STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL-013049	A. BUILDING: _____ B. WING _____	R-C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE DRAKE	1195 DRAKE MILL LANE SW CONCORD, NC 28025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure section and the Cabarrus County Department of Social Services conducted a complaint investigation and follow up survey on 09/30/25 through 10/02/25.	D 000		
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	D 259		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL-013049	A. BUILDING: _____ B. WING _____	R-C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE DRAKE	1195 DRAKE MILL LANE SW CONCORD, NC 28025

(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 259	Continued From page 1	D 259		

associated physical or mental limitations warranting the provision of the personal care services in the above care plan in accordance with G.S. 131D-2.15. This shall not apply to residents assessed through the Medicaid State Plan Personal Care Services Assessment for the portion of the assessment covering tasks needed for each activity of daily living of this Rule for which care planning and signing are directed by Medicaid.

This Rule is not met as evidenced by:
Based on observations record reviews and interviews, the facility failed to have an admission care plan signed by the assessor and signed by the Primary Care Provider within 15 days following completion for 1 of 6 sampled residents (#1).

The findings are:
Review of Resident #4's current FL2 dated 08/26/25 revealed:
-Diagnoses included severe late onset Alzheimer's dementia with agitation.
-She was ambulatory.
-She was intermittently disoriented.
-Her level of care was Special Care Unit (SCU).

Review of Resident #4's Resident Register dated 08/03/25 revealed an admission date of 08/01/25.

Review of Resident #4's admission care plan dated 0807/25 revealed:
-She was ambulatory without a device.
-She was oriented.
-She had significant memory loss and needed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL-013049	A. BUILDING: _____ B. WING _____	R-C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE DRAKE	1195 DRAKE MILL LANE SW CONCORD, NC 28025

(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 259	Continued From page 2 redirection. -The care plan was not signed by the assessor or the Primary Care Provider (PCP). Interview with the Administrator on 10/01/25 at 10:23am revealed: -Resident #4 used an outside PCP and the care plan was sent to the PCP for his signature but the facility had not received the care plan back. -The Special Care Coordinator (SCC) was responsible for completing the care plan and ensuring signatures were on the care plan within the required timeframe. -The SCC was hired after Resident #4's admission care plan was completed so the Resident Care Coordinator (RCC) was responsible to complete the care plan. Interview with the RCC on 10/02/25 at 10:52 revealed she gave the care plan to Resident #4's responsible party in August 2025 who was going to take it to the PCP to get it signed. Interview with the Administrator on 10/02/25 at 2:00pm revealed: -The RCC and the SCC were responsible for ensuring their signatures are on the care plan and the PCP signed the care plan within 15 days from its completion date.	D 259		
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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL-013049	A. BUILDING: _____ B. WING _____	R-C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE DRAKE	1195 DRAKE MILL LANE SW CONCORD, NC 28025

(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 270	Continued From page 3	D 270		

This Rule is not met as evidenced by:
Follow up to A1 Violation

Based on these findings, the previous A1 violation was not abated.

Based on observations, record reviews and interviews, the facility failed to provide supervision for 1 of 6 sampled residents who eloped from the facility without staff knowledge and was found outside of the building attempting to re-enter the building through a fire exit door located in the Special Care Unit (SCU).

The findings are:

Review of Special Care Unit Safety Measures-Wandering Residents /Door Codes revealed:
- "We" (the facility) identify residents who walk or wheel around unrestricted and are a threat to the leave the community unattended due to their confusion.
-After admissions - safeguards/assessments will be as follows:
-Inform staff upon admission and as necessary if the potential exists for a resident to wander.
-Perform a reassessment and change the care plan accordingly when significant changes occur which may indicate the potential for a Resident to wander.
- "We" (the facility) will practice the following Environment Safeguards:
-The Community will check the operations of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL-013049	A. BUILDING: _____ B. WING _____	R-C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE DRAKE	1195 DRAKE MILL LANE SW CONCORD, NC 28025

(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 270	Continued From page 4	D 270		

Mag Lock door security system, window systems and gate systems to ensure proper working order twice weekly.
-Guidelines for door codes in Special Care Unit:
-It is the policy of the Community to always maintain the safety of our Residents and Staff.
-The Community is equipped with Magnetic Locks that require door codes for exit and entry into the building. Door Codes will be provided to current employees only and are not to be shared with Residents, family members, or anyone not currently employed by the Community ...and are required to keep door codes confidential.
-Door Codes will be changed after an employee termination and anytime the code has been acquired by any person other than an employee.

Review of Resident #4's current FL2 dated 08/26/25 revealed:
-Diagnoses included severe late onset Alzheimer's dementia with agitation.
-She was ambulatory.
-She was intermittently disoriented.
-Her level of care was Special Care Unit (SCU).

