Resident #5 out of her room more because if the resident was in bed, she was going to try to get up.

Based on observations, interviews, and record reviews, it was determined Resident #5 was not interviewable.

Attempted telephone interviews with Resident #5's PCP on 09/25/25 at 8:31am and 09/29/25 at 1:37pm were unsuccessful.

2. Observation of the day room on the Special Care Unit (SCU) on 09/24/25 at various times from 8:58pm-12:46pm revealed:
-At 8:58am, there were 10 residents in the day room, and no staff members were present; a staff member did not return to the room until 9:05am.
-At 9:15am, the personal care aide (PCA) left the day room, leaving 5 residents in the day room unsupervised.
-At 9:18am, a resident was attempting to get off the couch and the Dietary Manager (DM) walked by and told the resident to sit back down.
-At 9:20am, the SCU Coordinator (SCC) walked through the day room and there were 3 residents in the day room; the SCC left the SCU at 9:22am.
-At 9:35am, there were 6 residents in the day room, and no staff were present.
-At 9:41am, a resident needed assistance, and a family member went and located a staff member.
-At 12:34pm, there were 10 residents in the day room, and no staff were present.
-At 12:42pm, a medication aide (MA) brought another resident into the room and left.
-At 12:46pm, a staff member came into the day room.

Observation of the day room on 09/25/25 from 11:55am-12:08pm revealed there were 10

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residents in the day room and no staff members were present.

Telephone interview with a resident's family member on 09/23/25 at 5:50pm revealed sometimes there were staff in the day room with the residents and sometimes there were not.

Interview with a second resident's family member on 09/24/25 at 10:30am revealed:
-She came to the facility several times per week.
-Sometimes there were staff in the day room, and sometimes there were not.

Confidential telephone interview with a resident's family member revealed a [named] resident would be observed walking without her walker, and there were no staff present to remind the resident.

Confidential telephone interview with another resident's family member revealed:
-She had walked around the SCU for 15-20 minutes before and not found a staff member.
-When she talked to staff members about no staff being in the day room, the staff responded that they could not watch the residents all the time.
-She recalled a female resident fell forward out of her chair in the day room with no staff present, but that resident had died earlier this year (2025).
-She had been in the day room before as long as 45 minutes, and no staff members were in sight of the day room.

Confidential interview with a staff member revealed:
-Residents in the SCU needed to be watched; that was why residents were falling.
-There were six [named] residents who needed to be watched because they were at risk for falls.

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D 270	Continued From page 103 -Some of the residents would "walk off" without their walker. Confidential interview with a second staff member revealed: -There were "plenty of times" when there were no staff members in the day room with the residents. -There had been falls in the day room because there were no staff in the room to provide supervision. Confidential interview with a third staff member revealed: -There were times when there were no staff in the day room with the residents; it happened a lot of times. -There needed to be more staff in the SCU to provide supervision. Confidential interview with a fourth staff member revealed: -The SCU needed more staff. -Staff were told the facility's staffing met the state requirements, but that was not enough because of the residents' needs, such as staff could not be in multiple places at once, which left the day room unsupervised. -If all the staff were in the dining room assisting residents, they would not know if a resident who was in another room needed assistance. Confidential interview with a health care professional revealed: -It was difficult to get inside the facility because there was no staff available to open the door. -It would then be hard to get into the SCU because there were no staff within sight to open the door. -There were no staff members in the SCU day room with the residents on multiple occasions	D 270		

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when she was at the facility.
-There was one resident who was leaning forward with her head on her knees.
-There would be multiple residents lined up in the day room when she was at the facility.
-The television would not even be turned on.
-There was no one interacting with the residents.
-She was concerned that the residents were neglected.

Interview with a PCA on 09/24/25 at 9:29am revealed:
-If there were residents in the day room, staff were supposed to be in the room to supervise.
-The residents in the day room were supposed to always be watched, so no one fell.
-There were 6 [named] residents who were at risk of falling.
-If the staff member needed to leave the room, they were supposed to find another staff member to cover the room.

Interview with a second PCA on 09/24/25 at 9:50am revealed staff were supposed to always be in the day room with residents; that was how she was trained.

Interview with a third PCA on 09/24/25 at 11:30am revealed:
-If a resident was in the day room, staff were supposed to be in the day room.
-There were residents who had walkers, and the residents would get up and walk without the walker if they were not reminded.
-All the residents in the SCU were at risk of falling.

Interview with a fourth PCA on 09/24/25 at 3:48pm revealed:
-There should always be staff in the day room.

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THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

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D 270	Continued From page 105 -Staff had to wait until another staff member came into the room before the staff member could leave the day room. -Three [named] residents were at high risk for falls. Interview with a fifth PCA on 09/24/25 at 4:00pm revealed: -Staff should always be in the day room. -There were 4 [named] residents who were at risk for falls. Interview with a MA on 09/24/25 at 4:06pm revealed: -Staff were not obligated to sit in the day room 24/7. -If staff were busy, no staff would be in the day room. -There were 2-3 residents who might forget their walker. -Staff could not prevent every fall. Interview with another MA on 09/25/25 at 10:26am revealed: -It would be impossible to have someone in the day room at all times. -Staff were supposed to go do what needed to be done and come right back. -The day room should not be left long unsupervised, like 3-5 minutes. Interview with the SCC on 09/24/25 at 4:11pm revealed: -There should be staff in the day room, but if something happened and staff needed to leave to provide care for a resident, then there may not be staff in the day room. -It was not acceptable for no staff to be in the day room unless the staff was providing care for a resident.	D 270		

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D 270	Continued From page 106 -Staff should be checking residents' rooms every 15-20 minutes. Interview with the Administrator on 09/24/25 at 5:40pm revealed: -Staff were responsible for making sure residents' needs were being met. -Staff did not have to be in the day room continuously but should be checking on the residents as often as needed; there was no set time. -Residents who were considered fall risks would have their care plans adjusted according to their needs. -When she walked through the SCU, there was typically someone in the day room with the residents. -If staff were doing resident care, then the day room may not have staff in the room.	D 270		
D 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures. This Rule is not met as evidenced by:	D 271		

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D 271	Continued From page 107 TYPE A2 VIOLATION Based on interviews and record reviews, the facility failed to ensure immediate response and intervention by staff for 1 of 1 sampled residents (#8) who broke her leg. The findings are: Review of Resident #8's current FL-2 dated 10/14/24 revealed: -Diagnoses included fractured right femur, pleural effusion, hypertensive heart disease with heart failure, osteoarthritis, aortic valve stenosis, chronic kidney disease, and gastro-esophageal reflux disease (GERD). -She was semi-ambulatory. -She was incontinent of bladder at times. Review of Resident #8's care plan dated 10/14/24 revealed: -She required limited staff assistance with eating. -She was totally dependent on staff with ambulation, transfers, toileting, bathing, dressing, and grooming. -Resident #8 was non-ambulatory; she used a wheelchair. -She was incontinent of bowel and bladder daily. -She was oriented. Review of Resident #8's Licensed Health Professional Support (LHPS) evaluation dated 10/30/24 revealed: -Resident #8 used an ambulation assistive device that required physical assistance. -Resident #8 had physical therapy and occupational therapy. -Resident #8 required assistance with transferring.	D 271		

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Review of Resident #8's LHPS evaluation dated 01/20/25 revealed:
-Resident #8 used an ambulation assistive device that required physical assistance.
-Resident #8 required assistance with transferring.

Review of Resident #8's accident/incident report for a fall dated 04/06/25 revealed:
-The report was completed by a medication aide (MA), and the event date was 04/06/25 at 1:05pm.
-The description was a fall in the resident's room, without injury.
-Location of the accident/incident was the resident's bathroom.
-There was a personal care aide (PCA) who witnessed the event.
-Resident #8's right leg gave out, and she was assisted to the floor by the PCA.
-Resident #8 stated her leg gave out.
-Resident #8 complained of pain in her right leg.
-No injury was noted.
-First aid was not administered.
-The resident was alert and oriented.
-The resident was sent to the Emergency Department (ED) on 04/06/25 at 1:59pm by Emergency Medical Service (EMS).
-Resident #8 was hospitalized.
-Status of Resident on 04/07/25 was the resident had no new diagnoses or treatment.

Review of Resident #8's electronic progress note dated 04/06/25 at 2:10pm revealed:
-Resident #8 had a fall.
-Resident #8 complained of pain in her leg after the fall.
-Resident #8's Primary Care Provider (PCP) was notified on 04/06/25 at 1:36pm.

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Review of Resident #8's EMS report dated 04/06/25 revealed:
-The EMS call was received at 1:40pm for a female resident who had leg pains from a fall.
-Resident #8 was in her room in bed upon EMS arrival, alert and oriented times 4.
-Resident #8 reported she was assisted to the bathroom that morning, her legs gave out, and she fell.
-Resident #8 was transported to the local hospital ED.

Telephone interview with Resident #8's Power of Attorney (POA) on 09/24/25 revealed:
-Resident #8 had her right hip replaced and a rod in her femur months before she was admitted to the facility in October 2024.
-Resident #8 was taken to the bathroom by a PCA.
-Resident #8's legs gave away, and the PCA assisted Resident #8 to the floor; she denied any pain.
-Resident #8 asked the PCA to call EMS to get her off the floor.
-The PCA got another staff member to assist in getting her off the floor with no success.
-Resident #8 asked again to call EMS to get her off the floor.
-The MA went to the kitchen and asked the dietary aide (DA) to assist with getting Resident #8 off the floor.
-The DA assisted with getting Resident #8 off the floor.
-Resident #8 heard a pop, and she told the staff that he had just broken her leg.
-Resident #8 called another family member because the facility did not call EMS.
-Resident #8's family member spoke to the staff and had them call EMS.
-She was transferred to the local hospital and

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then to a major medical hospital because she needed a specialist to perform a surgical repair on Resident #8's broken leg.

Telephone interview with Resident #8 on 09/29/25 at 9:17am revealed:
-She used a wheelchair for mobility when she resided in the facility.
-The PCAs would assist her to stand, and she would pivot to the wheelchair.
-On 04/06/25, the PCA assisted her to the bathroom in the wheelchair before lunch, which was served at 12:00pm.
-She stood up from the wheelchair, independently, and her legs "turned to jelly".
-She started falling, and the PCA "caught her" and assisted her to the floor.
-She did not fall, and she was not in pain.
-The PCA called for assistance from other staff to get her off the floor.
-She asked the staff to call 911 and have them send someone to get her off the floor; she asked several times, but the staff did not call 911.
-Three staff attempted twice to get her off the floor.
-When the dietary aide (DA) picked her off the floor, she felt a "pop" and her leg started hurting
-She told the staff "you broke my leg,"
-The MA went to the kitchen and got a male DA to assist with getting her off the floor.
-The DA and two PCAs picked her up after several attempts and sat her on the toilet.
-She told them again that her leg was broken, that her leg hurt, and to call 911.
-The staff placed her in a wheelchair, transferred her to her bed, and changed her brief.
-She told the MA again that her leg was broken and to call 911.
-The staff covered her with a sheet, and they left her room.

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D 271	Continued From page 111 -She lay in bed in pain and called her son; she did not know what time she called her family member. -A second shift PCA walked by her bedroom door while she was on the phone with her son and asked why she was in bed; she told the PCA what had happened. -She gave her phone to the PCA, who took her phone to the MA so she could speak to her family member. -The MA notified the PCP. -The MA administered Tylenol (used to treat pain) to her and then called 911. -She did not know what time EMS was called. -She was transferred to the local hospital; she was in the ED at the local hospital a couple of hours before being transferred to a larger medical center. -The orthopedic at the local hospital told her he did not do the type of surgery that was needed; she needed a specialist. -She had surgery on her right leg on 04/07/25. -She was in the hospital about a week before being transferred to a rehabilitation center. Interview with Resident #8's family member on 09/25/25 at 3:28pm revealed: -He received a telephone call from Resident #8 on 04/06/25 in the afternoon. -Resident #8 told him the staff had broken her leg and would not call EMS. -A staff member took Resident #8's telephone to the MA, and he asked the MA to call EMS for Resident #8. -He met with the orthopedic surgeon at the local hospital, who said Resident #8 would need a specialist to repair the break in her right leg. -Resident #8 had a periprosthetic fracture (a femur fracture that occurred around a previously implanted artificial hip joint).	D 271		

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-She was transferred to a major medical hospital because she needed a specialist to repair the fracture.
-She was transferred to the major medical hospital on Sunday evening, the day her leg was broken.
-Resident #8 had surgery late Sunday night 04/06/25 into the early morning of 04/07/25.

Telephone interview with a MA on 09/29/25 at 2:18pm revealed:
-She worked the day Resident #8 slid to the floor.
-She did not witness the incident; the PCA asked her to come to Resident #8's room to assist in getting Resident #8 off the floor.
-She saw Resident #8 lying on the bathroom floor.
-She and the PCA tried to get Resident #8 off the floor; "we tried several times."
-Resident #8 was complaining about pain in her legs and that her leg was broken; she always complained of pain in her legs.
-She did not assess Resident #8; she was assigned to the Special Care Unit (SCU), and she was helping with Resident #8 in the Assisted Living (AL).
-She went to the kitchen and asked a male DA to help get Resident #8 off the floor.
-The DA assisted the PCA and her in helping get Resident #8 to the wheelchair.
-She and the PCA transferred Resident #8 to bed and changed her brief.
-She did not call EMS; she thought another MA called EMS.

Telephone interview with the DA on 09/26/25 at 2:43pm revealed:
-He used to work as a DA, but he no longer worked at the facility.
-He remembered helping the PCA and MA get

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Resident #8 off the floor.
-The MA came to the kitchen and asked if he could help; the MA and PCA had tried to pick Resident #8 up, but they could not get her up.
-Resident #8 was lying on the bathroom floor when he got to her room.
-Resident #8 complained of her legs hurting.
-The PCA and MA helped him get Resident #8 off the floor to standing.
-Resident #8 kept complaining of pain in her right leg.
-Resident #8 asked for EMS to be called; someone called EMS, but he did not know who.
-He returned to the kitchen after Resident #8 was off the floor.

Interview with a second MA on 09/26/25 at 1:46pm revealed:
-She sent Resident #8 to the ED on 04/06/25.
-The PCAs helped transfer Resident #8 to the toilet when her legs gave out and the PCAs assisted her to the floor.
-She thought two PCAs and the SCU MA helped Resident #8 off the floor and back to bed.
-A PCA brought her Resident #8's phone because her family member wanted to speak to the MA.
-Resident #8's family member said Resident #8 was complaining of pain and thought her right leg was broken, and he wanted Resident #8 sent to the hospital.
-She called EMS, and they picked up Resident #8 and transported her to the local hospital.

Interview with a PCA on 09/29/25 at 3:31pm revealed:
-She worked second shift on 04/06/25.
-She walked past Resident #8's room that afternoon, around 2:45pm, when she came to work and saw Resident #8 was in bed.
-Resident #8 called for her to come into Resident

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#8's room.
-Resident #8 was on the phone with a family member.
-Resident #8 asked her to take her phone to the MA so her family member could tell them to call EMS for Resident #8.
-She was on the floor, and when the staff picked her up, they broke her leg.
-When a resident fell, they should not be moved until they have been assessed for injury.
-When there was an injury, the resident should stay still, and the MA should call EMS.
-She wondered why Resident #8 was in the bed, because Resident #8 was never in the bed in the middle of the afternoon.

Interview with the Resident Care Coordinator (RCC) on 09/26/25 at 9:10am revealed:
-She was on call on 04/06/25 when Resident #8 broke her right leg.
-She was told Resident #8 was assisted to the floor by a PCA because Resident #8's legs gave out, and Resident #8 did not complain of pain when she was assisted to the floor by the PCA.
-She thought 3 staff assisted Resident #8 off the floor and back to bed.
-Resident #8 did not complain of pain right away; it was later in the day.
-Resident #8 was transferred to the ED when she started complaining of pain.
-She was notified sometime after 1:00pm on 04/06/25 about Resident #8 complaining of pain in her right leg.
-Resident #8 needed assistance from staff when transferring.
-She notified the previous Administrator that Resident #8 had been sent to the ED for leg pain.
-She called the ED on 04/07/25; Resident #8 had been admitted to the local hospital, but she did not know why.

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D 271	Continued From page 115 -Resident #8 did not return to the facility. -She thought Resident #8 re-injured her right leg, but she was not sure. Interview with the Administrator on 09/26/25 at 4:00pm revealed: -It was her understanding that on 04/06/25, Resident #8's legs gave out, and the PCA assisted her to the floor. -The MAs and PCAs should have left Resident #8 on the floor if she was complaining of pain. -The MA should have assessed Resident #8 and called EMS since she was complaining of pain. -She did not know what could happen to Resident #8, who was complaining of pain, and the staff got her up and placed her in bed without calling EMS. _____ The facility failed to contact Emergency Medical Services when a resident (#8) was found on the floor and complained of right leg pain after staff attempted multiple times to move her. The resident sustained a broken leg requiring surgical repair by a specialist. This failure resulted in neglect and injury of the resident and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/13/25. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 29, 2025.	D 271		
{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	{D 273}		

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{D 273}	Continued From page 116 of residents. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A1 VIOLATION Based on these findings, the previous Type A1 Violation was abated. Non-compliance continues. THIS IS A TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow-up for 2 of 5 sampled residents (#8 and #10) related to weight loss. The findings are: Review of the facility's undated weight policy revealed a significant change was the onset of an unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period. 1. Review of Resident #10's current FL-2 dated 10/09/24 revealed: -Diagnoses included pleural effusion, hypertensive heart disease, atrial fibrillation, chronic kidney disease, osteoarthritis, hyperlipidemia, gastroesophageal reflux disease (GERD), and anemia. -She was intermittently disoriented. Review of Resident #10's Resident Register revealed: -She was admitted to the facility on 10/14/24. -She required assistance from staff with feeding, cutting up meat, and making sure she ate. -Her preferred meat was chicken, cut into bite-sized pieces.	{D 273}		

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{D 273}	Continued From page 117 Review of Resident #10's care plan dated 10/15/24 revealed: -She required limited staff assistance with eating. -There was no documentation to cut Resident #10's meat into bite-sized pieces or to assist with feeding. Review of Resident #10's care plan dated 12/02/24 revealed she was totally dependent on staff assistance for eating, and the entire meal should be chopped. Review of Resident #10's care plan dated 03/18/25 revealed she was totally dependent on staff assistance for eating, and the entire meal should be mechanically chopped. Review of Resident #10's LHPS assessment dated 12/18/24 revealed -There was no documentation of Resident #10's appetite, if staff needed to assist with feeding, and no documentation of Resident #10's weight. -Review of health status read, Resident #10 had significant weight loss this quarter; there was no weight documented. -Resident #10 started nutritional shakes three times daily, and she was placed on hospice services. Review of the hospice nursing note dated 03/24/25 revealed: -On 03/24/25, the on-call hospice nurse was paged to the facility. -Upon arrival Resident #10 was found without a pulse or respirations. -Time of death pronounced at 10:59pm on 03/24/25.	{D 273}		

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Review of Resident #10's signed physician orders dated 12/17/24 revealed:
-There was an order for nutritional shakes three times daily with meals for weight loss.
-Monitor weights weekly for 4 weeks, then resume monthly weights.
Review of Resident #10's Licensed Health Professional Support (LHPS) assessment dated 10/30/24 revealed there was no documentation of Resident #10's appetite, whether staff needed to assist with feeding, and no documentation of Resident #10's weight.

