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D 000	Initial Comments The Adult Care License Section conducted an annual and follow-up survey on July 15-17, 2026 and July 20, 2026.	D 000		
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. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record review the facility failed to provide supervision in accordance with the assessed needs for 1 of 6 sampled residents related to a resident with vascular dementia who was intermittently disoriented and eloped from the facility during the night without staff's knowledge (#6). The findings are: Review of the facility's license effective for 01/01/26 revealed: -The facility was licensed for 85 residents. -The facility was licensed as a special care unit (SCU). -The license was effective until 12/31/2026.	D 270		

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D 270	Continued From page 1 Review of the facility census dated 07/15/26 revealed there were 52 residents residing at the facility. Observation of the facility's exterior doors on 07/17/26 at 2:58pm revealed: -There were 11 doors that exited to the outside/exterior of the building and one (1) door that exited into an enclosed patio area designated as the smoking area. -The outside/exterior doors had intact pneumatic (technology that used compressed air or gas to generate, or control motion) closures at the top of the doors. -All entry/exit doors had a key-pad operated magnetic lock door closure system which required the entry of a code to disengage the magnetic lock. (Magnetic lock controlled door locks use an electrical magnetic closure to control the door opening to prevent unrestricted entrance or egression.) -Each outside/exterior door had a red alarm box affixed to the top of the door. -The red alarm box had a key slot with indication of on (alarmed) and off (dis-alarmed). -There were 3 outside/exterior doors which had the red alarm box in the off position as follows; the single outside/exterior doors from the main entrance into the facility and from the back of the building through the area of the vending machine that led to the dumpster area; and one set of glass double doors that led to the parking areas. Observation, along with the Maintenance Director, of the red alarm box operation on 07/17/26 at 3:00pm revealed: -The red alarm box was not deactivated when the magnetic lock keypad was used to open the door. -When activated, the red alarm box emitted a	D 270		

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piercing high tone when the door was opened and continued until a key was used to deactivate the alarm (silence the alarm).

Review of the facility's Magnetic Lock Policy revealed:
-All magnetic locks remained locked in order to maintain the safety of both the facility and the residents.
-An individual entering or leaving a locked facility/unit shall be responsible for securing the door and be held responsible for any loss or damage from failure to do so.
-Employees will not disarm or tamper with magnetic locks for any reason. The Executive Director (ED) is the only person on site allowed to disengage or override the magnetic lock system.

Review of the Guidelines for Supervision of Residents who Exhibit Difficult Behaviors Policy revealed:
-Management of behaviors began prior to admission by learning as much as possible about the resident and identifying at-risk behaviors.
-Staff involved in the admission process were to be trained to identify residents with difficult behaviors.
-Possible at-risk indicators included mental health diagnoses, elopement history and care giver or family report.

Review of the Missing Resident Policy revealed:
-A resident was considered missing when they were not in the facility (community) and staff cannot verify the resident's whereabouts and when there was reason to be concerned for the [missing] resident's safety.
-The facility should perform a physical search of the community interior as well as the immediate outside areas.

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-The facility should call the resident representative, or Guardian, to ensure the resident is not with the representative.
-When a resident was discovered missing the staff would immediately notify all community staff, including the supervisor and the ED.
-If the resident was not found by staff within 30 minutes of being deemed missing/to have eloped, the ED or Supervisor must notify local law enforcement (call 911) and proceed according to the facility's policy.
-Once the resident is located, the ED will ensure the resident is assessed by his/her Primary Care Provider (PCP) for arrangement for proper follow-up care.

Review of Resident #6's current FL2 dated 07/03/26 revealed:
-Diagnoses included vascular dementia, hypertension, chronic kidney disease, major depressive disorder, hyperlipidemia, aphasia following cerebrovascular disease (09/20/24) and irritable bowel syndrome.
-He was intermittently disoriented.
-He was ambulatory.
-He was continent of bowel and bladder.
-He communicated needs verbally and non-verbally.
-His current level of care was a skilled nursing facility.
-His recommended level of care was memory care.