Review of Resident #4's Resident Register dated 08/03/25 revealed an admission date of 08/01/25.

Review of Resident #4's care plan dated 10/1/25 revealed:
-She was ambulatory without a device.
-She had a history of wandering behaviors.
-She was resistant to care.
-She was always disoriented.
-She had significant memory loss and needed redirection.

Review of Resident #4's Accident and Incident report dated 09/26/25 2:55pm revealed:
-Description of the incident was documented as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL-013049	A. BUILDING: _____ B. WING _____	R-C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE DRAKE	1195 DRAKE MILL LANE SW CONCORD, NC 28025

(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 270	Continued From page 5 Elopement, 09/26/2025 at 2:40pm near fire exit door. -Type of incident was documented as Elopement-Resident #4 went through exit door. -Location of incident was documented as outside on facility grounds. -It was not witnessed by a staff member. -She was located by the Facility Manager. -Resident #4 was observed alone, holding onto the door handle outside of the SCU fire exit door. -Resident #4 did not have any negative outcome related to the incident and first aid was not administered. -Resident #4 was able to state her name and answer. -She was not seen by her Primary Care Provider (PCP) after the incident. -Additional follow-up was documented as elopement notification to the Primary Care Provider (PCP) and update the care plan. -The PCP, Administrator and Resident #4's responsible party were documented as notified. Interview with the Special Care Coordinator (SCC) on 10/01/25 at 11:37am and 2:55pm revealed: -She was working when Resident #4 eloped from the SCU. -Resident #4 liked to stand by the fire exit door in the SCU. -The Facility Manager brought Resident #4 back into the SCU. -Resident #4 was not injured. -The door was always locked via a magnetic lock and could only be unlocked with a code but did not have an alarm on the door at the time Resident #4 eloped. -She did not know what the code was to the door to unlock it. -She did not know how Resident #4 was able to	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL-013049	A. BUILDING: _____ B. WING _____	R-C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE DRAKE	1195 DRAKE MILL LANE SW CONCORD, NC 28025

(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 270	Continued From page 6	D 270		

elope from the SCU.

Interview with a medication aide (MA) on 10/01/25 at 1:15pm revealed:
-On 09/26/25 she was working in the SCU when Resident #4 eloped.
-She was at the medication cart when Resident #4 was standing by her and she asked Resident #4 how she was feeling, and if she wanted to listen to music or watch television.
-Resident #4 did not respond and she was not agitated but just walked away.
-Approximately five minutes later the Facility Manager brought Resident #4 back to the SCU and told her Resident #4 was located outside the building by the fire exit door pushing on the door handle trying to get inside.
-She asked Resident #4 if she was ok and Resident #4 responded "yes".
-She asked Resident #4 how she got outside, and Resident #4 responded "I don't know".
-Resident #4 had a history of going to the back exit door at times.
-Prior to the elopement the door would lock via means of a magnetic lock which needed a code to open the door.
-A sounding alarm was installed after the elopement in addition to the magnetic lock.

Interview with the Facility Manager on 10/01/25 at 1:37pm revealed:
-On 09/26/25 he left the building and walked out to his car which was facing the side of the building by the SCU.
-He did not see anyone in the parking lot.
-He was sitting in his car when he looked up and saw Resident #4 standing by a SCU exit door trying to get in.
-He walked Resident #4 around to the front entrance doors and brought Resident #4 back to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL-013049	A. BUILDING: _____ B. WING _____	R-C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE DRAKE	1195 DRAKE MILL LANE SW CONCORD, NC 28025

(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 270	Continued From page 7	D 270		

the SCU.

Interview with the Maintenance Manager on 10/01/25 at 3:04pm revealed:
-Prior to 09/26/25 there was a code that was required to open the door which released the magnetic lock with no alarm.
-He, along with the Administrator, checked all doors after the incident and the doors were working properly.
-He was not sure how Resident #4 got out of the building.

Interview with the Administrator and the Facility Manager on 10/1/25 at 3:15pm revealed the Administrator stated that the resident was gone a maximum of 15 minutes per her interview with the personal care aide (PCA).

Telephone interview with a personal care aide (PCA) on 10/01/25 at 4:42pm revealed:
-She was working the day Resident #4 eloped.
-She was doing rounds, picking up trash and observed Resident #4 by the exit doors that opened to the assisted living (AL).
-She checked on the residents every 30 minutes to one hour but did not document the checks.
-Resident #4 would stand by the exit doors in the SCU and would push on the doors, she would re-direct Resident #4 away from the doors.
-She was not sure what door Resident #4 used when she eloped from the facility.