Review of Resident #10's weight log revealed:
-On 10/18/24, Resident #10's admission weight was 104.5 pounds on the wheelchair scale.
-On 11/13/24, Resident #10's weight was 98 pounds, standing.
-On 11/15/24, Resident #10's weight was 98.3 pounds on the wheelchair scale.
-On 11/20/24, Resident #10's weight was 78 pounds; the type of scale was not identified.
-On 11/26/24, Resident #10's weight was 69.5 pounds, standing.
-On 11/27/24, 12/23/24, 12/24/24, and 12/25/24, Resident #10's weight was 69.5 pounds on the wheelchair scale.
-On 01/08/25 and 01/15/25, Resident #10's weight was 87 pounds on the wheelchair scale.
-On 02/16/25, Resident #10's weight was 82 pounds; the type of scale was not identified.

Review of Resident #10's electronic progress notes revealed:
-On 11/26/24, Resident #10's Power of Attorney (POA) was notified of Resident #10's weight loss; her current weight was 69.5 pounds.
-The POA asked staff to encourage Resident #10

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to have meals with another resident, instead of in her room.
-There was no documentation on 11/26/24 that the Primary Care Provider (PCP) was notified of the weight loss.
-On 12/10/24, recorded as a late entry on 01/16/25, Resident #10's PCP was notified of a weight variance; there were no weights documented.
-The PCP discussed a diet change and assistance with feeding: the PCP would assess Resident #10 on the next visit to the facility.
-There was no documentation that Resident #10's PCP was notified of significant weight loss on 11/13/24, 11/15/24, and 11/26/24.

Telephone interview with Resident #10's POA on 09/24/25 at 8:50am revealed:
-Resident #10 lost a lot of weight after she was admitted to the facility.
-She would take food and assist Resident #10 with eating; Resident #10 ate in her room for each meal.
-She had asked the staff to cut up Resident #10's food to make it easier for Resident #10 to eat, but the staff did not cut her food.
-The staff would bring Resident #10's meal tray into her room, set the meal tray on the bedside table, and never wake Resident #10 up to eat.
-She had entered Resident #10's room many times, morning or afternoon, and found the meal trays still in the room, untouched
-One afternoon, both of Resident #10's breakfast and lunch trays were in her room, untouched.
-Resident #10's food would sit in her room waiting for assistance, then her food would be cold; sometimes she was fed, and sometimes she was not.
-She took a cold plate of food to the Resident Care Coordinator (RCC), and she spoke with the

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Dietary Manager (DM), but nothing changed.
-Residents who ate their meals in their rooms and needed assistance from a personal care aide (PCA) with feeding had to wait until the residents in the dining room finished eating, as all the PCAs were required to be present in the dining room during meals.
-Resident #10's meals were constantly late and cold, and the staff would not feed Resident #10.

Interview with a PCA on 09/29/25 at 3:31pm revealed:
-She would obtain Resident #10's weight if the medication aide (MA) asked her to.
-She assisted Resident #10 with meals, but she did not eat a lot.

Interview with a second PCA on 09/26/25 at 2:09pm revealed Resident #10 needed to be fed, but she did not have a good appetite and would eat about ¼ of her meal.

Interview with a MA on 09/26/25 at 12:33pm revealed:
-Resident #10's weight was obtained by the MA or the PCA.
-The MA was responsible for entering the weight in the computer.
-The RCC was responsible for checking the weights for weight loss and notifying the PCP.

Interview with Resident #10's PCP's medical assistant on 09/29/25 at 10:00am revealed:
-The was documentation that Resident #10's PCP was notified on 12/17/24 of Resident #10's weight loss and current weight of 69.5 pounds.
-The PCP ordered nutritional shakes three times daily with meals for weight loss and to monitor weights weekly for 4 weeks, then resume monthly weights.

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{D 273}	Continued From page 121 -There was no other documentation of the PCP being notified of Resident #10's weight loss. Interview with the RCC on 09/29/25 at 10:00am revealed: -Had she known about the weight loss from 10/30/24 to 11/13/24, she would have asked for Resident #10 to be reweighed. -She would monitor Resident #10 by looking at her to see if she was losing weight, having the PCAs reweigh her, and observing her eating habits. -The PCAs would take Resident #10's tray to her room; she could feed herself. -Resident #10 fed herself when she was admitted to the facility, but required assistance once she started declining. -Resident #10 was not eating well; the staff tried to get her to eat with another resident, at Resident #10's POA's request. -She would eat with the other resident occasionally, but not very often. -She would probably notify the PCP if Resident #10 had a 6-pound weight loss. -On 11/20/24, she did notify the PCP by telemed of Resident #10's weight of 78 pounds. Review of the hospice progress note dated 03/24/25 revealed Resident #10 expired on 03/24/25 at 10:59pm. Attempted telephone interview with the LHPS nurse on 09/29/25 at 2:28pm was unsuccessful. Refer to the interview with the RCC on 09/29/25 at 10:00am. Refer to the interview with the Administrator on 09/29/25 at 4:00pm.	{D 273}		

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{D 273}	Continued From page 122 2. Review of Resident #8's current FL-2 dated 10/09/24 revealed: -Diagnoses included fractured right femur, pleural effusion, hypertensive heart disease with heart failure, osteoarthritis, aortic valve stenosis, chronic kidney disease, and gastroesophageal reflux disease (GERD). -She was semi-ambulatory. -She was incontinent of bladder at times. Review of Resident #8's Resident Register revealed an admission date of 10/14/24. Review of Resident #8's care plan dated 10/14/24 revealed: -She weighed 124 pounds. -She required limited assistance from staff with eating. -Her dietary restrictions were no added table salt. Review of Resident #8's signed physician's order dated 12/16/24 revealed there was an order to administer a nutritional shake twice daily with meals and to monitor weights every other week. Review of Resident #8's Licensed Health Professional Services (LHPS) assessment dated 01/20/25 revealed: -There was no documentation of Resident #8's appetite, if staff needed to assist with feeding, and no documentation of Resident #8's weight. -Resident #8 had significant weight gain this quarter. Review of Resident #8's weight log revealed: -There was documentation that Resident #8's admission weight was not taken on 10/15/24. -Resident #8's admission weight was taken on 10/18/24 at 2:51pm; her weight was 124 pounds. -Resident #8's weight on 11/15/24, 12/31/24, and	{D 273}		

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{D 273}	Continued From page 123 01/31/25 was 106 pounds. -Resident #8's weight on 02/16/25 was 123 pounds. Review of Resident #8's electronic progress notes revealed: -On 12/10/24, recorded as a late entry on 01/16/25, revealed Resident #8's Primary Care Provider (PCP) was notified of a weight variance; there were no weights documented. -Resident #8's PCP would assess Resident #8 on the next facility visit; continue to monitor. -On 01/13/25, recorded as a late entry on 01/16/25, revealed Resident #8's PCP was notified of a weight variance; there were no weights documented, and no documentation that the PCP responded. -There was no documentation of Resident #8's PCP being notified of weight loss from 124 pounds on 10/18/24 to 106 pounds on 11/15/24. Telephone interview with Resident #8 on 09/29/25 at 9:17am revealed: -The staff weighed her, but she did not remember how often they weighed her. -She knew she had lost some weight after being admitted to the facility, but she did not know how much. -She did not remember being offered any nutritional supplements when she resided in the facility. Telephone interview with Resident #8's Power of Attorney (POA) on 09/29/25 at 9:36am revealed: -Resident #8 lost "a lot" of weight after being admitted to the facility. -She did not know how frequently the staff weighed Resident #8. -The family provided nutritional supplements for Resident #8 when she started losing weight.	{D 273}		

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-The nutritional supplements were placed in the refrigerator in Resident #8's room.
-She would give Resident #8 a nutritional supplement when she visited.
-The facility did not offer Resident #8 nutritional supplements.

Interview with Resident #8's PCP's medical assistant on 09/29/25 at 10:00am revealed:
-On 12/16/24, the facility reported a weight of 106 pounds.
-The PCP ordered a nutritional shake twice daily with meals and to check her weight every 2 weeks.
-The PCP expected the orders to be followed.
-There was no other documentation of the PCP being notified of weight loss.

Interview with a personal care aide (PCA) on 09/29/25 at 3:31pm revealed:
-She would obtain weights on Resident #8 if asked by the medication aide (MA).
-She did not remember if Resident #8 had weight loss or not.

Interview with a MA on 09/26/25 at 12:33pm revealed:
-Resident #8's weight was obtained by the MA or the PCA.
-The MA was responsible for entering the weight in the computer.
-The Resident Care Coordinator (RCC) was responsible for checking the weights for weight loss and notifying the PCP.

Interview with the RCC on 09/29/25 at 10:00am revealed:
-She notified Resident #8's PCP of the weight loss on 12/10/24 and 01/13/25.
-The PCP assessed Resident #8 on 12/16/24 and

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{D 273}	Continued From page 125 ordered a nutritional shake twice a day with meals and weights every other week. Attempted telephone interview with the LHPS nurse on 09/29/25 at 2:28pm was unsuccessful. Refer to the interview with the RCC on 09/29/25 at 10:00am. Refer to the interview with the Administrator on 09/29/25 at 4:00pm. _____ Interview with the RCC on 09/29/25 at 10:00am revealed: -She compared the residents' current weight to their previous weight by running a report. -There was no certain amount of weight loss that a resident would need to have for the PCP to be notified. -She did not look at the weights every week; she only looked at the weights once a month, because the weights were obtained on the 15th of the month, so she would look at the monthly weights after the 15th. -She monitored residents' weights by looking at them to see if they were losing weight, having the PCAs weigh the residents, and observing eating habits. -She would notify the PCP if a resident had a 6-pound weight loss. -She was not aware of the policy that a significant change was a 5 percent weight loss in 10 days, or a 10 percent weight loss in 30 days. Interview with the Administrator on 09/29/25 at 4:00pm revealed: -The PCP should be notified of significant weight loss.	{D 273}		

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{D 273}	Continued From page 126 -The RCC should refer to the policy to determine significant weight loss. -The residents' weights were obtained by the MAs and documented in the computer. -The RCC should print a weight variance report each month to review. -The PCP should review the weights when they visited the resident. _____ The facility failed to notify the physician of weight loss for a resident who had weight loss of 35 pounds in 38 days (#10). Resident #8 lost 18 pounds in 28 days and was not administered nutritional shakes as ordered. 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 10/13/25. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 13, 2025.	{D 273}		
{D 276}	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure physicians' orders were	{D 276}		

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implemented for 1 of 5 sampled residents (Resident #8), including an order to check blood pressure daily for 10 days, apply and remove Thrombo-Embolic Deterrent (TED) hose as directed, provide a nutritional supplement with meals, and monitor weight every other week due to weight loss.

The findings are:

Review of Resident #8's current FL-2 dated 10/14/24 revealed diagnoses included fractured right femur, pleural effusion, hypertensive heart disease with heart failure, osteoarthritis, aortic valve stenosis, chronic kidney disease, and gastroesophageal reflux disease (GERD).

Review of Resident #8's Resident Register revealed an admission date of 10/14/24.

a. Review of Resident #8's signed physician's order dated 12/05/24 revealed there was an order to apply TED hose in the morning to both legs and remove TED hose at night for both legs.

Review of Resident #8's December 2024 electronic medication administration record (eMAR) from 12/05/24 to 12/31/24 revealed there was no entry to apply TED hose in the morning and remove at night to both legs.

Review of Resident #8's activity of daily living (ADL) form dated 12/16/24 to 12/31/24 revealed:
-The personal care aide (PCA) documented she assisted with donning TED hose each morning from 12/16/24 to 12/31/24 from 10:00am to 2:50pm.
-The PCA documented she assisted in removing the TED hose at night from 12/16/24 to 12/31/24 from 3:02pm to 10:47pm.

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{D 276}	Continued From page 128 Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/29/25 at 10:32am revealed: -The pharmacy did not have an order for TED hose, apply in the morning and remove at night for Resident #8. -The pharmacy did not dispense TED hose for Resident #8. -The pharmacy staff could have faxed a form for the staff to obtain measurements, and once the form was returned, the pharmacy could have dispensed the TED hose for Resident #8. -If the family wanted to purchase the TED hose from another source, the pharmacy needed the order to profile on Resident #8's orders for the facility. Telephone interview with Resident #8 on 09/29/25 at 9:17am revealed: -She recalled having a box of "sleeves" that the PCA would cut and place on her legs some mornings, but they were not tight. -She did not recall wearing TED hose when she resided in the facility. Telephone interview with Resident #8's Power of Attorney (POA) on 09/29/25 at 9:36am revealed: -Resident #8 had swelling in her legs. -She did not know if Resident #8 had an order for TED hose. -She did not see Resident #8 wearing TED hose when she visited. -She did have "grips" or "sleeves" that the PCAs placed on her lower legs, but they did not help with the swelling in Resident #8's lower legs. Interview with a PCA on 09/29/25 at 7:45am revealed: -Resident #8 did not wear TED hose.	{D 276}		

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{D 276}	Continued From page 129 -She worked first shift, and no one told her that Resident #8 had an order for TED hose and to assist Resident #8 with putting the TED hose on. Interview with a second PCA on 09/29/25 at 3:31pm revealed: -She did not remember Resident #8 wearing TED hose. -She would have helped Resident #8 take the TED hose off at bedtime if Resident #8 was wearing them. Interview with Resident #8's Primary Care Provider's (PCP) medical assistant on 09/29/25 at 10:00am revealed: -Resident #8 had an order for TED hose, apply in the morning and remove at bedtime, dated 12/05/24. -The TED hose were ordered because she had swelling in her lower extremities. -She was not sure if the facility obtained the TED hose for Resident #8. -She expected the staff to implement the orders that were written. Interview with a medication aide (MA) on 09/29/25 at 9:53am revealed: -She did not think Resident #8 had an order for TED hose. -She had a box of "grips" in her room. -The MAs or PCAs would cut a strip of grips long enough for her lower leg. -The grips would be placed on the lower legs from her ankle, just above her shoe, to her knee; the toe was opened. -She was a PCA when Resident #8 resided in the facility, and when she placed the grips on her lower legs, she did not document that she had placed them on her lower legs.	{D 276}		

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{D 276}	Continued From page 130 Telephone interview with the facility's Clinical Nurse Consultant on 09/29/25 at 2:39pm revealed: -If Resident #8 had an order for TED hose, the TED hose should have been included as part of the LHPS review. -She was concerned that Resident #8's order for TED hose had not been implemented. -If Resident #8's TED hose were ordered because of edema, the resident could have had ongoing swelling, which would be concerning if the resident had congestive heart failure. Interview with the Resident Care Coordinator (RCC) on 09/29/25 at 12:15pm revealed: -She did not know Resident #8 had an order for TED hose, apply in the morning and remove at night, until yesterday, 09/28/25. -She audited Resident #8's record yesterday on 09/28/25, since the surveyor had been reviewing her record. -She did not remember seeing the order for TED hose from December 2024. -She did not remember Resident #8 wearing TED hose. -The RCC, Special Care Unit Coordinator (SCC), or Administrator received orders and entered the orders into the eMAR. Interview with the Administrator on 09/29/25 at 4:00pm revealed: -The order for TED hose would be entered onto Resident #8's ADL form by the RCC or SCC. -The PCAs were responsible for ensuring the TED hose were applied in the morning and removed at bedtime. -The PCAs would document on the ADL form when the TED hose were placed on Resident #8 and when the TED hose were removed from Resident #8.	{D 276}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 276}	Continued From page 131 -She expected Resident #8's TED hose to be applied and removed as ordered. b. Review of Resident #8's signed physician's order dated 02/10/25 revealed there was an order for blood pressure (BP) checks daily for 2 weeks. Review of Resident #8's February 2025 eMAR from 02/10/25 to 02/27/25 revealed: -There was an entry to obtain Resident #8's BP monthly dated 02/13/25 and ended on 02/27/25. -There was documentation that Resident #8's BP was checked 8 of 14 opportunities from 02/13/25 to 02/27/25 and ranged from 113/76 to 178/64. -There was an exception documented 3 of 14 opportunities; the exception was Resident #8 was in the hospital. -There was no entry to obtain Resident #8's BP daily for 2 weeks dated 02/10/25. Telephone interview with the pharmacist from the facility's contracted pharmacy on 09/29/25 at 10:32am revealed: -The pharmacy did not receive an order for Resident #8's BP to be checked daily for 2 weeks. -The pharmacy would have entered the order into the eMAR if the order had been received. -The staff had the ability to enter orders, such as obtaining a BP into the eMAR. Telephone interview with Resident #8 on 09/29/25 at 9:17am revealed staff members checked her BP, but she did not remember how often. Interview with Resident #8's PCP's medical assistant on 09/29/25 at 10:00am revealed: -Resident #8 had an order to check her BP daily for 2 weeks and then twice weekly. -She expected the staff to follow the orders	{D 276}		

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{D 276}	Continued From page 132 written by the PCP. Interview with the RCC on 09/29/25 at 12:15pm revealed: -Resident #8 had an order for BP checks daily for two weeks and then twice weekly. -The MAs were responsible for obtaining the BP and recording the BP readings in the eMAR. -She expected the MAs to follow orders as written by the PCP. Interview with the Administrator on 09/26/25 at 4:00pm revealed: -She did not know who was responsible for entering the BP order onto the eMAR. -The MAs were responsible for taking the BP when it was on the eMAR. -She expected orders to be entered into the computer and followed. c. Review of Resident #8's signed physician's order dated 12/16/24 revealed there was an order to administer a nutritional supplement twice daily with meals and to monitor weights every other week. Review of Resident #8's December 2024 eMAR from 12/15/24 to 12/31/24 revealed: -There was no entry for Resident #8 to have a nutritional supplement twice daily with meals. -There was no entry to monitor Resident #8's weights every other week. -There was an entry to check Resident #8's weight monthly on 12/15/24. -There was no documentation of Resident #8's weight on 12/15/24; the eMAR was blank. Review of Resident #8's January 2025 eMAR revealed: -There was no entry for Resident #8 to have a	{D 276}		

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{D 276}	Continued From page 133	{D 276}		

nutritional supplement twice daily with meals.
-There was no entry to monitor Resident #8's weights every other week.
-There was an entry to check Resident #8's weight monthly on 01/15/25.
-There was no documentation of Resident #8's weight on 01/15/25; the eMAR was blank.

Review of Resident #8's weights revealed:
-There was documentation that Resident #8's admission weight was not taken on 10/15/24.
-Resident #8's admission weight was taken on 10/18/24 at 2:51pm; her weight was 124 pounds.
-Resident #8's weight on 11/15/24, 12/31/24, and 01/31/25 was 106 pounds.
-There was no documentation Resident #8's weight was checked every 2 weeks.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/29/25 at 10:32am revealed:
-The pharmacy did not receive an order for Resident #8 to have a nutritional supplement twice daily with meals or to obtain weights every two weeks.
-The pharmacy could have dispensed the nutritional supplements, or the family could provide them.
-The pharmacy would have entered the orders into the eMAR if the order was received.
-The staff had the ability to enter orders, such as serving nutritional supplements and obtaining weights into the eMAR.

Telephone interview with Resident #8 on 09/29/25 at 9:17am revealed:
-She did not remember receiving nutritional supplements when she resided in the facility.
-She did not remember being offered any nutritional supplements when she resided in the

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{D 276}	Continued From page 134	{D 276}		

facility.
-The staff weighed her, but she did not remember how often they weighed her.
-She knew she had lost some weight after being admitted to the facility, but she did not know how much.

Telephone interview with Resident #8's POA on 09/29/25 at 9:36am revealed:
-Resident #8 lost "a lot" of weight after being admitted to the facility.
-She did not know how frequently the staff weighed Resident #8.
-The family provided nutritional supplements for Resident #8 when she started losing weight.
-The nutritional supplements were placed in the refrigerator in Resident #8's room.
-She would give Resident #8 a nutritional supplement when she visited.
-Resident #8 did not get nutritional supplements with her meals.
-The facility staff did not offer Resident #8 nutritional supplements.

Interview with a PCA on 09/29/25 at 7:45am revealed:
-No one told her Resident #8 had an order for a nutritional supplement with meals.
-She did not give Resident #8 a nutritional supplement for weight loss.
-Resident #8 ate her meals in her room; she rarely came to the dining room.
-Resident #8 would snack during the day and picked over her meals.

Interview with a second PCA on 09/29/25 at 3:31pm revealed:
-Resident #8 did not receive a nutritional supplement with meals.
-No one had told her to administer a nutritional

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{D 276}	Continued From page 135 supplement to Resident #8 with meals. Interview with Resident #8's PCP's medical assistant on 09/29/25 at 10:00am revealed: -On 12/16/24, the facility reported a weight of 106 pounds. -The PCP ordered a nutritional supplement twice daily with meals and to check her weight every 2 weeks. -The PCP expected the orders to be followed. Interview with the RCC on 09/29/25 at 12:15pm revealed: -The order for weights every other week should have been entered into the eMAR by the pharmacy. -The RCC, SCC, and Administrator were responsible for entering orders onto the eMAR. -The MAs were responsible for obtaining the weights as ordered or asking the PCA to obtain the weights. -She did not remember seeing orders for a nutritional supplement twice daily with meals for Resident #8. -The order for the nutritional supplement should have been entered onto the eMAR so the MAs could document when it was administered. -She did not know if Resident #8 received a nutritional supplement or not; it was not documented anywhere. -The nutritional supplement could have been brought into the facility by the family or sent to the facility from the pharmacy. Interview with the Administrator on 09/26/25 at 4:00pm revealed: -The pharmacy was responsible for entering the nutritional supplement on the eMAR. -The RCC was responsible for faxing the order to the pharmacy to be entered on the eMAR.	{D 276}		

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{D 276}	Continued From page 136 -She expected all orders to be faxed to the pharmacy to be entered or for the RCC or SCC to enter the orders onto the eMAR or ADL form.	{D 276}		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the licensed health professional support (LHPS) was completed for 1 of 6 sampled residents (#8) within 30 days of residents developing a need for a new task including for thrombo-embolic	D 280		

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deterrent (TED) hose for bilateral leg edema.

The findings are:

Review of Resident #8's current FL-2 dated 10/14/24 revealed diagnoses included fractured right femur, pleural effusion, hypertensive heart disease with heart failure, osteoarthritis, aortic valve stenosis, chronic kidney disease, and gastro-esophageal reflux disease (GERD).

Review of Resident #8's Primary Care Provider's (PCP) order dated 12/05/24 revealed an order to apply TED hose to both legs in the morning and remove at night.

Review of Resident #8's care plan dated 10/14/24 revealed:
-She required limited staff assistance with eating.
-She was totally dependent on staff for ambulation, transfers, toileting, bathing, dressing, and grooming.
-Resident #8 was non-ambulatory; she used a wheelchair.
-She was incontinent of bowel and bladder daily.

Review of Resident #8's LHPS evaluation dated 10/30/24 revealed:
-Resident #8 used an ambulation assistive device that required physical assistance.
-Resident #8 had physical therapy and occupational therapy.
-Resident #8 required assistance with transferring.

Review of Resident #8's LHPS evaluation dated 01/20/25 revealed:
-Resident #8 used an ambulation assistive device that required physical assistance.
-Resident #8 required assistance with

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D 280	Continued From page 138 transferring. -There was no documentation related to the TED hose that were ordered on 12/05/24. Review of Resident #8's December 2024 electronic medication administration record (eMAR) from 12/05/24 to 12/31/24 revealed there was no entry for TED hose to be applied in the morning and removed at night to both legs. Interview with the Resident Care Coordinator (RCC) on 09/29/25 at 12:15pm revealed: -The LHPS nurse had a process to identify LHPS tasks and a schedule to know when the LHPS assessments were due. -She did not notify the LHPS nurse when a new task was ordered because she had her own schedule. -She did not know how the LHPS nurse knew which residents' needed to be assessed for LHPS tasks. Telephone interview with the facility's Clinical Nurse Consultant on 09/29/25 at 2:39pm revealed if Resident #8 had an order for TED hose, the TED hose should have been included as part of the LHPS review.	D 280		
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 containers.	D 286		

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This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure mealtime table service included a place setting consisting of a knife, fork, and spoon in the Special Care Unit (SCU) and glasses were provided for the residents' milk in both the Assisted Living (AL) and SCU.

The findings are:

1. Observations of the lunch meal service in AL on 09/23/25 from 12:49pm to 1:16pm revealed there were half pint unopened cartons of 1% milk at 6 place settings; there were no glasses to pour the milk into.

Observations of the breakfast meal service in AL on 09/24/25 from 7:25am to 8:09am revealed there were half pint unopened cartons of 1% milk at 10 place settings; there were no glasses to pour the milk into.

Observations of the lunch meal in the SCU on 09/23/25 from 1:00pm-1:24pm revealed:
-There were half-pint cartons of 2% milk at 11 place settings; there were no glasses to pour the milk into.
-There were 6 residents drinking milk from their cartons.
-At 1:10pm, the SCU Coordinator (SCC) brought glasses into the dining room and placed the glasses on the tables.
-The SCC poured milk into one resident's glass,

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started feeding the resident, and then left the dining room.
-At 1:15pm, the medication aide (MA) opened two residents' milk cartons but did not pour the milk into a glass and left the dining room.
-At another table, there was one resident who had milk and was drinking from her carton.
-Eight of eleven residents drank milk from their milk cartons.

Interview with the Dietary Manager on 09/24/25 at 8:45am revealed:
-The cook placed the cartons of milk at the place settings at meals for the residents.
-They did not open the cartons of milk, and they did not provide a glass.
-She was not aware that the milk was to be served in a glass.

Interview with the Resident Care Coordinator (RCC) on 09/24/25 at 5:14pm revealed:
-The dietary staff put the milk cartons on the tables before the meal.
-She was not aware the milk was to be served in a glass.

2. Observations of the lunch meal in the SCU on 09/23/25 from 1:00pm-1:24pm revealed:
-At 1:00pm, there were 15 residents sitting in the dining room.
-The residents had a spoon and a fork.
-None of the residents had a knife.
-The residents were served pork chops with the bone in.
-A male resident was struggling to cut his pork chop with a fork.
-A female resident picked up her pork chop and started eating the meat.

Interview with a resident on 09/23/25 at 1:06pm

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revealed he was having a hard time getting the meat off the bone, trying to use a fork.

Second interview with the resident on 09/23/25 at 3:16pm revealed:
-The only time he was given a knife was when the staff "slipped up" and gave him one.
-"It was everything I could do to get the meat away from the bone."

Observation of the breakfast meal in the SCU on 09/25/25 at 8:15am revealed:
-Residents were served ½ bagel and a sealed container of cream cheese, and ½ cup of apple sauce.
-The residents were trying to use their spoons to spread cream cheese.

Interview with a second resident on 09/24/25 at 8:44am revealed:
-She was only given a spoon and a fork, never a knife.
-It was ridiculous, because residents needed a knife to cut their meat.

Interview with a third resident on 09/24/25 at 10:06am revealed she could cut her own meat up if she had a knife, but she was never given a knife.

Interview with a personal care aide (PCA) on 09/24/25 at 9:29pm revealed:
-Residents in the SCU were given a fork and a spoon.
-The residents in the SCU were not given knives, but she did not know why.
-If a resident needed their food cut up, the staff did it for them.

Interview with a second PCA on 09/24/25 at

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D 286	Continued From page 142 9:50am revealed she had seen residents get a knife a couple of times, but not at every meal. Interview with a third PCA 09/24/25 at 11:30am revealed the residents in the SCU were not given knives because the residents would not know how to use them. Confidential telephone interview with a resident's family member revealed: -She had to cut meat up for her family member because the resident was not provided with a knife. -She was not sure if the meat was cut up when she was not there. -Her family member did not have a knife, but another resident at the table had a knife and a spoon. -She recalled cutting up the resident's chicken breast with a fork, but it would have been faster had she had a knife. Interview with another family member on 09/24/25 at 10:30am revealed: -She had not seen her family member be given a knife. -She had asked for a knife one time to cut up his meat and was given a plastic knife. -She could not cut the meat up with the plastic knife because it was so tough. Interview with a third family member on 09/24/25 at 10:37am revealed: -She was at the facility for a lot of meals. -Residents were not given knives, only forks and spoons. Interview with the Dietary Manager on 09/24/25 at 4:21pm revealed: -Silverware packages were prepared by the	D 286		

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D 286	Continued From page 143 dietary aide. -The dietary aides put a fork and a spoon in each package for the residents in the SCU. -She was not told to give residents in the SCU a knife. Interview with the SCU Coordinator (SCC) on 09/25/25 at 11:15am revealed: -Residents should be given a spoon and fork only. -If the resident was given a knife, it was because a new person was working in the kitchen. -Knives were not given to residents in the SCU because a resident had used a knife to threaten staff. -If anything needed to be cut, staff should assist the residents. -She was not concerned that a resident was picking up her pork chop and eating it, because that was how she ate a pork chop, too. Interview with the Administrator on 09/29/25 at 5:40pm revealed: -Residents in the SCU should be provided with a knife with their meals. -It was a dignity issue if residents were not given a knife to cut up their food.	D 286		
D 297	10A NCAC 13F .0904(d)(1) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (1) Each resident shall be served a minimum of three nutritionally adequate meals based on the requirements in Subparagraph (d)(3) of this Rule. Meals shall be served at regular times comparable to normal meal times in the community. There shall be at least 10 hours	D 297		

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D 297	Continued From page 144 between the breakfast and evening meals. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure meals were served at regular hours comparable to mealtimes in the community in both the Assisted Living (AL) and Special Care Unit (SCU). The findings are: 1. Observation of the dining room in the Assisted Living (AL) on 09/23/25 at 12:01pm revealed: -The meal service times were posted in the dining room. -The breakfast meal service time was scheduled for 7:30am. -The lunch meal service time was scheduled for 12:30pm. -The dinner meal service time was scheduled for 5:30pm. Observation of the AL dining room during the lunch meal service on 09/23/25 from 12:24pm to 1:16pm revealed: -The cook served beverages to the residents at 12:49pm. -The Dietary Manager (DM) and the cook served plated food to the residents at 12:57pm. -At 1:16pm, the last plate of food was served to a resident. Observation of the AL dining room during the breakfast meal service on 09/24/25 from 7:25am to 8:09am revealed:	D 297		

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-The dietary staff started to place beverages on the tables in the dining room at 7:50am.
-At 7:56am, plated food was placed on the tables in the dining room.
-At 8:09am, the last plate of food was placed on a resident's table.

Interview with a resident in the AL on 09/23/25 at 8:12am revealed:
-Breakfast was supposed to be served at 7:30am, lunch was to be served at 12:30pm, and dinner was to be served at 5:30pm.
-Meals were not always served on time according to the posted times in the dining room.
-Meals were usually served from 30 minutes to 1 hour late.
-A few days ago, dinner was not served until almost 7:00pm.

Interview with a second resident in the AL on 09/23/25 at 8:20am revealed:
-Meals used to be served at 7:00am, 12:00pm, and 5:00pm and were constantly late by an hour.
-The times for meals were changed to 7:30am, 12:30pm and 5:30pm a few weeks ago.
-She thought the times were changed so the meals would not be served late, but the meals were at least 30 minutes late after the serving times were changed.

Interview with a third resident in the AL on 09/23/25 at 8:43am revealed:
-Meals were not served timely.
-The times the meals were served was changed a few weeks ago; they were pushed back by 30 minutes to 7:30am, 12:30pm, and 5:30pm.
-The breakfast and lunch meal would still be served up to 30 minutes late.
-The dinner meal continued to be at least 30 minutes late or later; some evenings it would be

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after 6:00pm before the dinner meal was served.
-Last week, the residents in the dining room started banging on the tables with their silverware because the dinner meal was 75 minutes late.

Interview with a fourth resident in the AL on 09/23/25 at 8:45am revealed:
-Meals were not served on time regularly.
-Some days the meals were served 30 minutes late.

Interview with a fifth resident in the AL on 09/23/25 at 9:02am revealed:
-The residents never knew what time meals would be served.
-The dinner meal was the worst; it was always late.

Interview with a sixth resident in the AL on 09/24/25 at 7:32pm revealed:
-The meals were never served according to the times posted in the dining room.
-Breakfast was supposed to be served at 7:30am but was always served between 8:00am and 8:30am.
-The meals had been served late for months.
-There appeared not to be enough kitchen staff to serve the meals on time.

Interview with a seventh resident in the AL on 09/24/25 at 7:38am revealed:
-Breakfast was supposed to be served at 7:30am but was usually served around 8:00am or later.
-Lunch was supposed to be served at 12:30pm and was served closer to 1:00pm daily.
-Dinner was supposed to be served at 5:30pm but was served as late as 7:00pm on one evening.

Interview with a eighth resident in the AL on

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D 297	Continued From page 147 09/24/25 at 11:46am revealed: -She did not eat breakfast in the dining room; she ate breakfast she purchased in her bedroom daily. -She did not get up early for breakfast and slept late on most days. -She ate lunch and dinner in the dining room. -The lunch meal service and dinner meal service was always served 30 minutes or later daily. Interview with a resident's family member in the AL on 09/23/25 at 12:53pm revealed: -She was at the facility daily during the lunch meal service. -The lunch meal service was served late on some days, and had been as late as 1:12pm before the residents were served. Interview with a second resident's family member in the AL on 09/24/25 at 12:24pm revealed: -Meals were never served in the dining room at the posted mealtimes. -Yesterday 09/23/25, when he was in the facility, lunch was not served until after 1:00pm. -The kitchen staff members changed constantly. Interview with a personal care aide (PCA) on 09/24/25 at 4:50pm revealed: -She took residents to the AL dining room around 5:00pm. -She did not know why the dinner meal was being served late in AL. -The dinner meals were usually served after 5:30pm in AL. Interview with a medication aide (MA) on 09/24/25 at 4:38pm revealed sometimes the dinner meals were served later than 5:30pm in the AL.	D 297		

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Interview with the cook on 09/24/25 at 8:20am revealed:
-He served meals to the residents in the AL after serving the residents in the SCU.
-He usually served breakfast at 8:00am and lunch at 1:00pm in AL.
-He was aware of the posted mealtimes in the dining room.
-There were only two staff working in dietary.
-He placed all the drinks on the tables.
-He and the DM placed the plated food on the tables.

Refer to the interview with the DM on 09/24/25 at 8:45am.

Refer to the confidential interviews with a staff member.

Refer to the interview with the Resident Care Coordinator (RCC) on 09/24/25 at 5:14pm.

Refer to the interview with the Administrator on 09/24/25 at 11:02am.

2. Interview with a personal care aide (PCA) on 09/23/25 at 12:25pm revealed the residents in the SCU were not served lunch until 1:00pm.

Observation of the SCU lunch meal service on 09/23/25 at 1:00pm revealed the residents were served their lunch meal service at 1:00pm.

Interview with a resident on 09/23/25 at 3:16pm revealed they were supposed to eat at 12:30pm, but it was 1:00pm or later before they were served anything.

Interview with the SCC on 09/25/25 at 11:15am revealed:

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D 297	Continued From page 149 -Meals were often late in the SCU, sometimes about thirty minutes. -If the residents in the SCU were served first, the residents in the Assisted Living (AL) complained. -Sometimes the residents in AL were served first, and sometimes the residents in the SCU were served first. Refer to the interview with the DM on 09/24/25 at 8:45am. Refer to the confidential interviews with a staff member. Refer to the interview with the Resident Care Coordinator (RCC) on 09/24/25 at 5:14pm. Refer to the interview with the Administrator on 09/24/25 at 11:02am. _____ Interview with the DM on 09/24/25 at 8:45am revealed: -The posted meal schedule was breakfast at 7:30am, lunch at 12:30pm and dinner at 5:30pm in the SCU and AL dining rooms. -She was not able to serve meals in the SCU and AL on time because both dining rooms had the same mealtimes. -There were only two staff working in dietary. -One of the dining rooms would always have meals served late. -If there were more staff in dietary, she would be able to ensure the meals were served on time. Confidential interview with a staff member revealed: -Meals were routinely served late. -All of the kitchen staff quit, and the meals were served late thereafter. -Some days the meals were served an hour late.	D 297		

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D 297	Continued From page 150 -The residents normally sat in the dining room complaining about receiving their meals late. -The breakfast and lunch meal were always served later than the dinner meal. Interview with the RCC on 09/24/25 at 5:14pm revealed: -The meal schedule was breakfast at 7:30am, lunch at 12:30pm and dinner at 5:30pm in the SCU and AL dining rooms. -She did not work during the times breakfast was being served. -The lunch meal was usually served on time. Interview with the Administrator on 09/24/25 at 11:02am revealed: -The meal schedule was breakfast at 7:30am, lunch at 12:30pm and dinner at 5:30pm in the SCU and AL dining rooms. -The meals were served late in the AL because the dietary staff served the SCU residents first.	D 297		
{D 312}	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure assistance was provided for the residents in Assisted Living (AL) and in the Special Care Unit (SCU) when staff did not open	{D 312}		

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{D 312}	Continued From page 151 individual containers for the residents at mealtimes. The findings are: 1. Observations of the lunch meal service in AL on 09/23/25 from 12:49pm to 1:16pm revealed there were half-pint unopened cartons of 1% milk at 6 place settings. Observations of the breakfast meal service in AL on 09/24/25 from 7:25am to 8:09am revealed: -There were half-pint unopened cartons of 1% milk at 10 place settings. -One resident opened a carton of milk for another resident. -Five residents opened their own cartons of milk. -A personal care aide (PCA) opened four residents' cartons of milk. Interview with a PCA on 09/24/25 at 4:50pm revealed: -The dietary staff put the cartons of milk on the tables. -Most of the residents could open their milk themselves; some of the residents could not open their milk cartons. -Some of the residents would ask staff to open their milk cartons. Interview with the Dietary Manager on 09/24/25 at 8:45am revealed: -The cook placed the cartons of milk at the place settings at meals for the residents in AL. -They did not open the cartons of milk. -She was not aware that some of the residents were not able to open the milk cartons. Interview with the Resident Care Coordinator (RCC) on 09/24/25 at 5:14pm revealed:	{D 312}		

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{D 312}	Continued From page 152 -The dietary staff put the milk cartons on the tables before the meal. -Staff would help residents open the milk cartons if the residents needed help. Observations of the lunch meal in the SCU on 09/23/25 from 1:00pm-1:24pm revealed: -At 1:00pm, there were 15 residents sitting in the dining room. -There were half-pint cartons of 2% milk at 11 place settings. -At 1:07pm, a resident was struggling to open her carton of milk, and the dietary aide opened it for her. -The dietary aide did not assist any other residents in opening their carton of milk and left the dining room. -There were 2 residents at the same table whose milk cartons were not opened. Observations of the breakfast meal in the SCU on 09/24/25 from 7:34am-8:29am revealed: -The residents were served individual cups of apple sauce with a foil lid. -From 7:53am to 7:55am, one resident was trying to use her fork to open her cup of apple sauce and gave up. -At 8:00am, the resident tried again to open her apple sauce. -At 8:22am, the resident was again struggling to open her apple sauce, and a PCA assisted. -At 7:49am, a resident opened her apple sauce using her teeth. -At 8:02am, five of six residents at the table had been served a meal and were eating. -At 8:13am, the MA was notified by the surveyor that a resident had been at the table since 7:34am and had not been served. -At 8:15am, the resident was given a plate; she asked for a spoon.	{D 312}		

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{D 312}	Continued From page 153 -At 8:17am, the resident was given a spoon but was not given a fork or a napkin; she had one cup of a beverage. -At 8:26am, the resident had drank all her beverage, kept picking up the cup, and was trying to drink from the empty cup; she was still eating food. -At 8:29am, there were no staff in the dining room, and the resident appeared to be having difficulty trying to chew and swallow her food without a beverage; she asked the surveyor for a glass of milk. -A PCA went to the kitchen and got a glass of milk when asked to by the surveyor. -At 8:19am, a resident at the same table was asked if she was finished eating by a staff member, and the resident responded no, she was still waiting for sugar. -The MA confirmed the resident had asked for sugar when her meal was delivered. -A PCA provided the resident with a pack of sugar. Interview with a resident on 09/24/25 at 10:06am revealed: -She had a hard time getting containers open at meals. -Sometimes, staff would see her having a hard time, feel sorry for her, and help her, but not every time. Interview with the PCA on 09/24/25 at 9:29am revealed if she saw a resident needed assistance with a container, she tried to help them, but sometimes she was busy getting other residents to the dining room. Interview with a second PCA on 09/24/25 at 9:50am revealed: -The PCAs were supposed to help the residents	{D 312}		

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open their containers.
-If staff did not assist, it may have been because they were busy getting the residents to the dining room.