Telephone interview with a second PCA on 10/01/25 at 4:54pm revealed:
-She was working the day Resident #4 eloped from the facility.
-She had been walking back from the AL side and one of her coworkers told her that Resident #4 left the building by exiting out one of the SCU

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL-013049	A. BUILDING: _____ B. WING _____	R-C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE DRAKE	1195 DRAKE MILL LANE SW CONCORD, NC 28025

(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 270	Continued From page 8	D 270		

back exit doors.
-She saw the Administrator in the SCU who asked her to complete a head count on the residents.
-Resident #4 liked to "hang out" by the back doors.
-After the elopement she asked Resident #4 how she got out and Resident #4 replied "the door".
-She asked Resident #4 to show her how she got out and she pushed on the door, and the door was locked.
-To her knowledge no one used the fire exit doors in the SCU.

Second interview with the second PCA on 10/02/25 at 12:41pm revealed:
-When Resident #4 would get agitated, she would go to the exit doors on the SCU and stare out the window.
-She did not recall if Resident #4 was irritated the day of the elopement.
-She checked on residents 30 to 60 minutes.

Interview with the SCC on 10/02/25 at 1:05pm revealed she was not sure how often to check on the residents but thought 30-minute checks seemed appropriate.

Telephone interview with a third PCA on 10/02/25 at 1:45pm revealed:
-She worked second shift on 09/26/25 in the SCU.
-Resident #4 liked to stand by the fire exit doors and we would redirect Resident #4 and guide her away from the doors, asking Resident #4 to go for a walk with them or get her interested in something else.

Interview with the Administrator on 10/02/25 at 2:00pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL-013049	A. BUILDING: _____ B. WING _____	R-C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE DRAKE	1195 DRAKE MILL LANE SW CONCORD, NC 28025

(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 270	Continued From page 9 -She was made aware of Resident #4 being outside by the exit door by the Facility Manager who saw Resident #4 and brought her back inside. -Based on the interviews she completed with staff after Resident #4 eloped it was determined Resident #4 was missing a maximum of 15 minutes before she was brought back inside by the Facility Manager. Attempted telephone interview with Resident #4's PCP on 10/02/25 at 12:09pm was unsuccessful. Based on observations, interviews and record reviews it was determined that Resident #4 was not interview able. _____ The facility failed to provide supervision for Resident #4 who had a diagnosis of dementia and resided in the special care unit which resulted in Resident #4 eloping from the building without staff knowledge and was found outside near the parking lot attempting to get back into the building. The facility's failure resulted in serious neglect which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on October 1, 2025.	D 270		
D 328	10A NCAC 13F .0906(f)(4) Other Resident Care and Services 10A NCAC 13F .0906 Other Resident Care and Services (f) Visiting: (4) If the whereabouts of a resident are unknown and there is reason to be concerned about his	D 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL-013049	A. BUILDING: _____ B. WING _____	R-C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE DRAKE	1195 DRAKE MILL LANE SW CONCORD, NC 28025

(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 328	Continued From page 10	D 328		

safety, the person in charge in the home shall immediately notify the resident's responsible person, the appropriate law enforcement agency and the county department of social services.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to notify the local county Department of Social Services (DSS) of an incident involving 1 of 6 sampled residents (Resident #4) who eloped from the facility.

The findings are:

Review of the facility's undated Missing Resident Policy revealed:
-It is the community's policy to provide the safety and security of each Resident. To that end, each entry/exit door is equipped with a magnetic lock system keypad.
-In the event of a suspected missing Resident, a Resident will be considered missing when he/she is not in the community and we cannot determine his/her whereabouts.
-If the community discovers a Resident missing, they are to notify the supervisor and all other staff immediately.
-If a Resident is not found within 30 minutes, we will notify local law enforcement, the Residents family member/responsible person, the County Department of Social Services (DSS).
-Post notifications - Staff will assure that required agencies are notified and an accident/incident report is sent to DSS within 48 hours in the even medical intervention greater that first aid was provided.

Review of Resident #4's current FL2 dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL-013049	A. BUILDING: _____ B. WING _____	R-C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE DRAKE	1195 DRAKE MILL LANE SW CONCORD, NC 28025

(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 328	Continued From page 11 08/26/25 revealed: -Diagnosis included severe late onset Alzheimer's dementia with agitation. -She was ambulatory. -She was intermittently disoriented. -Her level of care was Special Care Unit (SCU). Review of Resident #4's Resident Register dated 08/03/25 revealed an admission date of 08/01/25. Review of Resident #4's care plan dated 10/1/25 revealed: -She was ambulatory without a device. -She wandered. -She resisted care. -She was always disoriented. -She had significant memory loss and needed redirection. Review of Resident #4's Accident and Incident report dated 09/26/25 2:55pm revealed: -Resident eloped on 09/26/25 at 2:40pm, fire exit door. -It was not witnessed by a staff member. -She was found by the Manager. -Resident was observed alone, holding onto the building door handle outside of the SCU fire exit door. -Resident did not have any negative outcome related to the incident and first aid was not administered. -Resident was able to state her name and answer. -She was not seen by her Primary Care Provider (PCP) after the incident. Interview with the Special Care Coordinator (SCC) on 10/01/25 at 11:37am and 2:55pm revealed: -She was working when Resident #4 was	D 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL-013049	A. BUILDING: _____ B. WING _____	R-C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE DRAKE	1195 DRAKE MILL LANE SW CONCORD, NC 28025

(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 328	Continued From page 12	D 328		

observed outside the exit door of the SCU.
-Resident #4 would like to stand by the exit door.
-The Manager brought Resident #4 back into the SCU.
-Resident #4 was not injured.
-The door is always locked and can only be unlocked with a code there was no alarm on the door at the time Resident #4 eloped.
-She did not know what the code was to the door to unlock it.
-She was not sure how Resident #4 got out the locked door outside of the building.

Interview with a medication aide (MA) on 10/01/25 at 1:15pm revealed:
-On 09/26/25 she was working in the SCU when Resident #4 eloped.
-She was at the medication cart when Resident #4 was standing by her and she asked Resident #4 how she was feeling, if she wanted to listen to music or watch television.
-Resident #4 did not respond, she was not agitated and just walked away.
-Approximately five minutes later the Manager brought Resident #4 back to the memory care unit and told her Resident #4 was outside the building.
-She asked Resident #4 if she was ok and Resident #4 responded "yes".
-She asked Resident #4 how she got outside, and Resident #4 responded "I don't know".

Interview with the Administrator on 10/02/25 at 2:00pm revealed:
-The person who witnessed the incident was responsible for filling out the incident report, in this case with Resident #4 she instructed the MA to complete the incident report.
-The SCC or the Administrator would review the incident report for completeness, and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL-013049	A. BUILDING: _____ B. WING _____	R-C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE DRAKE	1195 DRAKE MILL LANE SW CONCORD, NC 28025

(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 328	Continued From page 13 Administrator was responsible for sending it to DSS. -She was told by upper management that she did not need to send the report to DSS because Resident #4 did not leave the grounds, was not injured, and did not receive anything greater than first aid. -It was determined based on interviews that Resident #4 was missing for approximately 15 minutes or less.	D 328		
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 A1 VIOLATION Based on record review and interviews, the facility failed to ensure residents were treated with dignity and respect related to 1 of 6 sampled residents (#1), who was receiving end-of-life care at the facility and was sent to the hospital, which was against her wishes documented in her Hospice plan of care. The findings are: Review of Resident #1's most current FL2 dated 09/12/24 revealed: -Resident #1's diagnoses included Alzheimer's dementia, bipolar disorder, type II diabetes, hypertension, and hypercholesterolemia. -Resident #1 was semi-ambulatory.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL-013049	A. BUILDING: _____ B. WING _____	R-C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE DRAKE	1195 DRAKE MILL LANE SW CONCORD, NC 28025

(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 338	Continued From page 14 -Resident #1 had intermittent disorientation. -Resident #1 resided in the Special Care Unit (SCU). Review of Resident #1's Resident Register revealed an admission date of 10/09/23. Review of Resident #1's record revealed: -Resident #1 was admitted to hospice care (end-of-life care) on 06/06/25 for symptom management, comfort, anxiety, behaviors/ mood, atrophy (over-all decline), fall prevention, confusion, combativeness, and increased drowsiness/sleep. -Resident #1 was at risk for falls and had recent falls on 08/02/25, 08/05/25, and 08/12/25. -Resident #1's fall reports and progress notes (08/01/25 - 08/19/25) documented her code status as "full code" (meaning she was to receive lifesaving efforts and treatment in the event she stopped breathing). -There was a "Do Not Resuscitate" (DNR) order form signed by the facility nurse practitioner (NP) that was not dated. -Resident #1 was transferred from the facility to the emergency department (ED) post fall on 08/12/25. -There was documentation the facility notified hospice and Resident #1's Power of Attorney (POA) that Resident #1 had an unwitnessed fall and was transferred to the ED on 08/12/25. Review of Resident #1's Hospice plan of care goals dated 08/08/25 revealed: -Resident #1 had a DNR located on her chart. -Resident #1 was to receive comfort-directed care. -Resident #1 was to receive no resuscitation. -Resident #1 was to have no further hospitalizations.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL-013049	A. BUILDING: _____ B. WING _____	R-C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE DRAKE	1195 DRAKE MILL LANE SW CONCORD, NC 28025

(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 338	Continued From page 15	D 338		

-Resident #1 was to have no invasive procedures.
-Resident #1 was to remain at the facility until end of life.
-Staff were able to safely administer medications at the facility.
-There was documentation the care plan was reviewed with the Administrator and facility staff.