Interview with a third PCA 09/24/25 at 11:30am revealed:
-Whoever was working should assist the residents with opening containers.
-Some residents would just look at the containers and not know what to do if someone did not assist them.

Confidential telephone interview with a resident's family member revealed:
-Staff did not help residents open packages.
-She had gone around and helped residents open their packages a lot of times because there would be no staff in the dining room.
-Even when the residents were served snacks, they would receive no assistance from staff in opening the packages.

Interview with the Dietary Manager on 09/24/25 at 4:21pm revealed the PCAs were responsible for helping residents in the SCU open containers.

Interview with the SCC on 09/25/25 at 11:15am revealed:
-Staff should have opened the residents' cartons of milk.
-Staff should have helped residents with opening packages
-She expected the staff members to look around the dining room to see who needed assistance.

Interview with the Administrator on 09/24/25 at 11:02am revealed she was not aware that some residents were unable to open milk cartons and other food containers without assistance.

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D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 18 sampled residents were free from abuse (#16, #17), including one resident who sustained a skin tear to his forearm after being grabbed by a staff member (#16) and another resident who had bruising on her hand after being grabbed by a staff member (#17); 1 of 18 sampled residents (#18) was treated with respect and privacy after requesting a secure room to prevent another resident from wandering into his room (#18); and multiple residents who did not receive assistance in a timely manner when staff did not respond to call bells and whistles. The findings are: Review of the facility's undated resident rights policy revealed: -The Administrator and staff would make every effort to assist residents in exercising their declaration of resident rights. -Residents had the right to be treated with respect, consideration, dignity, and full recognition of his or her individuality and privacy. -Residents had the right to be free of mental and physical abuse, neglect, and exploitation.	D 338		

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1. Review of Resident #16's current FL-2 dated 09/11/25 revealed:
-Diagnoses included Alzheimer's dementia, congestive heart failure, and metabolic encephalopathy.
-Special Care Unit (SCU) was the recommended level of care.
-The resident was intermittently disoriented and non-ambulatory.
-The resident's skin was documented as normal but had moisture associated skin damage (MASD) to the buttocks.

Review of Resident #16's Resident Register revealed an admission date of 09/15/25.

Review of Resident #16's SCU care plan dated 09/17/25 revealed:
-He needed prompting to complete a meal.
-He was incontinent and required staff assistance for toileting needs and hygiene.
-He used a wheelchair requiring staff assistance.
-He required extensive staff assistance with bathing, dressing, grooming and hygiene, and transferring.

Review of Resident #16's admissions screening evaluation dated 09/17/25 revealed:
-Resident #16 had bruising and discoloration on his arms.
-There was no documentation of skin tears or bandages on the resident's arm.

Review of Resident #16's shower skin assessments dated 09/19/25, 09/22/25, and 09/24/25 revealed:
-There was no abrasion, skin tear, or laceration documented as seen on the resident's arm.
-There was no documentation of a bandage.

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Review of Resident #16's primary care provider's (PCP) after-visit summary dated 09/22/25 revealed:
-Resident #16 was being seen for an initial visit.
-Resident #16 had bruising on both upper extremities; there was no documentation of skin tears.

Review of Resident #16's progress notes revealed there was no entry for wound care for Resident #16's skin tear to his arm.

Observation of Resident #16's right forearm on 09/23/25 at 12:45pm revealed white gauze wrapped multiple times around the arm.

Observation of Resident #16's right forearm on 09/29 25 at 12:36pm revealed:
-Resident #16 had a bandage on his arm; the tape was dated 09/27/25.
-There was a small dark spot that had seeped through the bandage.
-The medication aide (MA) used a saline solution to soften and remove the bandage.
-The area underneath the dressing revealed the skin was pulled back from an area that was 1 inch by 2 inches.
-The area where the skin was pulled back had exposed tissue with bleeding.
-The arm was bruised around the skin tear.

Interview with Resident #16 on 09/25/25 at 10:46am revealed:
-He was lying in bed one morning, and a staff member grabbed his arm and "twisted it up"; he demonstrated twisting the skin on the forearm area.
-"It was like they twisted my skin until it bled"; it hurt "really bad".
-He did not know the names of the staff.

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-Another staff member asked him who did that to his arm, and he pointed at the other staff member who was in the room and said it was her; he did not know her name.
-That staff member then said, "No, it happened the night before".
-He thought the staff members were too rough trying to get him out of bed.

Interviews with Resident #16's family member on 09/25/25 at 10:46am and 12:10pm revealed:
-Resident #16 had multiple skin tears and bruises that occurred since he moved in less than 2 weeks ago.
-Resident #16 had complained to her about how rough the staff were with him.
-Resident #16 told her it felt like they had pulled his shoulders out of the socket.
-Resident #16 had bruising on his shoulders as well as his arm.
-Her concern was she did not know how Resident #16 was being handled.

Telephone interview with Resident #16's family member on 09/29/25 at 11:24am revealed:
-Resident #16 did have some bruising on his arms that he received prior to moving into the facility.
-Resident #16 had a bandage on his left arm from a skin tear that was caused during the transfer to the facility.
-Resident #16 did not have a bandage on his right arm on the day he moved into the facility.

Interview with the Special Care Unit Coordinator (SCC) on 09/25/25 at 12:30pm revealed:
-Resident #16 moved into the facility with bruises on both arms.
-Resident #16 had bandages on both arms when he moved in.

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-Resident #16's skin assessment was completed at move-in to show he had injuries.

Interview with the SCC on 09/29/25 at 12:43pm revealed:
-Resident #16 moved into the facility with bandages on both arms.
-She forgot to document the bandages on Resident #16's skin assessment sheet.
-Resident #16's skin tear was being taken care of with normal first aid; the staff cleaned the wound, applied a cream such as neosporin (used to provide infection protection for minor wounds), and covered the wound.
-The bandage was being changed as needed, based on whether it had bled through or if it needed to be changed after a shower.

Interview with a housekeeper on 09/29/25 at 7:41am revealed:
-Resident #16 was sitting in the day room, and saw all the skin pulled back on the resident's arm; he thought it was on 09/22/25.
-He told a staff member about Resident #16's arm, but he did not recall who.
-An hour later, the MA put a bandage on Resident #16's arm.

Interview with a MA on 09/29/25 at 9:55am and 12:40pm revealed:
-Resident #16 was admitted to the facility with bandages on his arms.
-When Resident #16 moved in, he had a brown bandage on his right arm.
-A personal care aide (PCA) told her Resident #16 was bleeding through the bandage.
-She did not know what was under the bandage until that day.
-Resident #16 had been at the facility for two weeks, so it was one day last week, the week of

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09/15/25.
-When she changed the bandage, she noted a skin tear.
-She told the SCC and redressed the resident's arm.

Interview with a PCA on 09/29/25 at 8:36am revealed:
-He recalled seeing a bandage on one of Resident #16's arms about 3-4 days after the resident was admitted, but he did not recall which arm.
-He did not know what happened to the resident's arm.

Interview with a second PCA on 09/29/25 at 11:52am revealed:
-She saw a bandage on Resident #16's arm one day last week.
-The bandage was pulling up, and she thought it looked like his skin had been scraped away during a transfer.

Interview with a third PCA on 09/29/25 at 11:57am revealed:
-She did not recall Resident #16 having a bandage on his arm on 09/21/25.
-When she saw Resident #16 again on 09/26/25, he had a white bandage on his arm.
-She did not know what happened to Resident #16's arm.
-Resident #16 was a two-person transfer and had to be lifted under his arm for transfers.

Interview with a fourth PCA on 09/29/25 at 12:34pm revealed:
-A couple of days after Resident #16 was at the facility, the MA put a bandage on Resident #16's arm.
-Resident #16's arm was "not like that" when he

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moved in.
-Resident #16 said not to pull him by his arms because it would tear his skin.

Interview with Resident #16's PCP's medical assistant on 09/29/25 at 10:17am revealed:
-There was no documentation about Resident #16 having a skin tear on his arm.
-On 09/23/25, the PCP was notified of a skin tear on the resident's scrotum.
-There was no other documentation about skin tears.
-The PCP would have requested a picture of the skin tear to determine how the skin tear needed to be treated.
-The PCP should have been called about Resident #16's skin tear.

Telephone interview with the Clinical Nurse Consultant on 09/29/25 at 2:39pm revealed:
-She did not know if the facility had a standing order for skin tears.
-If a resident needed wound care, it would be documented on the resident's Licensed Health Professional Services (LHPS) review form.
-Resident #16's LHPS review was scheduled for one day this week, the week of 09/29/25.

Interview with the Administrator on 09/29/25 at 4:40pm revealed:
-She was not aware Resident #16 had a skin tear on his arm, and it was not known how it occurred.
-Staff should have documented Resident #16's skin tear.
-She should have been notified Resident #16 had a skin tear, so she could have investigated how it occurred.

2. Review of Resident #17's current FL-2 dated 08/06/25 revealed:

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-Diagnoses included neurocognitive disorder with lewy bodies and hypertension.
-Special Care Unit (SCU) was the recommended level of care.
-The resident was intermittently disoriented and ambulatory.

Review of Resident #17's care plan dated 08/11/25 revealed:
-The only documentation on the form was a box that was checked, indicating that the resident wandered.
-The care plan form was signed by the Special Care Unit Coordinator (SCC) and the facility's primary care provider (PCP).

Review of Resident #17's SCU care plan dated 08/11/25 revealed:
-She did not have behaviors.
-She fed herself after setting up meals and snacks.
-She was continent and required staff assistance with hygiene.
-She was independent without devices.
-She required limited staff assistance with bathing.
-She required supervision from staff with dressing, grooming, and hygiene.
-She was independent with transferring.

Review of Resident #17's Licensed Health Professional Support (LHPS) assessment dated 08/05/25 revealed no documentation of any bruising.

Review of Resident #17's progress notes dated 08/15/25-09/17/25 revealed:
-On 09/13/25, Resident #17's family member observed a bruise on the resident's right hand.
-There was no other documentation about the

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bruise.

Review of Resident #17's shower skin assessments revealed:
-On 09/10/25 and 09/12/25, there was no bruising seen.
-There was no skin assessment provided from 09/13/25-09/23/25.

Review of Resident #17's primary care provider's (PCP) after-visit summary dated 09/16/25 revealed:
-Resident #17 was seen for bruising on the right hand and left leg pain.
-Resident #17 told her family she was grabbed forcefully on her right hand.
-There was bruising on the dorsal (back) area of her right hand between the thumb and index finger.
-The bruising was the approximate size of a thumbprint.

Telephone interview with Resident #17's PCP on 09/24/25 at 5:32pm revealed:
-She saw Resident #17 for bruising on 09/16/25.
-She could tell Resident #17's bruise was a thumbprint.
-Resident #17's bruising was from the resident being pulled.

Review of Resident #17's incident and accident reports from 09/10/25-09/13/25 revealed there were no incident and accident reports for this date range.

Observation of a photo of Resident #17's right hand on 09/27/25 at 1:02pm revealed:
-The photo was taken on 09/13/25 at 12:18pm.
-The photo showed dark red and blue bruising on the back of the hand between the thumb and

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D 338	Continued From page 164 forefinger. Interview with Resident #17's family member on 09/23/25 at 3:48pm revealed: -Resident #17 was complaining that her hand hurt, and the family member noted the bruise. -Resident #17 said a staff member grabbed her, and she told the staff it hurt. -She did not identify the staff member. -A [named] medication aide was told about the bruise. Interview with the MA on 09/29/25 at 9:55am revealed: -Resident #17 showed her the motion of someone grabbing her hand when she asked her about the bruise. -She told the SCC, who told her to document it, and she did. -She did not do an incident report because she only did those for an event or a fall. Interview with the SCC on 09/29/25 at 9:59am revealed: -She was contacted by a staff member about Resident #17's bruise. -She asked different staff members if they knew what happened. -She could only remember asking a [named] staff member. -Bruises of unknown origin were reported to the Administrator so she could investigate. Interview with the Administrator on 09/29/25 at 5:40pm revealed: -She was not aware Resident #17 had a bruise on her hand, and that it was not known how it occurred. -When staff saw the bruise, it should have been documented.	D 338		

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D 338	Continued From page 165 -She should have been notified of the bruise if it was not known what happened, so she could investigate. Based on observations, interviews, and record reviews it was determined Resident #17 was not interviewable. _____ Interview with the SCC on 09/25/25 at 12:30pm revealed: -Skin assessments were done during showers or if an injury was noticed. -Staff completed skin assessments and let the family and PCP know about the injury. -The resident was asked how it happened, and staff and family were interviewed to determine how the injury occurred. Telephone interview with the Clinical Nurse Consultant on 09/29/25 at 2:39pm revealed: -A skin assessment should be done at admission and at every shower. -Skin tears and/or bruising should be documented and then reported to the MA, who would then let the care manager know. -An internal investigation would be done to try to determine where the injury came from. 3. Review of Resident #18's current FL2 dated 09/02/25 revealed: -Diagnosis of Parkinson's disease dementia. -He was intermittently disoriented. -Recommended level of care was Special Care Unit (SCU). Review of Resident #18's Resident Register revealed an admission date of 09/09/25. Review of Resident #18's care plan dated 09/19/25 revealed:	D 338		

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-He was ambulatory with a walker.
-His orientation was sometimes disoriented.
-His memory was forgetful and needed reminders.
-He required limited staff assistance with eating.
-He required supervision/set-up from staff with dressing, grooming/personal hygiene, and toileting.
-He was independent in toileting, ambulation, bathing, and transferring.

Interview with Resident #18 on 09/23/25 at 3:16pm revealed:
-He woke up last night, and two female residents were standing at the foot of his bed.
-It scared him when the residents were standing at the foot of his bed.
-If his room was not locked, he was going to continue to "get the wanderers" coming into his room.
-The last staff person out of his room was not locking the door.

Telephone interview with Resident #18's family member on 09/23/25 at 6:25pm revealed:
-Resident #18 complained about women coming into his room, and it was terrifying to him.
-She had talked to staff at the facility about it and was told there were residents who were wandering, and there was nothing they could do about it.
-She was told, unfortunately, that was what residents did in a SCU.
-She talked to the SCU Coordinator (SCC), who told her the door used to lock from the outside, and she would ask the Maintenance Director to look at it "about a week ago".

Observation of Resident #18's door on 09/25/25 at 8:50am revealed:

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D 338	Continued From page 167 -There was an 8.5 x 11-inch piece of white paper with a 4.5 x 4.5-inch clip-art picture of a stop sign that read as "stop do not enter"; the word stop was colored in red, and the do not enter area was colored in yellow. -The door handle had a push-button lock on the inside handle. -When the door was closed and the lock was pushed in, the door was locked and would need a key to be opened. -When the door was open and the lock was pushed in, if the door was pulled closed, the lock automatically unlocked. Interview with a personal care aide (PCA) on 09/24/25 at 9:29am revealed there were residents who wandered into other residents' rooms, but no one had complained to her about it. Interview with a second PCA on 09/24/25 at 9:50am revealed: -Resident #18 had complained about a resident coming into his room. -She told the medication aide (MA), but she did not recall which MA. -She knew it was a [named] resident. -She was told to redirect the resident. -She thought the resident's door could be closed after pushing the lock button, and the door would be locked. -No one had told her to lock the resident's door when she left the room Interview with a third PCA on 09/24/25 at 3:48pm revealed: -There were 3 [named] residents who wandered. -Resident #18 complained about a female resident going into his room. -Resident #18 had not asked her to lock his door. -No one told her to lock Resident #18's door.	D 338		

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D 338	Continued From page 168 Telephone interview with Resident #18's mental health provider on 09/24/25 at 11:03am revealed: -Staff could lock Resident #18's door if he wanted the door to be locked. -Staff needed to remember to lock Resident #18's door when they left the room for his safety. -Anything that affected the resident, if it upset him, could affect the resident's mental health. Interviews with the Maintenance Director on 09/24/25 at 10:58am and 12:25pm revealed: -No one had told him a resident needed a different door lock in the SCU. -If someone had told him a resident needed a door handle with a lock, he would contact corporate to request a different door lock. Interview with the SCC on 09/25/25 at 11:04am revealed: -Resident #18 had complained multiple times about residents going into his room. -She had put a sign on the door, but the other residents could not comprehend the sign. -She told the residents who were going into Resident #18's room not to go in, but the residents had dementia, and they were not going to remember. -She showed Resident #18 how to lock his door. -Staff could not lock the door as they were leaving because even if they pushed the lock button in it, it popped back out when the door was pulled closed. -She had not told Resident #18 or his family member that maintenance could get a new lock. -The conversation she had with Resident #18 and his family was that the resident could lock the door himself after the care staff left his room. -Realistically, she did not expect Resident #18 to get out of bed and lock his door every time a staff	D 338		

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member left the room.
-She did not tell Resident #18 or his family that she would talk to the Maintenance Director about a different lock.

Interview with the Administrator on 09/29/25 at 4:40pm revealed:
-No one had told her Resident #18 had complained about other residents wandering into his room.
-The door lock could be changed.
-For Resident #18's peace of mind, the door lock should have been changed.

4. Interview with a resident who resided on the AL in resident room #115 on 09/23/25 at 8:12am revealed:
-There was a problem with the call bell system.
-The system would work for a few days and then stop working.
-The call bell system was not working yesterday, 09/22/25.
-She pulled the pull-cord to alert staff about not receiving her evening medication.
-She looked into the hallway and did not see any staff.
-A personal care aide (PCA) went into her bedroom about an hour later to check on her.
-She asked the PCA to find a medication aide (MA) so she could receive her medication.
-A MA came to her bedroom about 20 minutes later.
-She was worried about other residents who required more assistance but were unable to reach staff because of the call bells not working properly.