Review of Resident #1's Hospice visit note dated 08/11/25 revealed Resident #1 was transitioning towards end-of-life and there was documentation Resident #1's hospice plan of care was reviewed with the Administrator and facility staff.

Review of the "Continuity of Care Document" (transfer summary) that accompanied Resident #1 to the hospital, dated 08/12/25 revealed:
-There was inaccurate documentation that Resident #1 was a "full code."
-There was no documentation of a DNR code status.
-There was no documentation Resident #1 was under hospice care.

Review of the hospital discharge summary dated 08/13/25 revealed:
-Resident #1 presented at the ED via emergency medical services (EMS) on 08/12/25 post fall at the facility.
-Resident #1's code status was "full code".
-Resident #1's discharge diagnoses included a new/ worsening fractured femur, urinary tract infection "UTI", right upper face abrasion, lower left arm wound and tailbone wound.
-Resident #1 was treated with IV fluids.
-Resident #1 was admitted to the hospital from the ED.
-The Attending physician was later informed Resident #1 was under hospice care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL-013049	A. BUILDING: _____ B. WING _____	R-C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE DRAKE	1195 DRAKE MILL LANE SW CONCORD, NC 28025

(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 338	Continued From page 16 -The POA did not want Resident #1 to be admitted to the hospital, did not want Resident #1 treated for the UTI, and wanted Resident #1 discharged back to the facility with hospice care. -Resident #1 was to be discharged back to the facility without oral antibiotics per POA's request. Review of the Administrator's progress note dated 08/12/25 revealed: -The Administrator spoke with Resident #1's POA regarding plans for Resident #1 to discharge from the hospital back to the facility. -The Administrator informed Resident #1's POA that Resident #1could not return to the facility with an untreated UTI. -The Administrator would follow-up with hospice regarding a possible move to inpatient hospice care. Telephone interview with Resident #1's POA on 09/30/25 at 10:37am revealed: -She was contacted by the facility's Resident Care Coordinator (RCC) on 08/12/25 and was informed Resident #1 had a fall, hit her head, and was being sent to the ED. -Resident #1 was transported to the ED without her DNR document and without documentation Resident #1 was receiving hospice care or that she was transitioning towards end-of-life. -She did not want Resident #1 sent to the hospital and preferred to have a hospice visit to evaluate after the fall. -She was contacted by the ED physician and was told Resident #1 may have a UTI. -She informed the ED physician that Resident #1 was under hospice care, had a DNR, was not to receive treatment for the UTI, and not receive any life sustaining efforts. -The hospital NP contacted the facility to discuss transferring Resident #1 back to facility and was	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL-013049	A. BUILDING: _____ B. WING _____	R-C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE DRAKE	1195 DRAKE MILL LANE SW CONCORD, NC 28025

(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 338	Continued From page 17	D 338		

told Resident #1 could not return to the facility unless she was treated at the hospital for the UTI.
-She spoke with the RCC who informed her Resident #1 could not return to the facility unless she was treated at the hospital.
-She stated she was very upset, then contacted hospice and discussed her wishes for Resident #1 not to be treated with antibiotics and to receive comfort measures through hospice.
-She agreed to have Resident #1 transferred to inpatient hospice care when transportation was available on 08/13/25.

Interview with the medication aide (MA) on 10/01/25 at 11:36am revealed:
-She was working when Resident #1 had a fall on 08/12/25 and sustained an abrasion to her forehead.
-The personal care aides (PCAs) informed her Resident #1 had an unwitnessed fall and was on the floor in the Quiet Room.
-She went to the Quiet Room, found Resident #1 lying on her stomach and did not appear to be in any obvious distress besides an abrasion or rug burn on her forehead.
-She contacted hospice and the POA to inform them of the fall.
-She recalled that the POA agreed to whatever plan hospice would recommend.
-The RCC approved Resident #1's transfer to the ED and she contacted EMS.
-She printed Resident #1's Continuity of Care Document and face sheet before EMS arrived at the facility to transport Resident #1 to the ED.
-Resident #1 was transported to the ED before the hospice nurse arrived at the facility.
-She could not recall if Resident #1's code status or hospice information was listed on the Continuity of Care Document since the medical information is pulled from a computer system and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL-013049	A. BUILDING: _____ B. WING _____	R-C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE DRAKE	1195 DRAKE MILL LANE SW CONCORD, NC 28025

(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 338	Continued From page 18	D 338		

populates the document.
-She did not see a DNR order in the DNR folder for Resident #1.