Observation of a resident who resided on the AL in resident room #112 on 09/23/25 at 8:28am revealed:

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D 338	Continued From page 170 -The resident was sitting in a recliner in his bedroom. -The resident was not able to reach his call bell pull-cord. -The pull-cord was hanging behind his chair out of reach. -There was no whistle or bell in the resident's room. Interview with a resident who resided in AL in resident room #112 on 09/23/25 at 8:29am revealed: -The resident was trying to pull his call bell pull-cord for 20 minutes. -The resident was trying to alert staff to let them know he was ready to go to the dining hall for breakfast. -He was not able to reach his pull-cord because it was behind his chair. -The resident suffered from a stroke and was not able to turn his body to reach for the pull-cord. -He was total care and required assistance with feeding, bathing, dressing, toileting, and transferring. -When the string was not placed next to his shoulder, he was not able to pull the pull-cord. Interview with a resident who resided in AL in resident room #302 on 09/23/25 at 8:43am revealed: -The call bells did not work; they had been broken for several months. -The staff gave him a whistle to blow if he needed anything. -He was ambulatory, and he rarely needed the assistance of the staff, so he did not blow his whistle. -The resident across the hall blew her whistle during the night because she needed assistance going to the bathroom.	D 338		

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D 338	Continued From page 171 -The whistles were annoying, especially at night, but it was the only way residents could get assistance when the call bell system was not working. Interview with a resident who resided in AL in resident room #205 on 09/23/25 at 12:04pm revealed: -The call bells did not work; they had not worked properly for the past month. -She was given a whistle by staff but did not use it. -She suffered from chronic obstructive pulmonary disease (COPD) and had shortness of breath and could not blow a whistle. -On 09/09/25, she pulled the call bell off and on for an hour during the night; no staff member responded. -She walked to the medication room, and no staff were in the room. -She needed staff to administer her as needed (PRN) medication. -She walked down the 200-hall and the 100-hall looking for staff and did not see anyone. -She walked to the dining room and back down the 100-hall towards her bedroom. -She never found a staff member and went to bed without receiving her medication. -On 09/10/25 at 12:30am, she pulled the call bell to see if staff would respond. -She walked to the medication room, and a staff member was sitting in the room. -She asked the staff member why they did not respond to her call bell and was told that the staff member was on her break. -She told the Administrator about the incident and was told that the Administrator would speak to staff. -Nothing had changed after she told the Administrator because the staff were not	D 338		

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D 338	Continued From page 172 responding to the call bells. _____ The facility failed to ensure residents were free from abuse including one resident who sustained a skin tear to his arm after staff twisted his arm during personal care which resulted in pain (#16). Another resident had bruising to her hand which she said was caused by the staff and said it hurt her (#17); and a resident (#18) was treated with respect and privacy who had requested a lock for his door to keep other residents from entering his room at night but a lock was not provided which resulted in the resident feeling scared at night. Multiple residents needed assistance from staff, but staff did not respond to the residents' call bells or whistles, including a resident who needed medication and no one responded to her call bell. 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 10/13/25. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 13, 2025.	D 338		
{D 358}	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies	{D 358}		

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{D 358}	Continued From page 173 and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION Based on the findings, the previous A2 Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 4 of 9 sampled residents for record review (#4, #7, #8 and #10) including a blood thinner (#4); a medication to control blood sugar (#7); a medication for nerve pain (#8); and a medication to elevate blood pressure, a fluid medication, and a supplement (#10). 1. Review of Resident #7's current FL-2 dated 04/15/25 revealed: -Diagnoses included diabetes mellitus, hypertension, hyperlipidemia, and osteoarthritis. -There was an order for Metformin 500mg extended release (ER) (used to lower blood sugar) 2 tablets daily. Review of Resident #7's physician orders revealed there were no further orders for metformin. Review of Resident #7's physician's progress note dated 09/22/25 revealed: -There was an order to discontinue Metformin 500mg ER 2 tablets with meals three times a day. -There was an order for Metformin 500mg ER 2 tablets once daily with meals. -The Primary Care Provider (PCP) noticed on the electronic medication administration record (eMAR) the Metformin dose was increased to 2 tablets daily with all 3 meals.	{D 358}		

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{D 358}	Continued From page 174 -The PCP was unclear where the order came from, because the resident had not been seen by his Endocrinologist in a while. -The resident admitted to having diarrhea with the increased frequency. -The PCP requested the resident to return to taking 2 tablets once a day. Review of Resident #7's September 2025 eMAR from 09/01/25 to 09/25/25 revealed: -There was an entry for Metformin 500 mg ER 2 tablets once daily with a scheduled administration time of 8:00am. -There was documentation Metformin 500 mg ER was administered once daily at 8:00am from 09/01/25 to 09/17/25. -There was a second entry for Metformin 500 mg ER 2 tablets once daily with meals with scheduled administration times of 8:00am, 12:00pm, and 8:00pm. -There was documentation Metformin 500 mg ER was administered at 8:00am, 12:00pm, and 8:00pm twelve times from 09/18/25 to 09/22/25. -There were exceptions documented on 09/18/25 and 09/22/25; the exception was not administered, refused. -There was a third entry for Metformin 500 mg ER 2 tablets every morning with breakfast with a scheduled administration time of 8:00am. -There was documentation Metformin 500 mg ER was administered once daily at 8:00am from 09/23/25 to 09/25/25. Observation of Resident #7's medications on hand on 09/25/25 at 10:52am revealed: -There was a bubble pack labeled Metformin 500mg ER take 2 tablets every morning with breakfast available for administration. -The bubble pack was dispensed on 09/22/25 with 16 tablets.	{D 358}		

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{D 358}	Continued From page 175 -Six bubbles had been punched and there were 10 bubbles (one tablet in each bubble) for a total of 10 tablets of Metformin 500mg ER remaining in the bubble pack. Telephone interview with a Pharmacist from the facility's contracted pharmacy on 09/25/25 at 3:24pm revealed: - Metformin ER was used to lower blood sugars. -Taking an increased dosage of metformin could cause diarrhea. -Metformin ER was an extended release medication; an extended release medication was administered daily and the medication would be timed released throughout the day. -Resident #7's current order on file was for Metformin ER 500mg take 2 tablets with breakfast and was received on 09/22/25. -Resident #7's previous order was for Metformin ER 500mg take 2 tablets once daily and was received on 05/14/25. -They had not received an order for Metformin ER 500mg 2 tablets three times a day. -The pharmacy dispensed 1 punch card of 16 tablets of Metformin ER 500mg on 09/08/25 for eight days. -The pharmacy dispensed 1 punch card of 14 tablets of Metformin ER 500mg on 09/15/25 for seven days. -The pharmacy dispensed 1 punch card of 16 tablets of Metformin ER 500mg on 09/22/25 for eight days. Telephone interview with Resident #7's Primary Care Provider (PCP) on 09/26/25 at 9:25am revealed: -The provider saw the Resident #7 on 09/22/25 and noticed on the eMAR the order for metformin had been increased to three times a day. -She was not sure where the order came from.	{D 358}		

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{D 358}	Continued From page 176 -She discontinued the medication and wrote a new order for the metformin to be administered once daily. -Taking metformin more than once daily could cause diarrhea. -The resident complained of diarrhea after receiving the increased dosage of metformin. -She expected the facility to administer medication as ordered. Interview with Resident #7 on 09/24/25 at 8:07am revealed: -He took two tablets of metformin every morning. -A week ago, the medication aides (MA)s started administering the medication three times a day. -He told the MAs that he was not supposed to be taking the medication three times a day. -He started to experience diarrhea and refused to take the medication. -He called his PCP and was told there had not been a change to the metformin order. -The PCP saw him on 09/22/25 and changed the order to once daily -He refused to take the medication for a few days, and the schedule was changed back to once a day. Interview with a MA on 09/25/25 at 4:48pm revealed: -Metformin was scheduled to be administered once daily in the morning. -The resident was upset and asked why the order was changed. -She told the Resident Care Coordinator (RCC) that the resident was refusing and complaining about the change to the order. -When she went to work a few days later the order was changed to once a day. -She administered medication according to the eMAR.	{D 358}		

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{D 358}	Continued From page 177 -She did not enter orders on the eMAR. -The pharmacy and RCC were able to enter orders on the eMAR. Interview with a second MA on 09/25/25 at 4:58pm revealed: -She administered medications according to the eMAR. -She did not enter medications on the eMAR. -The pharmacy and RCC entered medications on the eMAR. -The resident's metformin was always scheduled to be administered once daily at 8:00am. -She noticed the change on the eMAR last week to administer the metformin three times a day. -The resident complained about the taking the medication more than once daily and refused to take the medication on a few days. Interview with a third MA on 09/25/25 at 5:43pm revealed: -She administered medications according to the eMAR. -Last week when she was administering the resident's night medications, the metformin showed up on the eMAR to be administered at 8:00pm. -She had not administered metformin to the resident at night. -She asked the resident about the change and the resident said he was not supposed to be taking the medication at night. -The next night that she worked, the metformin was not on the eMAR to be administered at night. -The RCC was able to enter medications on the eMAR but she was not. -The resident had not complained to her that he experienced diarrhea. Interview with the RCC on 09/25/25 at 4:09pm	{D 358}		

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{D 358}	Continued From page 178 revealed: -The pharmacy was responsible for entering orders on the eMAR. -She entered orders on the eMAR when a medication was needed right away. -When the pharmacy review was completed, there was a recommendation to change the administration of the metformin from once daily to three times a day. -The order to increase the metformin was placed on the eMAR by the pharmacy. -Receiving two tablets of metformin three times a day could cause diarrhea. -She was responsible for approving orders before the MAs administered the medication. -She did not recall the resident complaining about experiencing diarrhea. -The PCP came to the facility on 09/22/25 and changed the order back to once daily. Interview with the Administrator on 09/26/25 at 8:10am revealed: -Orders were entered on the eMAR by the pharmacy and the RCC was responsible for verifying the order. -There were times the RCC entered medications on the eMAR. -The order for Resident #7's metformin was changed after a recommendation from the pharmacy. -She was not aware of the side effects of the resident receiving too much metformin. -She was concerned the resident did not receive the medication as ordered. Second interview with the Administrator on 09/26/25 at 1:09pm revealed: -The pharmacy staff stated they did not enter the order on the eMAR for metformin three times a day.	{D 358}		

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{D 358}	Continued From page 179 -She did not know who entered the order on the eMAR. Refer to the interview with the MA on 09/29/25 at 12:35pm. Refer to the interview with the RCC on 09/26/25 at 9:10am. 2. Review of Resident #4's current FL-2 dated 05/21/25 revealed diagnoses included pain in the right knee, chronic kidney disease, mild cognitive impairment, actinic keratosis, poly-osteoarthritis, and the presence of a right artificial knee joint. Review of Resident #4's signed physician's orders dated 05/21/25 revealed there was an order for clopidogrel 75mg (a blood thinner) one tablet daily for cerebral vascular accident (CVA). Review of Resident #4's August 2025 eMAR from 08/13/25 to 08/23/25 revealed: -There was an entry for clopidogrel 75mg daily for CVA with a scheduled administration time of 8:00am. -There was documentation that clopidogrel 75mg was administered 1 of 11 opportunities and was documented as "on hold" 10 of 11 opportunities from 08/13/25 to 08/23/25. Review of Resident #4's electronic progress note dated 08/22/25 revealed: -The RCC asked the pharmacist when clopidogrel 75mg would be delivered to the facility. -The pharmacist replied, that they were waiting on a prescription. -The RCC stated, she had faxed the prescription to the pharmacy last week and again that morning.	{D 358}		

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{D 358}	Continued From page 180 -The pharmacist confirmed the medication would be delivered tomorrow, 08/23/25. Review of Resident #4's electronic progress note dated 08/24/25 revealed the medication aide (MA) documented that she sent a request to the Primary Care Provider (PCP) for a new prescription for clopidogrel 75mg for Resident #4 and for a hold order until the medication was delivered to the facility. Review of a triage note dated 08/24/25 revealed: -The facility staff requested a prescription of clopidogrel 75mg daily and to have an order to place the clopidogrel 75mg on hold until the medication arrived from the pharmacy. -There was an order to refill clopidogrel 75mg daily and place clopidogrel on hold until the medication was received from the pharmacy dated 08/24/25. -The facility should follow up with the PCP for medication refills prior to the residents running out. Telephone interview with a representative from the facility's contracted pharmacy on 09/23/25 at 3:30pm revealed: -Resident #4 had an order for clopidogrel 75mg daily for CVA dated 06/05/25. -The pharmacy dispensed clopidogrel for the first month based on the order on the FL-2, then a prescription was needed. -The pharmacy dispensed 7 clopidogrel 75mg tablets weekly in the multi-dose pack; the last dispensed date was 06/26/25, which was to start on 07/01/25. -The multi-dose packs were dispensed several days before the multi-dose pack started; the facility started their multi-dose packs on Tuesday of each week.	{D 358}		

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{D 358}	Continued From page 181 -The pharmacy sent 8 notices to the facility and to the PCP, between 06/25/25 and 08/23/25 that a new prescription was needed. -The pharmacy received a new prescription on 08/24/25 and dispensed 7 clopidogrel 75mg tablets in the weekly multi-dose pack on 8/28/25, 09/04/25 and 09/11/25. Interview with a MA on 09/29/25 at 9:53am revealed: -Resident #4 was on clopidogrel, but he had run out of medication. -The MAs were documenting "on hold" because the medication was not in the facility. -She did not know why the medication was not in the facility. -She did not know there was no order to hold clopidogrel until 08/24/25; she thought the hold order had been written earlier in August 2025. Interview with the RCC on 09/29/25 at 12:15pm revealed she thought there was an order to hold clopidogrel 75mg. Attempted telephone interview with Resident #4's PCP on 09/29/25 at 9:00am was unsuccessful. Refer to the interview with the MA on 09/29/25 at 12:35pm. Refer to the interview with the RCC on 09/26/25 at 9:10am. 3. Review of Resident #10's current FL-2 dated 10/14/24 revealed diagnoses included pleural effusion, hypertensive heart disease, atrial fibrillation, chronic kidney disease, osteoarthritis, hyperlipidemia, gastro-esophageal reflux disease (GERD), and anemia.	{D 358}		

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{D 358}	Continued From page 182 Review of Resident #10's Resident Registry revealed an admission dated of 10/14/24. a. Review of Resident #10's triage note dated 11/21/24 revealed: -Resident #10's chest x-ray (CXR) dated 11/21/24 showed congestive heart failure (CHF) with an increasing infiltrate (the process of a substance or cells entering and accumulating in tissue where they do not belong) compared to 10/17/24. -The fluid accumulation had worsened. -There was an order for furosemide 20mg (used to treat fluid retention) for 5 days to be administered at 2:00pm for the increased edema, in addition to furosemide 20mg daily that was scheduled at 8:00am daily. Review of Resident #10's triage note dated 11/23/24 revealed: -The facility staff reported that Resident #10 stated she could not breathe, she was on oxygen at 2L/M, and she was not wheezing, coughing, or congested. -The Nurse Practitioner (NP) stated the CXR from 11/21/24 showed CHF with increased infiltrates. -The NP asked, Did Resident #10 have any increased edema or weight, and had Resident #10 started the additional furosemide 20mg that was ordered on 11/21/24. -The staff reported that Resident #10 had not started the additional dose of furosemide 20mg at 2:00pm for 5 days that was ordered on 11/21/24; the medication had not arrived from the pharmacy. The NP asked, Did Resident #10 have any furosemide available? -The staff replied, "Yes, during the scheduled administration time at 8:00am." -The NP said, "administer a dose of furosemide 20mg now."	{D 358}		

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{D 358}	Continued From page 183 Review of Resident #10's November 2024 electronic medication administration record (eMAR) from 11/22/24 to 11/26/24 revealed: -There was an entry for furosemide 20mg daily for 5 days with a scheduled administration time of 2:00pm. -There was documentation that furosemide was not administered 2 of 5 opportunities on 11/22/24 and 11/26/24 at 2:00pm. -There were two exceptions documented; the exceptions were medication unavailable, and the medication ended on 11/26/24. -There was no entry for furosemide 20mg to be administered now on 11/23/24 and no documentation furosemide was administered Review of the facility's contracted pharmacy packing slip dated 11/21/24 revealed: -The pharmacy dispensed 5 furosemide 20mg tablets on 11/21/24. -The pharmacy packing slip verified the medication was received and signed for on 11/22/24. Telephone interview with a representative from the facility's contracted pharmacy on 09/25/25 at 9:05am revealed: -Resident #10 had an order for furosemide 20mg daily at 2:00pm for 5 days. -The pharmacy dispensed 5 furosemide 20mg tablets on 11/21/24 for administration from 11/22/24 to 11/26/24. -The pharmacy did not receive an order dated 11/23/24 for furosemide 20mg now. Interview with the Resident Care Coordinator (RCC) on 09/26/25 at 9:10am revealed: -The furosemide 20mg at 2:00pm for 5 days must be approved by the RCC or the Special Care Unit	{D 358}		

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Coordinator (SCC) before the medication could be administered.
-The furosemide 20mg at 2:00pm was delivered on 11/22/24 but was not approved until 11/23/24; she did not know why the furosemide was not approved until the day after it was delivered.
-She would have expected the mediation aide (MA) to question why there was an extra punch card with 5 furosemide 20mg tablets available for administration when the medication was first delivered and why there were 2 furosemide 20mg tablets remaining at the end of the 5 days.

Interview with the Administrator on 09/29/25 at 4:00pm revealed:
-She was not clinical but thought furosemide was administered for swelling.
-She expected the MAs to read the directions on the eMAR and follow the orders as written.

Attempted a telephone interview with Resident #10's Primary Care Provider (PCP) on 09/29/25 at 9:00am was unsuccessful.

b. Review of Resident #10's triage note dated 10/30/24 revealed:
-Resident #10's potassium level was 2.4 (the normal value for potassium was 3.5-5.4).
-There was an order to start potassium chloride 20mEq (used to treat a low potassium level) extended release (ER) twice daily for 5 days.
-Repeat the potassium level in one week.

Review of Resident #10's laboratory report dated 11/06/24 revealed Resident #10's potassium level was 2.8.

Review of Resident #10's October 2024 eMAR from 10/30/24 to 10/31/24 revealed:
-There was no entry for potassium chloride ER

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20mEq twice daily for 5 days.
-There was no documentation that potassium chloride ER was administered in October 2024 from 10/30/24 to 10/31/24.

Review of Resident #10's November 2024 eMAR from 11/01/24 to 11/05/24 revealed:
-There was an entry for potassium chloride ER 20mEq twice daily for 5 days with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation potassium chloride ER 20mEq was administered 3 of 10 opportunities from 11/01/24 to 11/05/24.
-There was an X documented twice daily from 11/01/24 through 11/03/24, and 11/04/24 at 8:00am was blank.

Review of the facility's contracted pharmacy packing slip dated 10/30/24 revealed:
-The pharmacy dispensed 10 potassium chloride 20mEq tablets on 10/30/24.
-The pharmacy packing slip verified the medication was received and signed by a MA on 10/31/24.

Telephone interview with a representative from the facility's contracted pharmacy on 09/25/25 at 9:05am revealed:
-Resident #10 had an order for potassium chloride ER 20mEq take one tablet twice daily for 5 days dated 10/30/24.
-The pharmacy dispensed 10 potassium chloride ER 20mEq tablets on 10/30/24 for Resident #10.
-Potassium chloride was a supplement which was used when a resident's potassium was low.

Interview with the RCC on 09/26/25 at 9:10am revealed:
-The potassium chloride dated 10/30/24 must be approved by the RCC or SCC before the

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medication could be administered.
-The potassium chloride ER 20mEq was delivered on 10/31/24 but was not approved until 11/01/24; she did not know why the potassium chloride was not approved until the day after it was delivered.
-She would have expected the MA to question why there was a punch card with 10 potassium chloride 20mEq tablets available for administration when the medication was first delivered, and why there were 7 potassium chloride 20mEq tablets remaining at the end of the 5 days.

Interview with the Administrator on 09/29/25 at 4:00pm revealed:
-She was not clinical and did not know why the PCP ordered potassium for Resident #10.
-She expected the MAs to read the directions on the eMAR and follow the orders as written.

Attempted a telephone interview with Resident #10's PCP on 09/29/25 at 9:00am was unsuccessful.

_____
Interview with the courier from the facility's contracted pharmacy on 09/25/25 at 9:40am revealed:
-He delivered medications to the facility every day.
-He arrived daily between 9:00am and 10:00am.
-He had a MA verify the medications he brought and the MA would sign the packing slip.

Interview with a MA on 09/29/25 at 12:35pm revealed:
-New medications could not be administered until the order was approved on the eMAR by the RCC, SCC, or the Administrator.
-Once the order was approved, the order could

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be seen on the eMAR, and the medication could be administered to the resident.

Interview with the RCC on 09/26/25 at 9:10am revealed:
-When the pharmacy received the new order, they would enter it into the eMAR.
-When the medication was dispensed and delivered to the pharmacy, the MA received and checked the medication in.
-The MA would place the packing slip in her box so she could see when a new medication was delivered.
-When a new medication was delivered, she would approve the order so it would show up on the eMAR for the MA to administer.
-The facility was new in October 2024, and there were no processes in place for tracking orders and auditing medication carts.

c. Review of Resident #10's signed physicians' order dated 10/09/24 revealed:
-There was an order for Midodrine (used to treat hypotension) 2.5mg take 2 tablets three times daily
-There was no parameter order to hold Midodrine.

Review of Resident #10's signed physician's order dated 11/20/24 revealed there was an order for Midodrine 2.5mg take 2 tablets three times daily; hold for systolic blood pressure (SBP) greater than 130.

Review of Resident #10's November 2024 eMAR from 11/20/24 to 11/30/24 revealed:
-There was an entry for Midodrine 2.5mg take two tablets (5mg) three times daily; hold for SBP greater than 130 scheduled for administration at 8:00am, 2:00pm, and 8:00pm.
-There was documentation Midodrine was

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administered 32 of 32 opportunities from 11/20/24 to 11/30/24.
-There was no documentation of SBP readings to determine if Midodrine should be held.

Review of Resident #10's December 2024 eMAR revealed:
-There was an entry for Midodrine 2.5mg take two tablets (5mg) three times daily; hold for SBP greater than 130 scheduled for administration at 8:00am, 2:00pm, and 8:00pm from 12/01/24 to 12/31/24.
-There was documentation Midodrine was administered 12 of 12 opportunities from 12/01/24 to 12/04/24.
-There was no documentation of SBP readings to determine if Midodrine should be held from 12/01/24 to 12/04/24.
-There was documentation that Midodrine was not held 5 of 11 opportunities when the SBP was greater than 130 from 12/05/24 to 12/31/24.
-The SBP readings ranged from 132 to 158.

Review of Resident #10's January 2025 eMAR revealed:
-There was an entry for Midodrine 2.5mg take two tablets (5mg) three times daily; hold for SBP greater than 130 scheduled for administration at 8:00am, 2:00pm, and 8:00pm from 01/01/25 to 01/31/25.
-There was documentation that Midodrine was not held for 10 of 21 opportunities when the SBP was greater than 130 from 01/01/25 to 01/31/25.
-The SBP readings ranged from 134 to 159.

Review of Resident #10's February 2025 eMAR from 02/01/25 to 02/24/25 revealed:
-There was an entry for Midodrine 2.5mg take two tablets (5mg) three times daily; hold for SBP greater than 130 scheduled for administration at

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{D 358}	Continued From page 189 8:00am, 2:00pm, and 8:00pm from 02/01/25 to 02/24/25. -There was documentation that Midodrine was not held 5 of 10 opportunities when the SBP was greater than 130 from 02/01/25 to 02/24/25. -The SBP ranged readings from 134 to 141. Telephone interview with a representative from the facility's contracted pharmacy on 09/25/25 at 9:05am revealed Resident #10 had an order for Midodrine 2.5mg take 2 tablets three times daily; hold for SBP greater than 130 dated 11/20/24. Interview with the RCC on 09/26/25 at 9:10am revealed: -She did not know that the MA administered Midodrine when the medication should have been held. -The MAs should read the entry on the eMAR and follow the directions. -She did not know why the MAs would administer a medication when the SBP was greater than 130, when the order read to hold the medication for a SBP greater than 130. -She expected the MAs to read the instructions on the eMAR and follow them. Interview with the Administrator on 09/29/25 at 4:00pm revealed: -She was not clinical and did not know why Midodrine should have been held for a SBP greater than 130. -She expected the MAs to read the directions on the eMAR and follow the orders as written. Attempted a telephone interview with Resident #10's PCP on 09/29/25 at 9:00am was unsuccessful. Refer to the interview with the MA on 09/29/25 at	{D 358}		

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{D 358}	Continued From page 190 12:35pm. Refer to the interview with the RCC on 09/26/25 at 9:10am. 4. Review of Resident #8's current FL-2 dated 10/09/24 revealed: -Diagnoses included fractured right femur, pleural effusion, hypertensive heart disease with heart failure, osteoarthritis, aortic valve stenosis, chronic kidney disease, and gastroesophageal reflux disease (GERD). -There was an order for pregabalin 25mg (used to treat nerve pain) daily. Review of Resident #8's signed physician order dated 10/18/24 revealed there was an order to increase pregabalin 25mg to three times daily. Review of Resident #8's record revealed there was no order to discontinue pregabalin. Review of a triage note dated 01/06/25 revealed there was an order to resume pregabalin 25mg three times daily. Review of Resident #8's October 2024 electronic medication administration record (eMAR) from 10/18/24 to 10/29/24 revealed: -There was an entry for pregabalin 25mg three times daily with a scheduled administration time of 8:00am, 2:00pm, and 8:00pm. -There was documentation pregabalin was not administered 4 of 23 opportunities from 10/18/24 to 10/26/24. -The exceptions documented were awaiting pharmacy, and medication was unavailable. -There was a second entry for pregabalin 25mg three times daily with a scheduled administration time of 8:00am, 2:00pm, and 8:00pm.	{D 358}		

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{D 358}	Continued From page 191 -There was documentation pregabalin was not administered 2 of 4 opportunities from 10/29/24 to 10/30/24. -The exception was documented as the medication was unavailable. -There was no documentation on 10/27/24 and 10/28/24; there was an X on the eMAR. -There was documentation that pregabalin 25mg three times daily ended on 10/30/24. Review of Resident #8's November 2024 eMAR revealed: -There was no entry for pregabalin 25mg three times daily. -There was no documentation pregabalin 25 mg was administered in November 2024. Review of Resident #8's December 2024 eMAR revealed: -There was no entry for pregabalin 25mg three times daily. -There was no documentation pregabalin 25 mg was administered in December 2024. Review of Resident #8's January 2025 eMAR from revealed: -There was no entry for pregabalin 25mg three times daily from 01/01/25 to 01/05/25. -There was no documentation pregabalin 25mg was administered from 01/01/25 to 01/05/25. -There was an entry for pregabalin 25mg three times daily entered on 01/06/25 with a scheduled administration time of 8:00am. 2:00pm, and 8:00pm. -There was documentation pregabalin 25 mg was not administered on 01/06/25 at 8:00am. -The exception was that the order had not been approved. Telephone interview with a representative from	{D 358}		

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the facility's contracted pharmacy on 09/25/25 at 9:05am revealed:
-Resident #8 had an order for pregabalin 25mg three times daily dated 10/17/24.
-The pharmacy dispensed 9 pregabalin 25mg tablets on 10/17/24 for a 3-day supply.
-The pharmacy dispensed 45 pregabalin 25mg tablets on 10/29/24, 01/06/25, and on 02/03/25 for a 15-day supply.
-The pharmacy dispensed 90 pregabalin 25mg tablets on 03/04/25 for a 30-day supply.
-The pharmacy did not have an order to discontinue pregabalin in October 2024.
-The pharmacy would not discontinue an order on the eMAR without an order.
-The facility had access to the eMAR to discontinue medication orders.
-Pregabalin was a controlled substance and was not on cycle fill.
-The facility was responsible for notifying the pharmacy when they were running low on a controlled substance so the pharmacy could dispense the controlled substance timely.
-The pharmacy did not dispense pregabalin in November 2024 or December 2024 because the facility did not request pregabalin to be refilled.
-Pregabalin was used for nerve pain.

Telephone interview with Resident #8 on 09/29/25 at 9:17am revealed:
-She knew she took Pregabalin; but could not remember how many times a day she took it.
-She did not recall having nerve pain, but she did have pain in her legs when she resided in the facility.

Interview with a medication aide (MA) on 09/29/25 at 9:53am revealed:
-She would notify the primary care provider (PCP) when controlled substances were down to a two

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week supply remaining.
-Two weeks would be plenty of time for the new prescription to get to the pharmacy, so the resident would not run out of their controlled medications.
-She did not like it when the residents had to do without their medications, and she had residents who had to go without because their medications were not in the facility.

Interview with the Resident Care Coordinator (RCC) on 09/29/25 at 9:10am revealed:
-Resident #8 had an order for pregabalin three times daily.
-She did not know pregabalin was discontinued on the eMAR in October 2024 if there was no order to discontinue the medication.
-She did not know who discontinued pregabalin on the eMAR, when there was no order to discontinue the medication.
-She did not know the pharmacy had an active order for pregabalin.
-She would have told the MA to discontinue the medication if she had an order, but she did not have an order to discontinue pregabalin.
-If the MA saw a medication on the medication cart and it was not on the eMAR, she would expect them to question why the medication was no longer on the eMAR.
-If she had been made aware, she would have notified the provider and the pharmacy to see what happened with this medication and why it was no longer on the eMAR.

Interview with the Administrator on 09/29/25 at 4:00pm revealed:
-She did not know Resident #8 did not receive her pregabalin in November 2024 and December 2024 because it was discontinued on the October 2024 eMAR.

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{D 358}	Continued From page 194 -She did not know why the pharmacy would discontinue a medication on the eMAR if there was no order to discontinue pregabalin. -She would have expected the MAs to question why the medication was on the medication cart and not on the eMAR for administration. Attempted telephone interview with Resident #8's PCP on 09/29/25 at 9:00am was unsuccessful. Refer to the interview with the MA on 09/29/25 at 12:35pm. Refer to the interview with the RCC on 09/26/25 at 9:10am. _____ Interview with the MA on 09/29/25 at 12:35pm revealed: -She did not do medication cart audits; no one had told her to audit the medication carts. -She removed discontinued medications from the medication cart when the RCC told her a medication had been discontinued. Interview with the RCC on 09/26/25 at 9:10am revealed: -She did not do medication cart audits. -The MAs were responsible for auditing the medication carts. -The MA was to ensure the medications listed on the eMAR were in the facility, remove expired medications, and ensure the medication cart was clean. -She was not trained appropriately when she was hired; it was a new facility, and processes were not in place. -The PCP orders were not left in the facility on the same day the PCP wrote the order. -The PCP would send the orders to the pharmacy and the facility a couple of days after the PCP	{D 358}		

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{D 358}	Continued From page 195 visit. _____ The facility failed to administer medications as ordered to a resident (#10) who was ordered a medication for fluid retention and had a chest x-ray which showed congestive heart failure and the resident was complaining of shortness of breath. Resident #10 was also ordered a medication for a low potassium level of 2.5 and only received 3 of 10 doses and the repeat potassium level in one week was 2.8, and there was an order to hold a medication to treat low blood pressure when the SBP was greater than 130, and the medication was administered 44 times without checking the resident's blood pressure and was administered 20 times when the SBP was greater than 130 (#10). Another resident was ordered a blood thinner to prevent cerebral vascular accidents and the medication was not available for administration for at least 6 weeks (#4), which increased the resident's risk of a stroke. Resident #7 was administered a medication to lower blood sugar more than once daily and experienced diarrhea. The facility's failure to administer medication as ordered placed the residents at substantial risk of physical harm which constitutes an Unabated Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/26/25.	{D 358}		
{D 366}	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the	{D 366}		

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THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

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{D 366}	Continued From page 196 staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication aide (MA) observed a resident take their medications that were left on the dining room table and a supplement left on a resident's nightstand. The findings are: 1. Observation of the dining room on 09/23/25 at 8:11am revealed: -There was an opened multi-dose pack with at least 9 pills on a dining room table. -There were 3 residents sitting at the dining room table and 23 other residents sitting in the dining room. Interview with a resident on 09/23/25 at 9:02am revealed: -The MA left her medications on the dining room table that morning. -She was eating breakfast, and she did not want to stop eating to take her medications. -The MA left her 14 pills on the dining room table for her to take. -Most of the MAs would place the medications on the table or hand them to the resident and walk away; they did not watch her take her medications.	{D 366}		

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{D 366}	Continued From page 197 Interview with the MA on 09/24/25 at 5:25pm revealed: -She watched residents take their medications. -She did leave medications on the dining room table for one resident that morning because the resident was eating breakfast. -The resident asked her to leave her medications on the table; she would take them when she finished eating breakfast. -She left the residents' medications on the table and checked to see that the medications were not on the dining room table when she helped clean the dining room after breakfast. -She could not be sure if the resident took the medications or not. -Someone else could have taken the medications. Interview with a second resident on 09/26/25 at 8:54am revealed: -On 09/23/25, the MA gave her seven pills in a white cup with a cup of water and left her bedroom. -Some MAs watched her take all of her medications, and other MAs did not. -She took two pills during lunch, and the MA placed the pills in the white cup and placed it on the dining room table for her to take. -She took four to five pills at night, and the MA always left her pills in the white cup on her bedside table with a cup of water. -There was one MA who always watched her take all of her medications. Interview with third resident on 09/26/25 at 10:05am revealed: -She took eight pills in the morning. -The MAs placed the medication on the side table in her bedroom and walked away. -When she was in the dining room, the MAs left	{D 366}		

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her medication in a cup with water for her to take.
-She took two pills during lunch and four pills at night.
-The MAs that worked during the day tended to watch her take her medications.
-The evening MAs never watched her take her medication.
-She had frequent urinary tract infections (UTIs), and the MA always left her suppository for her to take on her own.

Interview with a second MA on 09/26/25 at 11:26am revealed:
-She did not leave medication in a resident's bedroom to administer at a later time.
-She never left medication in the dining room for a resident to administer.
-She watched all residents take their medication before she left the resident.

Interview with the Resident Care Coordinator (RCC) on 09/29/25 at 12:15pm revealed:
-She tried to make rounds every hour.
-She had not noticed any medications left in a resident's room or the dining room for residents to take.
-The MA should not leave medications with a resident to take when the resident wanted.
-The MA was responsible for watching the residents take their medications before the MA walked away.
-The MA should not leave medications; another resident may walk by and pick them up and take the medications, thinking the medications was theirs.

Interview with the Administrator on 09/26/25 at 4:00pm revealed:
-Medications should not be left on the dining room table for a resident to take after they

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{D 366}	Continued From page 199	{D 366}		

finished eating.
-The MA should watch residents take their medication during the administration of the medications.
-When medicines were left on the dining room table, anyone could have walked by and picked the medications up.
-The MA would not know if the resident took the medications or not.
-She expected the MAs to watch the residents take their medications.

2. Observation of the morning medication pass on 09/24/25 at 8:30am revealed:
-The medication aide (MA) entered a resident's room and removed a nutritional shake from the resident's refrigerator.
-The MA opened the nutritional shake, inserted a straw, and offered the shake to the resident.
-The resident took a few sips of the nutritional shake through the straw and told the MA she "had enough".
-The MA placed the nutritional shake on the bedside table and reminded the resident to drink her nutritional shake, then the MA left the resident's room.

Observation of the resident's room on 09/24/25 at 9:40am revealed the nutritional shake remained on the bedside table and was 3/4 full.

Review of the resident's September 2025 electronic medication administration record (eMAR) on 09/24/25 revealed:
-There was an entry for a nutritional shake three times daily for nutritional support with a scheduled time of 8:00am, 2:00pm, and 8:00pm.
-There was documentation that the nutritional shake was administered at 8:00am on 09/24/25.
-There was no documentation that the resident

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{D 366}	Continued From page 200 took a few sips, and the nutritional shake was left at the resident's bedside. Interview with the MA on 09/24/25 at 5:40pm revealed: -The resident had an order for a nutritional shake three times daily with meals. -She removed a nutritional shake from the resident's refrigerator, opened it, and gave it to the resident. -The resident took a few sips of the nutritional shake and laid down in the bed. -She left the nutritional shake on the resident's nightstand; the resident would eventually drink it all. -She always left the nutritional shake by the resident's bedside and documented on the eMAR that the resident was given the nutritional shake. Interview with the Special Care Unit Coordinator (SCC) on 09/26/25 at 12:18pm revealed: -The MA was not expected to watch the resident drink the entire nutritional shake when it was served. -The MA was expected to return to the room to ensure the nutritional shake was consumed by the resident. -The MA should document on the eMAR after the nutritional shake was consumed. -If the resident did not drink all the nutritional shake, she expected the MA's documentation on the eMAR to reflect that. Interview with the Administrator on 09/29/25 at 4:00pm revealed: -She did not expect the MA to stay with the resident while she drank the nutritional shake. -When the MA documented on the eMAR she was confirming that she had given the nutritional shake to the resident.	{D 366}		

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{D 366}	Continued From page 201 Attempted a telephone interview with the resident's Primary Care Provider (PCP) on 09/29/25 at 9:00am was unsuccessful. Based on observations, interviews, and record reviews, it was determined the resident was not interviewable.	{D 366}		
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: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 1 sampled resident (#18) had a physician's order to self-administer a medication observed in the resident's room. The findings are: Review of the facility's undated Self-Managed	D 375		

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Medications policy revealed:
-A resident who desired to self-manage medications must successfully complete the Self-Administration Assessment, which would be completed by the Resident Care Coordinator (RCC).
-Once the resident successfully passed the Self-Administration Assessment, the RCC would obtain an order allowing the resident to self-administer medications from the resident's Primary Care Provider (PCP).
-The resident would be assessed quarterly for the ability to safely self-administer medications.

Review of Resident #18's current FL2 dated 09/02/25 revealed:
-Diagnoses included Parkinson's disease dementia.
-He was intermittently disoriented.
-Recommended level of care was Special Care Unit (SCU).
-There was no order for self-administration of any medication.

Review of Resident #18's Resident Register revealed an admission date of 09/09/25.

Observation of Resident #18's room on 09/23/25 at 8:40am revealed a bottle of sinex nasal spray (used for temporary relief of congestion in the nose) sitting on his bedside table.

Review of Resident #5's September 2025 electronic medication administration records (eMARs) from 09/09/25-09/23/25 revealed there was no entry for sinex nasal spray.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/29/25 at 10:23am revealed:

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-Sinex was used to treat allergy symptoms such as a stuffy nose.
-Resident #18 did not have an order for sinex nasal spray.
-Resident #18 did not have an order to self-administer medications.
-Sinex directions were to use 2-3 sprays in each nostril, no more than twice daily.
-If sinex was used more than the suggested dosage, the resident could have rebound congestion, meaning it would cause increased congestion instead of treating the symptoms.