Telephone interview with the Hospice Social Worker on 09/30/25 at 4:10pm revealed:
-She visited Resident #1 twice monthly and was visiting the facility on 08/12/25.
-Resident #1 had a code status of DNR before she was admitted to hospice services on 06/06/25.
-She spoke with the POA who was adamant she did not want Resident #1 sent to the hospital, post fall and wanted the hospice nurse to assess the resident.
-The hospital NP contacted her and informed her the facility would not accept Resident #1 for readmission unless she was treated for her UTI.
-The hospital NP recommended Resident #1 transfer to inpatient hospice care since the facility would not accept readmission unless she was treated.
-Resident #1 was subsequently transferred to inpatient hospice care on 08/13/25 to receive comfort care.

Telephone interview with the hospice Team Manager on 09/30/25 at 3:30pm revealed:
-Hospice received a phone call on 08/12/25 from the facility and was informed Resident #1 had an unwitnessed fall, hit her head.
-The assigned nurse was dispatched to the facility to assess the Resident #1 post fall.
-Resident #1 was sent to the ED before the assigned hospice nurse arrived at the facility to assess the resident.
-Resident #1 was diagnosed with a fractured femur and UTI at the hospital.
-The hospital NP contacted the hospice Social Worker and informed her the facility would not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL-013049	A. BUILDING: _____ B. WING _____	R-C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE DRAKE	1195 DRAKE MILL LANE SW CONCORD, NC 28025

(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 338	Continued From page 19	D 338		

allow Resident #1 to return to the facility unless she was treated for the UTI.
-Resident #1's POA contacted the hospice Social Worker and informed her she did not want Resident #1 to be treated with antibiotics.
-The hospital NP contacted hospice and recommended Resident #1 be transferred to inpatient hospice care for comfort measures that included honoring the POA's wishes not to be treated with antibiotics.
-Resident #1 was transferred from the hospital to inpatient hospice care on 08/13/25 and subsequently died on 08/19/25.

Interview with the RCC on 10/01/25 at 11:50am revealed:
-She was covering both roles as RCC and SCC (Special Care Coordinator) from July 2025 through August 2025.
-She was working on 08/12/25 and was informed Resident #1 had an unwitnessed fall in the Quiet Room.
-She authorized Resident #1's transfer to the ED due to an unwitnessed fall.
-She later spoke with Resident #1's POA and informed her Resident #1 could not return to the facility unless she was treated for the UTI.
-She was aware the POA did not want Resident #1 treated for the UTI and wanted her to return to the facility.
-She and the Administrator went to visit Resident #1 on 08/13/25 and was told the resident was transferred to inpatient hospice care.
-She consulted with the Administrator before informing the POA the resident could not return to the facility until she was treated for the UTI.

Interview with the Facility Manager on 10/01/25 at 9:00am revealed:
-He was new in his role at the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL-013049	A. BUILDING: _____ B. WING _____	R-C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE DRAKE	1195 DRAKE MILL LANE SW CONCORD, NC 28025

(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 338	Continued From page 20	D 338		

-The RCC or SCC were responsible for auditing resident charts and updating the medical record.
-He did not know why Resident #1's Continuity of Care Document and medical record was showing the incorrect code status of "full code."
-He expected an accurate Continuity of Care Document, face sheet, DNR if applicable, and any other pertinent medical records to accompany residents who were transferred to the hospital.
-He did not know why Resident #1 was sent to the ED before hospice could arrive to assess her.

Interview with the Administrator on 10/03/25 at 12:55pm revealed:
-She was notified by the RCC that Resident #1 had an unwitnessed fall with a head injury and was sent to the hospital for evaluation.
-She was not aware the POA did not want Resident #1 sent to the hospital.
-She was aware Resident #1 was receiving hospice care and did not know she had a DNR.
-Continuity of Care Document, resident face sheet, medication list, and DNR if applicable, accompany all residents who are sent to the hospital.
-She did not know Resident #1 was sent to the hospital without her DNR and without documentation of hospice care.
-She could not locate the date when Resident #1 became a DNR.
-The RCC or SCC were responsible for updating resident records, including code status.
-She expected accurate medical records to be sent with residents who were transferred to the hospital.
-After she spoke with the RCC, she spoke with the POA and informed her Resident #1 needed to be treated for the UTI before she could return to the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL-013049	A. BUILDING: _____ B. WING _____	R-C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE DRAKE	1195 DRAKE MILL LANE SW CONCORD, NC 28025

(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 338	Continued From page 21 -Resident #1's POA did not want the resident treated for the UTI and wanted her discharged back to the facility with hospice. -She did not know Resident #1 was transitioning towards end-of-life before she was transferred from the facility to the ED. -She did not know Resident #1's rights were not maintained. -She expected all resident rights to be maintained. Attempted telephone interview with the hospital NP on 10/01/25 at 1:27pm and 10/02/25 at 12:46pm were unsuccessful. Attempted telephone interview to the facility NP on 10/01/25 at 1:20pm was unsuccessful. [Refer to tag 433, 10A NCAC 13F .1201 Resident Record (Type B Violation)]. The facility failed to ensure Resident #1was treated with dignity and respect when she was sent to the hospital after an unwitnessed fall and then transferred to in-patient hospice care while she was transitioning towards end-of-life, resulting in disregard of the resident's wishes for end-of-life documented in the resident's Hospice plan of care to be provided at the facility. This failure resulted in neglect and constitutes Type A 1 violation. The facility provided a plan of protection in accordance with G. S. 131D-34 on 10/01/25 for the violation. CORRECTION DATE FOR TYPE A1 VIOLATION SHALL NOT EXCEED NOVEMBER 1, 2025.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL-013049	A. BUILDING: _____ B. WING _____	R-C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE DRAKE	1195 DRAKE MILL LANE SW CONCORD, NC 28025

(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 433	Continued From page 22	D 433		
D 433	10A NCAC 13F .1201(a) Resident Records 10A NCAC 13F .1201Resident Records (a) The following shall be maintained on each resident in an orderly manner in the resident's record in the adult care home and made available for review by representatives of the Division of Health Service Regulation and county departments of social services: (1) FL-2 or MR-2 forms and the patient transfer form or hospital discharge summary, when applicable; (2) Resident Register; (3) receipt for the following as required in Rule .0704 of this Subchapter: (A) contract for services, accommodations and rates; (B) house rules as specified in Rule .0704(a)(2) of this Subchapter; (C) Declaration of Residents' Rights (G.S. 131D-21); (D) the home's grievance procedures; and (E) civil rights statement; (4) resident assessment and care plan; (5) contacts with the resident's physician, physician service or other licensed health professional as required in Rule .0902 of this Subchapter; (6) orders or written treatments or procedures from a physician or other licensed health professional and their implementation; (7) documentation of immunizations against influenza virus and pneumococcal disease according to G.S. 131D-9 or the reason the resident did not receive the immunizations based on this law; and (8) the Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form if the resident is being or has been discharged.	D 433		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL-013049	A. BUILDING: _____ B. WING _____	R-C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE DRAKE	1195 DRAKE MILL LANE SW CONCORD, NC 28025

(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 433	Continued From page 23	D 433		

When a resident leaves the facility for a medical evaluation, records necessary for that medical evaluation such as Subparagraphs (1), (4), (5), (6) and (7) above may be sent with the resident.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on record review and interviews, the facility failed to ensure the "Do Not Resuscitate" (DNR) order and hospice records were sent with 1 of 1 sampled resident (#1) who was on end of life care was transferred to the local emergency department (ED).

The findings are:

Review of Resident #1's most current FL2 dated 09/12/24 revealed:
-Resident #1's diagnoses included Alzheimer's dementia, bipolar disorder, type II diabetes, hypertension, and hypercholesterolemia.
-Resident #1 was semi-ambulatory.
-Resident #1 had intermittent disorientation.
-Resident #1 resided in the Special Care Unit (SCU).

Review of Resident #1's Resident Register revealed an admission date of 10/9/23.

Review of Resident #1's record revealed:
-Resident #1 was admitted to end-of-life care (hospice) on 06/06/25 for symptom management, comfort, anxiety, behaviors/ mood, atrophy (over-all decline), fall prevention, confusion, combativeness, and increased drowsiness/sleep.
-Resident #1 was at risk for falls and had recent falls on 08/02/25, 08/05/25, and 08/12/25.
-Resident #1's fall reports and progress notes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL-013049	A. BUILDING: _____ B. WING _____	R-C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE DRAKE	1195 DRAKE MILL LANE SW CONCORD, NC 28025

(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 433	Continued From page 24	D 433		

(08/01/25 - 08/19/25) documented her code status as "full code" (meaning she was to receive life saving efforts and treatment in the event she stopped breathing).
-There was a DNR order form signed by the facility nurse practitioner (NP) that was not dated.
-There was documentation the facility notified hospice and Resident #1's Power of Attorney (POA) that Resident #1 had an unwitnessed fall and was transferred to the ED on 08/12/25.