Second observation of Resident #18's room on 09/23/25 at 3:16pm revealed the bottle of sinex was in a drawer on the other side of the resident's room

Interview with Resident #18 on 09/23/25 at 3:16pm revealed:
-The sinex was on his bedside table, where he always kept it.
-He did not know how the sinex bottle got in the drawer.
-He used the sinex sometimes 2-3 times per night, depending on how dry his nose was.
-He had to have the sinex because his nose was so "stopped up" he could not sleep.

Telephone interview with Resident #18's family member on 09/23/25 at 6:25pm revealed:
-Resident #18 took the sinex with him when he moved into the facility.
-The sinex bottle was always on his bedside table, where he could reach it.
-Resident #18 usually used the sinex every night when he was at home.
-Resident #18 used the sinex to open his nasal passages.
-She was not concerned Resident #18 would use

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D 375	Continued From page 204 too much of the medication. Interview with a personal care aide (PCA) on 09/24/25 at 12:16pm revealed she had not seen the nose spray in Resident #18's room; if she had, she would have given it to the medication aide (MA). Interview with a MA on 09/25/25 at 10:26am revealed: -She had not seen medications in Resident #18's room. -Resident #18 was not capable of self-administering medications, not even a nose spray. Interview with Resident #18's previous PCP medical assistant on 09/29/25 at 10:17am revealed: -Resident #18 did not have an order for sinex nasal spray. -Resident #18 did not have an order to self-administer medications. -Resident #18's PCP services were transferred to the hospice provider on 09/15/25. Telephone interview with Resident #18's hospice nurse on 09/29/25 at 10:33am revealed: -Resident #18 did not have an order for sinex nasal spray. -Resident #18 did not have an order to self-administer any medications. -She did not know if Resident #18 would be able to self-administer the sinex. -If Resident #18 wanted to self-administer the sinex, they would have to get an order from the hospice physician for the medication to be kept at bedside. Interview with the Special Care Unit Coordinator	D 375		

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D 375	Continued From page 205 (SCC) on 09/25/25 at 11:15am revealed: -Resident #18 did not have an order for self-administration. -A self-administration assessment had not been completed on Resident #18. -If Resident #18 had medications in his room, he brought them with him when he moved in. -Families were told they could not bring anything in that was ingestible because residents in the SCU could not comprehend if it was edible or not. Interview with the Administrator on 09/29/25 at 7:09pm revealed: -If a resident had medication in their room, there should be an assessment and an order from the PCP to self-administer. -She would be concerned that the resident had not administered the medication correctly.	D 375		
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 and interviews, the facility failed to ensure the medication cart was locked when not under the direct physical supervision of a medication aide (MA). The findings are:	D 378		

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D 378	Continued From page 206 Review of the facility's undated Medication Services policy revealed all medications for residents who received medication administration would be stored in the designated medication storage area of the facility. Observation of the medication cart on 09/23/25 at 8:05am revealed: -The medication cart was in the foyer of the facility when the surveyor entered the facility. -The medication cart was unlocked and not under the direct supervision of the MA. -The MA was in the dining room, which was off the foyer. -There were 3 surveyors and the Business Office Manager (BOM) in the foyer, and a resident entering the dining room. -The MA returned to the medication cart and secured it. Interview with the MA on 09/24/25 at 5:44pm revealed: -She left the medication cart unlocked by accident. -She usually secured the medications by locking the medication cart. -Any resident could open the medication cart and get medications out of it. Interview with the Resident Care Coordinator (RCC) on 09/29/25 at 10:00am revealed: -Medications on the medication cart should be secured by locking the medication cart when the MA was not standing next to the medication cart. -Anyone, a resident or visitor, could walk by the unlocked medication cart and remove medication from it. -She expected the MAs to secure medications by ensuring the medication cart was locked when the MA was not preparing medications.	D 378		

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D 378	Continued From page 207 Interview with the Administrator on 09/26/25 at 4:00pm revealed: -The medication cart should not be unlocked if it was unattended. -Someone could walk by the medication cart, open it, and remove medications. -She expected the medication cart to be locked when unsupervised by the MA.	D 378		
{D 388}	10A NCAC 13F .1007 (c) Medication Disposition 10A NCAC 13F .1007 Medication Disposition (c) Medications, excluding controlled medications, shall be destroyed at the facility or returned to a pharmacy within 90 days of the expiration or discontinuation of medication or following the death of the resident. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure discontinued medications were disposed of or returned to the pharmacy within 90 days for 2 of 7 residents (#6 and #12), including an inhaler (#6) and a medication to manage diabetes (#12). The findings are: 1. Review of Resident #12's current FL-2 dated 07/18/25 revealed: -Diagnoses included hypertension, hypertensive heart disease with heart failure, atrial fibrillation, heart failure, gastroesophageal reflux disease, osteoarthritis, diabetes mellitus type 2, and dementia.	{D 388}		

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{D 388}	Continued From page 208 -There was no order for Januvia 52mg (used to lower blood sugar). Observation of the morning medication pass on 09/24/25 at 8:11am for Resident #12 revealed: -The medication aide (MA) removed Resident #12's multi-dose pack dated 09/24/25 for the 8:00am morning medication pass from the medication cart. -There were 6 pills in the multi-dose pack, including a Januvia 50mg tablet. -The MA scanned the multi-dose pack, and a warning was displayed on the computer screen "Januvia 50mg was discontinued". -The MA sanitized her hands, donned gloves, removed the Januvia 50mg tablet from the multi-dose pack, and disposed of the pill in the trash. -The MA administered 5 pills to Resident #12. Review of Resident #12's September 2025 electronic medication administration record (eMAR) from 09/01/25 to 09/24/25 revealed there was no entry for Januvia 50mg. Observation of Resident #12's multi-dose pack from 09/24/25 to 09/29/25 revealed there was a Januvia 50mg tablet in the 8:00am multi-dose pack for each day. Review of Resident #12's signed physician order dated 12/04/24 revealed there was an order to discontinue Januvia 50mg daily. Telephone interview with a representative from the facility's contracted pharmacy on 09/24/25 at 3:36pm revealed: -Resident #12 had an order for Januvia 50mg daily. -Januvia was an active order and was placed in	{D 388}		

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the multi-dose pack every 7 days and delivered to the facility for administration.
-The pharmacy did not have an order to discontinue Januvia 50mg.
-The facility had the ability to discontinue medications, enter new orders, and change the time of administration of medications on the eMAR.

Interview with the MA on 09/24/25 at 8:11am revealed:
-She removed the Januvia from the multi-dose pack because a message popped up on the computer screen that Resident #12's Januvia was discontinued when the multi-dose pack was scanned.
-She did not know how long Januvia had been discontinued.
-She had not told the Resident Care Coordinator (RCC) that Januvia was still in the multi-dose pack.

Interview with a second MA on 09/26/25 at 12:33pm revealed:
-She had administered medications to Resident #12.
-When she scanned Resident #12's multi-dose pack, a message popped up on the computer screen that Januvia was discontinued.
-She would remove Januvia from the multi-dose pack and discard the medication in the drug buster.
-She did not remember telling the RCC there was a discontinued medication in Resident #12's multi-dose pack.

Interview with the RCC on 09/25/25 at 4:22pm revealed:
-The MAs should have let the RCC, Special Care Unit Coordinator (SCC), or Administrator know

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that a medication that was no longer on the eMAR was still being dispensed in the multi-dose pack.
-She did not know who discontinued the medication on the eMAR.
-The order to discontinue Januvia should have been sent to the pharmacy in December 2024 when the order was written.
-She expected the MAs to let the RCC, SCC, or Administrator know that a discontinued medication was still on the medication cart.

Interview with the Administrator on 09/26/25 at 4:00pm revealed:
-Orders to discontinue a medication should be faxed to the pharmacy.
-She did not understand how the pharmacy did not get the order, but the medication was removed from the eMAR.
-The MAs should have told the RCC or SCC that a discontinued mediation was still being dispensed from the pharmacy.

Attempted a telephone interview with Resident #12's Primary Care Provider (PCP) on 09/29/25 at 9:00am was unsuccessful.

Based on observations, interviews, and record reviews, it was determined Resident #12 was not interviewable.

Refer to the interview with the RCC on 09/25/25 at 11:42am.

Refer to the interview with the Administrator on 09/26/25 at 8:10am.

2. Review of Resident #6's current FL-2 dated 08/06/25 revealed diagnoses included chronic obstructive pulmonary disease,

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{D 388}	Continued From page 211 gastro-esophageal reflux, and anemia. Review of Resident #6's six month signed physician's order dated 08/18/25 revealed there were no orders for Trelegy Ellipta (used to treat chronic obstructive pulmonary disease) 100-62.5-25mcg. Observations of Resident #6's medication on hand on 09/25/25 at 10:48am revealed: -The medication cart had a drawer for storing topical medication, eye drops, and inhalant sprays. -There was a medication card labeled Trelegy Ellipta 100-62.5-25mcg dispensed on 02/12/25 with an expiration date of 08/28/25. Interview with a medication aide (MA) on 09/25/25 at 11:32am revealed: -The Resident Care Coordinator (RCC) was responsible for completing medication cart audits. -She had never performed a cart audit. -Discontinued or expired medications were removed from the cart. -She was not aware of how the RCC disposed of inhalers. -She was not aware the expired medication was on the cart. Interview with the RCC on 09/25/25 at 11:42am revealed: -She was not aware there was an expired medication on the cart for Resident #6. -The inhaler was to be placed in a black bag and thrown in the dumpster. Interview with the Administrator on 09/26/25 at 8:10am revealed: -She was not aware of how inhalers were to be disposed of.	{D 388}		

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{D 388}	Continued From page 212 -She was not aware there was an expired medication on the cart for Resident #6. Refer to the interview with the RCC on 09/25/25 at 11:42am. Refer to the interview with the Administrator on 09/26/25 at 8:10am. _____ Interview with the RCC on 09/25/25 at 11:42am revealed: -She was responsible for conducting medication cart audits. -Discontinued and expired medications were removed from the medication cart during the cart audit. -She conducted cart audits weekly. -She performed the last cart audit on 09/18/25. Interview with the Administrator on 09/26/25 at 8:10am revealed: -The RCC was responsible for completing medication cart audits weekly. -Discontinued and expired medications were removed from the cart during cart audits.	{D 388}		
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	D 394		

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D 394	Continued From page 213 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. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure controlled	D 394		

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substances were destroyed at the facility for 2 of 2 sampled residents (#8 and #10) and was witnessed by a licensed pharmacist, dispensing practitioner, or a designee of the licensed pharmacist or dispensing practitioner.

The findings are:

Review of the facility's undated controlled substance policy revealed:
-Only a single dose of controlled substances could be destroyed/disposed of in the facility.
-Another staff member must witness the disposition of the controlled substance and initial the count sheet.
-If the controlled substance count was incorrect or a discrepancy was found, the Resident Care Coordinator (RCC) or Special Care Unit Coordinator (SCC) and the Administrator must be notified immediately.
-Supervisory staff would direct a preliminary investigation to rule out a documentation error.
-Staff would document the reporting and the resolution of the discrepancy on an incident reporting form.

1. Review of Resident #8's current FL-2 dated 10/09/24 revealed diagnoses included fractured right femur, pleural effusion, hypertensive heart disease with heart failure, osteoarthritis, aortic valve stenosis, chronic kidney disease, and gastroesophageal reflux disease (GERD).

Review of Resident #8's signed physician order dated 01/06/25 revealed there was an order for pregabalin 25mg (used to treat nerve pain) three times daily.

Review of Resident #8's electronic controlled substance count sheet (CSCS) from 02/24/25 to

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D 394	Continued From page 215 04/06/25 revealed: -On 02/24/25, the facility received 45 pregabalin 25mg tablets with a starting amount of 45 pregabalin 25mg tablets on 02/24/25. -On 03/05/25, the facility received 90 pregabalin 25mg tablets, with a total of 108 pregabalin 25mg tablets to administer. -On 04/06/25, there were 13 pregabalin 25mg tablets remaining. -There was no documentation that the 13 pregabalin tablets had been destroyed. Observation of Resident #8's medications on hand on 09/25/25 revealed there were no pregabalin 25mg tablets available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 09/25/25 at 9:05am revealed: -Resident #8 had an order for pregabalin 25mg three times daily dated 10/17/24. -The pharmacy dispensed 45 pregabalin 25mg tablets on 02/24/25 for a 15-day supply. -The pharmacy dispensed 90 pregabalin 25mg tablets on 03/04/25 for a 30-day supply. -No pregabalin had been returned to the pharmacy for destruction. Interview with a medication aide (MA) on 09/29/25 at 9:53am revealed she did not recall destroying controlled substances for Resident #8. Interview with the RCC on 09/29/25 at 12:15pm revealed she could not remember destroying Resident #8's pregabalin. Refer to the telephone interview with the pharmacist at the facility's contracted pharmacy dated 09/29/25 at 10:32am.	D 394		

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D 394	Continued From page 216 Refer to the interview with a MA on 09/29/25 at 9:53am. Refer to the interview with the RCC on 09/29/25 at 12:15pm. Refer to the interview with the Administrator on 09/26/25 at 4:00pm. 2. Review of Resident #10's current FL-2 dated 10/09/24 revealed diagnoses included pleural effusion, hypertensive heart disease, atrial fibrillation, chronic kidney disease, osteoarthritis, hyperlipidemia, gastroesophageal reflux disease (GERD), and anemia. a. Review of Resident #10's signed physician order dated 03/18/25 revealed there was an order for Fentanyl 12mcg patches (used to treat pain) apply every 72 hours. Review of Resident #10's electronic controlled substance count sheet (CSCS) from 03/19/25 to 03/22/25 revealed: -On 03/19/25, the facility received 10 fentanyl 12mcg patches. -There was documentation a fentanyl 12mcg patch was applied to Resident #10 on 03/19/25 and 03/22/25 with a remaining count of 8 patches. -There was no documentation that the remaining 8 patches had been destroyed. Observation of Resident #10's medications on hand on 09/25/25 revealed there were no fentanyl patches on hand for Resident #10. Telephone interview with the pharmacist at the facility's contracted pharmacy on 09/26/25 at	D 394		

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D 394	Continued From page 217 11:35am revealed: -Resident #10 had an order for Fentanyl 12mcg patches one patch every 72 hours dated 03/18/25. -The pharmacy dispensed 10 Fentanyl 12mcg patches on 03/18/25 for a 30-day supply. -The facility had drug busters and destroyed controlled medications in the facility. -No Fentanyl patches had been returned to the pharmacy for destruction. Interview with a medication aide (MA) on 09/29/25 at 9:53am revealed she did not recall destroying controlled substances for Resident #10. Interview with the RCC on 09/29/25 at 12:15pm revealed: -Resident #10's fentanyl patches were destroyed in the drug buster. -She did not document the destruction of the fentanyl patch. -She did not have anyone witness the destruction of the fentanyl patches. -She did not realize at the time of the destruction of the controlled substances that she needed a witness when destroying the controlled substances. b. Review of Resident #10's signed physician order dated 03/03/25 revealed there was an order for hydromorphone 2mg (used to treat pain) tablets take 1.5 tablets every 3 hours as needed. Review of Resident #10's signed physician order dated 03/18/25 revealed there was an order for hydromorphone 2mg tablets take 1/2 tablet every 3 hours as needed. Review of Resident #10's electronic CSCS from	D 394		

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03/03/25 to 03/22/25.
-On 03/03/25, the facility received 12 hydromorphone 2mg tablets dispensed from a local pharmacy.
-On 03/13/25, there was documentation 6 hydromorphone 2mg tablets were wasted by the RCC; the staff who wasted the controlled substance and the witness were the same.
-On 03/18/25, the facility received, from a local pharmacy, 12 whole tablets (24 - ½ tablets) of hydromorphone 2mg tablets administer ½ tablet every 4 hours.
-There was documentation the 14 ½ tablets of hydromorphone 2mg were wasted by the RCC on 03/22/25; the staff who wasted the controlled substance and the witness were the same.

Review of pharmacy receipts from the local pharmacy provided by the RCC revealed on 03/02/25, there was a receipt that 12 hydromorphone 2mg tablets were dispensed from a local pharmacy.

Observation of Resident #10's medications on hand on 09/25/25 revealed there were no hydromorphone tablets on hand for Resident #10.

Telephone interview with the pharmacist from the facility's contracted pharmacy dated 09/29/25 at 10:32am revealed:
-The pharmacy received an order for Resident #10 for hydromorphone 2mg take 1.5 tablets every 3 hours as needed on 03/01/25.
-The pharmacy did not dispense the order dated 03/01/25 because it was not a valid prescription for a controlled substance.

Telephone interview with the pharmacist at the local pharmacy on 09/29/25 at 10:18am revealed:
-The pharmacy had an order for hydromorphone

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2mg tablets take ½ tablet (1mg) every 4 hours as needed.
-The pharmacy dispensed 12 whole tablets (24 - ½ tablets) for a 4-day supply.
-Resident #10's medication was picked up on 03/18/25; he did not know who picked the medication up.
-No hydromorphone tablets had been returned to the pharmacy for destruction.

Interview with a MA on 09/29/25 at 9:53am revealed she did not recall destroying controlled substances for Resident #10.

Interview with the RCC on 09/29/25 at 12:15pm revealed:
-Resident #10's hydromorphone tablets were destroyed in the drug buster.
-She did not document the destruction of the hydromorphone tablets.
-She did not have anyone witness the destruction of the hydromorphone tablets.
-She did not realize at the time of the destruction of the controlled substances that she needed a witness when destroying the controlled substances.

c. Review of Resident #10's signed physician order dated 03/04/25 revealed there was an order for hydromorphone 1ml/mg liquid give 1ml every 3 hours as needed for pain.

Review of Resident #10's signed physician order dated 03/12/25 revealed there was an order for hydromorphone 1mg/1ml take 1ml every 4 hours.

Review of Resident #10's electronic CSCS from 03/03/25 to 03/22/25.
-On 03/05/25, the facility received 30 syringes of hydromorphone 1mg/1ml to be administered

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every 3 hours as needed.
-On 03/13/25, there was documentation 27 syringes of hydromorphone 1mg /1ml were wasted by the RCC; the staff who wasted the controlled substance and the witness were the same.
-On 03/22/25, the facility received 30 hydromorphone 1ml/mg syringes, for a balance of 30.
-There was documentation hydromorphone 1ml/mg was administered 4 times from 03/22/25 to 03/24/25, with a balance of 26 hydromorphone syringes remaining.
-There was no documentation that the remaining 26 syringes of hydromorphone had been destroyed.

Observation of Resident #10's medications on hand on 09/25/25 revealed there were no hydromorphone syringes or tablets on hand for Resident #10.

Telephone interview with the pharmacist from the facility's contracted pharmacy dated 09/29/25 at 10:32am revealed:
-The pharmacy had an order for Resident #10 for hydromorphone 1ml/mg liquid give 1ml every 3 hours as needed for pain dated 03/04/25.
-The pharmacy dispensed 30 syringes of hydromorphone 1mg/ml liquid in each syringe on 03/04/25 and 03/21/25.
-The pharmacy did not receive an order for Resident #10 for hydromorphone 1mg/ml every 4 hours for pain.
-No hydromorphone liquid had been returned to the pharmacy for destruction.