Review of Resident #1's Hospice plan of care dated 08/08/25 revealed her care goals were for Resident #1 to receive comfort directed care, no resuscitation, have no further hospitalizations/invasive procedures, and to remain at the facility until end of life.

Review of Resident #1's Hospice visit note dated 08/11/25 revealed Resident #1 was transitioning towards end-of-life.

Review of the "Continuity of Care Document" (transfer summary) that accompanied Resident #1 to the hospital, dated 08/12/25 revealed:
-There was inaccurate documentation that Resident #1 was a "full code."
-There was no documentation of a DNR code status.
-There was no documentation Resident #1 was under hospice care.

Review of Resident #1's hospital discharge summary dated 08/13/25 revealed:
-Resident #1 presented at the ED via emergency medical services (EMS) on 08/12/25 post fall at the facility.
-Resident #1's code status was "full code".
-Resident #1 had a new/ worsening fractured femur and urinary tract infection (UTI).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL-013049	A. BUILDING: _____ B. WING _____	R-C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE DRAKE	1195 DRAKE MILL LANE SW CONCORD, NC 28025

(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 433	Continued From page 25	D 433		

-Resident #1 received with intravenous (IV) fluids.
-Resident #1 was admitted to the hospital from the ED.
-The Attending physician was later informed Resident #1 was under hospice care.

Telephone interview with Resident #1's POA on 09/30/25 at 10:37am revealed:
-She was contacted by the Resident Care Coordinator (RCC) on 08/12/25 that Resident #1 had a fall, hit her head, and was being sent to the emergency room.
-Resident #1 was transported to the ED without her DNR document and information indicating Resident #1 was receiving hospice services or that she was transitioning towards end-of-life.

Interview with the Hospice Social Worker on 09/30/25 at 4:10pm revealed:
-Resident #1 had a code status of DNR before she was admitted to hospice services on 06/06/25.
-The facility did not send Resident #1's DNR or hospice care information when she was transported to the hospital.

Interview with the medication aide (MA) on 10/01/25 at 11:36am revealed:
-She printed Resident #1's Continuity of Care Document and face sheet before EMS arrived at the facility to transport Resident #1 to the ED.
-She could not recall if Resident #1's code status or hospice information was listed on the Continuity of Care Document since the medical information is pulled from a computer system and populates the document.
-DNR orders were kept in the DNR folder in the MA /chart office.

Interview with the Facility Manager on 10/01/25 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL-013049	A. BUILDING: _____ B. WING _____	R-C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE DRAKE	1195 DRAKE MILL LANE SW CONCORD, NC 28025

(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 433	Continued From page 26	D 433		

9:00am revealed:
-The RCC or Special Care Coordinator (SCC) were responsible for auditing resident charts and updating the medical record.
-He did not know why Resident #1's Continuity of Care Document and medical record was showing the incorrect code status of "full code."
-He expected an accurate Continuity of Care Document, face sheet, DNR (if applicable), and any other pertinent medical records to accompany residents who were transferred to the hospital.

Interview with the RCC on 10/01/25 at 11:50am revealed:
-She was covering as SCC from July 2025 through August 2025.
-She was working on 08/12/25 and was informed Resident #1 had an unwitnessed fall in the Quiet Room (a sitting room with a sofa that Resident #1 liked to frequent and was located by the nurse's station), where she had been lying on the couch.
-The MA was responsible for printing the Continuity of Care Documents and paperwork needed for resident transfers to the ED/ hospital.
-Resident #1's DNR and hospice care information should have accompanied Resident #1 when she was transported to the hospital.

Interview with the Administrator on 10/02/25 at 12:55pm revealed:
-She did not know Resident #1 was a DNR.
-She was aware Resident #1 was receiving hospice care.
-Continuity of Care Documents, resident face sheet, medication list, and DNR (if applicable) accompany residents who are sent to the hospital.
-She did not know Resident #1 was sent to the hospital without her DNR and without

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL-013049	A. BUILDING: _____ B. WING _____	R-C 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE DRAKE	1195 DRAKE MILL LANE SW CONCORD, NC 28025

(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 433	Continued From page 27 documentation of hospice care. -She could not locate the date when Resident #1 became a DNR. -The RCC or SCC were responsible for updating resident records, including code status. -She expected accurate medical records to be sent with residents who were transferred to the hospital. Attempted telephone interview with the facility NP on 10/01/25 at 1:20pm was unsuccessful. [Refer to tag 338, 10A NCAC 13F .0909 Resident Rights (Type A1 Violation)]. _____ The facility failed to send Resident #1's Do Not Resuscitate form when she was transported to the hospital, resulting in disregard for Resident #1's end-of-life wishes. The failure was detrimental to the welfare of Resident #1 and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on October 23, 2025. _____ The CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 16, 2025.	D 433		