Telephone interview with Resident #8's Power of Attorney (POA) on 09/29/25 at 9:36am revealed:
-She had hospice call a prescription for

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hydromorphone into a local pharmacy so she could pick it up because the facility did not have any.
-She picked Resident #10's pain medication up at the local pharmacy and took it to the facility.
-She thought she gave the medication to the RCC, but she was not sure.
-She thought she had picked up medication from a local pharmacy several times.

Interview with a MA on 09/29/25 at 9:53am revealed she did not recall destroying controlled substances for Resident #10.

Interview with the RCC on 09/29/25 at 12:15pm revealed:
-Resident #10's hydromorphone liquid was destroyed in the drug buster.
-She did not document the destruction of the hydromorphone liquid.
-She did not have anyone witness the destruction of the hydromorphone liquid.
-She did not realize at the time of the destruction of the controlled substances that she needed a witness when destroying the controlled substances.

Attempted telephone interview with a representative from a second local pharmacy on 09/29/25 at 10:30am was unsuccessful.
second local pharmacy on 09/29/25 at 10:30am was unsuccessful.

d. Review of Resident #10's signed physician orders dated 12/07/24 revealed there was an order for lorazepam 0.5mg 1/2 tablet every 8 hours.

Review of Resident #10 signed physician orders dated 03/12/25 revealed there was an order for

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D 394	Continued From page 222 lorazepam 0.5mg 1/2 tablet every 4 hours. Review of Resident #10's electronic CSCS from 02/22/25 to 03/23/25 revealed: -On 02/22/25, the facility received 89 lorazepam 0.5mg tablets, take 1/2 tablet for a total of 89 lorazepam doses available for administration. -On 03/13/25, there was documentation 43 lorazepam 0.5mg take 1/2 tablets were wasted by the RCC; the staff who wasted the controlled substance and the witness were the same. -On 03/18/25, the facility received 168 lorazepam 0.5mg 1/2 tablets for a total of 164 doses available for administration. -On 03/23/25, there were 141 lorazepam 0.5mg tablets remaining; there was no documentation that the lorazepam was wasted. Telephone interview with the pharmacist at the facility's contracted pharmacy dated 09/29/25 at 10:32am revealed: -The pharmacy had an order for Resident #10 for lorazepam 0.5mg take 1/2 tablet every 8 hours dated 12/07/24. -The pharmacy dispensed 21 whole tablets (42 - 1/2 tablets) on 12/07/24. -The pharmacy dispensed 45 tablets (90 - 1/2 tablets) on 12/20/24, 01/20/25, 02/21/25. -The pharmacy had an order for Resident #10 for lorazepam 0.5mg take 1/2 tablet every 4 hours dated 03/12/25. -The prescription was invalid; the facility was notified, and a new prescription was received on 03/17/25. -The pharmacy received an order for lorazepam 0.5mg every 6 hours as needed for anxiety dated 03/17/25. -The pharmacy dispensed 84 whole tablets (168 - 1/2 tablets) on 03/17/25 for a 28-day supply. -The pharmacy received an order for lorazepam	D 394		

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D 394	Continued From page 223 0.5mg every 4 hours dated 03/19/25 -No lorazepam tablets had been returned to the pharmacy for destruction. Interview with a MA on 09/29/25 at 9:53am revealed she did not recall destroying controlled substances for Resident #10. Interview with the RCC on 09/29/25 at 12:15pm revealed: -Resident #10's lorazepam tablets were destroyed in the drug buster. -She did not document the destruction of the lorazepam tablets -She did not have anyone witness the destruction of the lorazepam. Refer to the telephone interview with the pharmacist at the facility's contracted pharmacy on 09/29/25 at 10:32am. Refer to the interview with a MA on 09/29/25 at 9:53am. Refer to the interview with the RCC on 09/29/25 at 12:15pm. Refer to the interview with the Administrator on 09/26/25 at 4:00pm. _____ Telephone interview with the pharmacist from the facility's contracted pharmacy on 09/29/25 at 10:32am revealed: -The pharmacy did not accept any discontinued controlled substances to destroy. -It was the responsibility of the facility to destroy controlled substances properly. Interview with a MA on 09/29/25 at 9:53am revealed:	D 394		

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D 394	Continued From page 224 -Controlled medications were destroyed in the drug buster. -When controlled medications were destroyed, the staff member destroying the medication should count the number of pills or amount of medication to be destroyed in front of another staff member. -The number of pills, the name of the medication, and the resident's name should be documented on the CSCS sheet after the medications had been destroyed. -The CSCS should be signed by the person destroying the medications and a witness. -She had wasted medications before, but she always had a witness. -The RCC would discontinue the controlled substance in the eMAR, pull the controlled substance from the medication cart, and give the controlled substance to the MA to destroy. -She would destroy the medications in the drug buster while the RCC was in the room with her. Interview with the RCC on 09/29/25 at 12:15pm revealed: -She would document the number of tablets destroyed on the CSCS sheet. -All controlled substances were destroyed in the drug buster. -She destroyed all the controlled substances that remained at discharge or death. -She destroyed more than a single dose. -She did not realize at the time of the destruction of the controlled substances that she needed a witness when destroying the controlled substances. Interview with the Administrator on 09/26/25 at 4:00pm revealed: -When controlled substances were delivered to the facility, the RCC was responsible for adding	D 394		

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D 394	Continued From page 225 the number of pills delivered to the CSCS. -When a controlled substance was administered, the MA would document on the electronic CSCS the number of pills that were administered. -If the controlled substance was wasted, the MA should have a witness watch her waste the medication and sign the CSCS with her. -The RCC must have a witness when controlled substances were wasted. -Based on the facility's policy, only single-dose medication could be wasted.	D 394		
D 406	10A NCAC 13F .1009 (b) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to follow up on a pharmacy review recommendation for 1 of 4 sampled resident (#10). The findings are: Review of Resident #10's current FL-2 dated 10/14/24 revealed diagnoses included pleural effusion, hypertensive heart disease, atrial fibrillation, chronic kidney disease, osteoarthritis, hyperlipidemia, gastro-esophageal reflux disease (GERD), and anemia.	D 406		

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Review of Resident #10's pharmacy review dated 12/04/24 revealed:
-Resident #10 had an order for midodrine 5mg (used to treat hypotension) three times daily, scheduled at 8:00am, 2:00pm, and 8:00pm, and hold if the systolic blood pressure (SBP) was greater than 130.
-The last dose of midodrine should be taken 4 hours before bedtime because high blood pressure upon lying down could occur, which could cause blurred vision, headaches, and pounding in the ears while lying down after taking this medication.
-The pharmacist suggested changing the administration times of midodrine to 8:00am, 12:00pm, and 5:00pm to prevent elevations in supine blood pressure.
-There was an area on the pharmacy medication review for the Primary Care Provider (PCP) to respond to the recommendation by checking accept or deny, and for the PCP's signature.
-The pharmacy medication review dated 12/04/24 had not been responded to by the PCP and had not been signed.

Review of Resident #10's review dated 03/05/25 revealed:
-Resident #10 had an order for a lorazepam 0.5mg (used to treat anxiety) tablet, take ½ tablet (0.25mg) every 8 hours for anxiety, but was being administered at 9:00am, 3:00pm, and 9:00pm; this schedule was three times daily, not every 8 hours.
-Please consider clarifying the order to be three times daily instead of every 8 hours.
-There was an area on the pharmacy medication review for the PCP to respond to the recommendation by checking accept or deny, and for the PCP's signature.
-The pharmacy medication review dated 03/05/25

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D 406	Continued From page 227 had not been responded to by the PCP and had not been signed. Interview with the Resident Care Coordinator (RCC) on 09/26/25 at 9:10am revealed: -The Administrator was responsible for faxing the pharmacy review recommendations to the PCP. -Once the pharmacy review recommendations had been reviewed and signed by the PCP, she or the Special Care Unit Coordinator (SCC) would fax any new orders to the pharmacy if needed. -She did not know if anyone was responsible for following up to ensure the pharmacy review recommendations were reviewed and returned to the facility by the PCP. Interview with the Administrator on 09/26/25 at 4:00pm revealed: -The RCC and SCC were responsible for getting the pharmacy medication review recommendations to the PCPs for review. -If the PCPs did not return the pharmacy medication review form, she expected the RCC and SCC to follow up on the recommendations. -Once the recommendation was returned to the facility and there were orders on the recommendation, the RCC or the SCC would fax the recommendations to the pharmacy to be entered onto the electronic medication administration record (eMAR).	D 406		
D 482	10A NCAC 13F .1501 (a) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501Use Of Physical Restraints And Alternatives (a) An adult care home shall assure that a physical restraint, any physical or mechanical	D 482		

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D 482	Continued From page 228 device attached to or adjacent to the resident's body that the resident cannot remove easily and that restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms for which the resident's physician or physician extender has determined warrant the use of restraints and not for discipline or convenience purposes; (2) used only with a written order from a physician or physician extender except in emergencies where the health or safety of the resident is threatened, according to Paragraph (d) of this Rule; (3) the least restrictive restraint that would provide a safe environment for the resident and prevent physical injury; (4) used only after alternatives that would provide a safe environment for the resident to prevent physical injury and prevent a potential decline in the resident's functioning have been tried and documented by the administrator or their designee in the resident's record as being unsuccessful; (5) used only after an assessment and care planning process has been completed, except in emergencies where the health or safety of the resident is threatened, according to Paragraph (d) of this Rule; (6) applied correctly according to the manufacturer's instructions and the physician's or the physician extenders' order; and (7) used in conjunction with alternatives in an effort to reduce restraint use. For the purposes of this Rule, "physician extender" means a licensed physician assistant or licensed nurse practitioner. Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident	D 482		

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D 482	Continued From page 229 while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to obtain a physician's order for the use of physical restraints for 1 of 1 sampled resident (#5) related to pushing the resident up to a table and locking her wheelchair brakes to prevent falls. The findings are: Review of the facility's undated Physical Restraint policy revealed: -The use of physical restraints referred to the application of a physical or mechanical device attached to or adjacent to the resident's body that the resident could not remove easily, which restricted freedom of movement or normal access to getting out of bed, as opposed to enhancing mobility of the resident while in bed. -Except in emergencies, residents should be physically restrained only with a written order from a physician. -Restraints could not be used for discipline or staff convenience. -The restraint could only be applied for medical	D 482		

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symptoms such as, but not limited to, confusion with risk of falls and risk of abuse or injurious behaviors to self.
-Except in the event of an emergency, an alternative must be tried and documented.
-If alternatives to physical restraints failed, the least restrictive restraint would be used, as appropriate within the immediate circumstances.
-Restraints would be verified that they were applied correctly in accordance with the physician's orders and used in conjunction with alternatives in an effort to reduce the use of the restraints.
-During restraint usage, staff would document the care that was provided to residents during the time of the restraint usage and the behaviors of the resident during the use of the restraints.
-A restraint assessment and care plan would be completed.
-The decision for restraints would be a team decision.
-Emergency restraints would only be used in a temporary situation, and the physician would be notified within 24 hours.
-Physical restraints would only be applied by staff who had received training.

Review of Resident #5's FL2 dated 03/09/25 revealed:
-Diagnoses included dementia, hypertension, and chronic obstructive pulmonary disease (COPD).
-She was intermittently disoriented.
-She required staff assistance with bathing and dressing.
-She was semi-ambulatory.
-She was incontinent of bowel and bladder.
-Level of care was Special Care Unit (SCU).
-There was no order for a restraint.

Review of Resident #5's care plan dated 08/11/25

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revealed:
-She required limited staff assistance with eating.
-She was independent with toileting, ambulation, and transferring.
-She required supervision from staff for bathing, dressing, and grooming.
-There was no documentation for an assessment of a restraint.

Review of Resident #5's Licensed Health Professional Support (LHPS) evaluation dated 09/16/25 revealed:
-Personal care tasks included ambulation using assistive devices that required physical assistance and transferring semi-ambulatory or non-ambulatory residents.
-The type of assistive device required for ambulation was a wheelchair.
-The type of transfer assistance was from the bed to the chair/chair to the bed.
-The type of assistance required by staff for transferring was a one-person assist.
-She leaned forward at all times.
-Resident #5 had 11 falls since the last LHPS evaluation dated 03/11/25.
-There was a section for the types of restraints used (least restrictive); lap tray, lap cushion, and wedge cushion were listed as an option, but not checked as used.
-There were no other restraints listed.
-There was a section for the frequency the restraint was checked and released, but there was no documentation.
-There was a section for the reasons for the use of restraints; to prevent falls and to prevent sliding from a chair were listed but not checked as used.
-There was a section for residents' response to the restraint, but there was no documentation the resident was assessed.
-Resident #5 required assistance with ambulation

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and transfers with one-person assistance.

Review of Resident #5's progress notes, incident and accident reports, and 72-hour reports from 03/14/25-09/18/25 revealed:
-Resident #5 had documented falls on 03/14/25, 03/23/25, 06/07/25, 06/27/25, 07/07/25, 07/27/25, 08/12/25, 08/16/25, 09/09/25, and 09/18/25.
-On 09/03/25, Resident #5 was going to be discharged from physical therapy services in two weeks due to lack of participation and failure to thrive and showed no interest in attempting physical therapy.
-There was no documentation about the use of restraints.

Review of Resident #5's primary care provider's (PCP) after-visit summaries from 07/14/25-09/22/25 revealed there were no orders or discussion related to restraints.

Observation of Resident #5 on 09/24/25 at various times from 7:34am-12:47pm revealed Resident #5 was sitting in her wheelchair and had her head lying on the table in the day room; her wheelchair brakes were locked.

Observation of Resident #5 on 09/25/25 at various times from 9:11am-11:45am revealed Resident #5 was sitting in her wheelchair had her head lying on the table in the day room; her wheelchair brakes were locked.

Confidential interview with staff revealed:
-Resident #5 laid her head on the table all day; that was all she did.
-Resident #5 was kept at the table to keep her from falling.

Interview with a personal care aide (PCA) on

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09/24/25 at 8:35am revealed:
-Resident #5 would "fold in half" if she were not placed at the table.
-Resident #5 had several falls.
-A cloth was put on the table to keep Resident #5 from hitting her head.
-Resident #5 could not unlock her wheelchair brakes.

Interview with another PCA on 09/24/25 at 9:29am and 12:16pm revealed:
-Resident #5 was not in bed because she was a fall risk.
-The table kept Resident #5 from falling.
-Resident #5 had a blanket under her head at the table so her face did not hit the table.
-She did not want Resident #5 to fall when she leaned over too far in her wheelchair.

Interview with a third PCA 09/24/25 at 11:30am revealed:
-Resident #5 was put at the table because her bend had gotten worse; her "posture was gone".
-Resident #5 would roll over and fall out of her wheelchair.
-The table kept Resident #5 from falling.

Interview with a fourth PCA on 09/29/25 at 8:36am revealed:
-He had only worked at the facility for about 3 weeks, and he had observed Resident #5 leaning forward in her wheelchair; she had bad posture.
-Resident #5 was pushed all the way up to the table and her wheelchair brakes were locked on 09/18/25.
-Resident #5 then pushed herself away from the table and fell out of her wheelchair.

Interview with a medication aide (MA) on 09/25/25 at 10:26am revealed:

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-If Resident #5 was in bed, she would try to get up.
-Resident #5's family wanted the resident in the day room for staff to watch her.
-When Resident #5 was sitting in her wheelchair, she leaned forward.
-If Resident #5 was not positioned at the table, she would fold in half (lean forward with her head on her knees).
-They were trying to prevent falls from Resident #5 leaning over too far.
-Resident #5 had a blanket laid on the table for her comfort.
-If the blanket was not on the table, Resident #5 would lay her head flat on the table.
-If Resident #5 was transferred to a regular chair, she would still lean forward.
-Resident #5 sat at the table every day.
-Resident #5 could move away from the table if she really tried, but she did not think the resident had the strength to do so.
-Resident #5 could not unlock her wheelchair brakes herself.

Interview with another MA on 09/25/25 at 10:26am revealed:
-Resident #5 needed to be somewhere she could be watched at all times.
-Staff knew they had to watch Resident #5 to keep her safe.
-Staff tried their best to keep Resident #5 comfortable in her position.
-We put a blanket on the table to keep Resident #5 comfortable.
-Resident #5 was pushed up to the table so she had somewhere to lay her head.
-If Resident #5 was not at the table, she would lie forward "way down" in her wheelchair.
-When Resident #5 laid down in her wheelchair, she could fall, and that was why the staff pushed

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her up to the table; "we do not want her to fall".
-Resident #5 could not unlock her wheelchair brakes.
-Most of the time, staff did not lock Resident #5's wheelchair brakes because that would be considered a restraint.
-If Resident #5's wheelchair brakes were locked and staff saw her starting to move, the staff would then unlock the brakes for her.

Telephone interview with Resident #5's mental health provider on 09/24/25 at 11:03am revealed:
-Resident #5 was not placed in bed because the resident would try to get up and have a fall.
-Locking the wheels on wheelchairs was the facility's protocol.
-If a resident was at risk for falls, you would want to lock the wheels.
-She thought Resident #5 was parked at the table so she could lie her head down if she wanted to.
-Parking Resident #5 at the table could be considered a restraint, but what was the alternative?
-Resident #5 was now at a place where, with her head always down and requiring total care, the resident might need a higher level of care.

Interview with the Special Care Unit Coordinator (SCC) on 09/25/25 at 11:15am revealed:
-Resident #5's wheels were locked because if they were not, she would roll back.
-Resident #5 would be able to push herself away from the table and would then "fold over," and because she would be leaning too far, she would fall.
-Resident #5 could unlock her wheelchair brakes herself.
-Resident #5 had unlocked her wheelchair herself; she did not know if she had any falls after unlocking the wheelchair brakes.

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D 482	Continued From page 236 Telephone interview with the facility's Clinical Nurse Consultant on 09/29/25 at 2:39pm revealed: -She completed an LHPS assessment on Resident #5 on 09/16/25. -Resident #5 was sitting in her wheelchair and was leaning forward, but not all the way over. -Resident #5 was not at the table and her brakes were not locked. -If Resident #5 could not release her brakes, sitting her at a table with the brakes locked would be considered a restraint. Telephone interview with Resident #5's Occupational Therapist (OT) on 09/29/25 at 4:01pm revealed: -Resident #5 had recently been discharged from OT services, but he was not sure of the date. -He did not think Resident #5 had the capacity to unlock her wheelchair brakes. Interview with the Administrator on 09/29/25 at 5:40pm revealed: -A resident had to be able to unlock their wheelchair brakes, or it would be considered a restraint. -She did not know if Resident #5 could lock or unlock her wheelchair brakes without assistance. -She was concerned that Resident #5 was being confined to her wheelchair and table. -Had she known, she would have educated the staff, because it was considered a restraint, and she would have told them to stop. -The family did not want Resident #5 in the bed. -The family told the SCC they could not afford sitters to have 1:1 care. -The sitters may have been suggested to prevent falls, but she was not sure.	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL091-012	A. BUILDING: _____ B. WING _____	R-C 09/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BRIDGES ON PARKVIEW	105 PARKVIEW DR E HENDERSON, NC 27536

(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 482	Continued From page 237 Based on observations, interviews, and record reviews, it was determined Resident #5 was not interviewable. Attempted telephone interview with Resident #5's physical therapist (PT) on 09/29/25 at 1:32pm was unsuccessful. Attempted telephone interviews with Resident #5's PCP on 09/25/25 at 8:31am and 09/29/25 at 1:37pm were unsuccessful.	D 482		