Review of Resident #6's Resident Register revealed:
-The resident was admitted on 07/10/26.
-Resident #6's assistance needs required was blank for documentation.
-His personal habits included smoking.
-The Resident Register was signed by the

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D 270	Continued From page 4 Guardian on 07/09/26. Review of Resident #6's discharge summary from the skilled nursing facility dated 07/10/26 revealed: -His cognitive status was blank. -He was independent for making decisions regarding tasks of daily life. -He was independent for locomotion, transfers, walking, always continent for urine and bowel. -He was non-verbal using a communication book. -He required medication management. -Final disposition was transferred to another assisted living/memory care facility. Review of Resident #6's Personal Care Physician Authorization and Care Plan dated 07/13/26 revealed: -There was no documentation of wandering behaviors. -He was sometimes disoriented, and forgetful and needed reminders. -Activities of daily living (ADL) were documented as independent for transferring and ambulation; needed supervision for eating; and required limited assistance with toileting, bathing, dressing, and grooming/personal hygiene. Review of Resident #6's Personal Care Physician Authorization and Care Plan dated 07/14/26 for significant change revealed: -There was documentation of wandering behaviors. -He was sometimes disoriented, and forgetful and needed reminders. -Activities of daily living (ADL) were documented as independent for transferring and ambulation and eating, and required limited assistance with toileting, bathing, dressing, and grooming/personal hygiene.	D 270		

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D 270	Continued From page 5 Review of Resident #6's Personal Care logs revealed: -On 07/13/26 at 10:31pm, there was documentation Resident #6 was assisted with Staff removing clothing, socks and shoes. -On 07/14/26 at 3:38am, There was documentation staff assisted Resident #6 with putting on his clothing, socks,] and shoes, and cleaned his room. Review of Resident #6's care notes revealed: -On 07/10/26 at 2:22pm, the Resident Care Coordinator (RCC) documented the resident showed signs of some agitation and his Guardian was notified of the changes. -On 07/11/26 at 6:05am, a medication aide (MA) supervisor documented Resident #6 was awake throughout the night, repeatedly requested to smoke a cigarette every hour. Staff educated the resident on the community's designated smoking schedule. Resident exhibited restlessness and difficulty sleeping due to restriction but currently is in bed resting quietly. Staff will continue to monitor closely during day shift. Resident #6 was on 72 hours of increased supervision. -On 07/13/26 at 9:19am, the resident seemed to be adjusting well with the facility. -On 07/13/26 at 9:23am, the resident was doing fine. -On 07/14/26 at 2:30am, a MA left a voicemail message for the Guardian to call the facility in the morning when they get the message related to elopement of Resident #6. -On 07/14/26 at 2:54am, Resident #6's elopement occurred during shift change. Staff immediately activated emergency protocol and called 911. Fortunately, the resident was located shortly thereafter and had been safely returned to the facility.	D 270		

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-On 07/14/26 at 8:13am, the Administrator documented that the Guardian called in that morning. She advised the Guardian that Resident #6 "made his way out during shift change by staff not watching doors". Currently, right now the resident was sleeping. She advised the Guardian she would have Resident #6's primary care provider (PCP) check him upon the PCP's return to the facility tomorrow (07/15/26).
-On 07/15/26 at 7:03am, the resident was placed on 15-minute safety observations/visual checks effective immediately.

Review of Resident #6's Incident report dated 07/14/26 revealed:
-The incident was an elopement, with time the incident occurred documented for 1:00am and the report completed at 2:15pm.
-The incident was described as an elopement without injury.
-The statement from staff involved was that during the shift change, a resident eloped from the facility. Emergency services (911) were called.
-Once the resident was found, his vital signs were taken by staff at 2:40am.
-On 07/14/26 at 2:30am, the resident's Guardian and PCP were notified by telephone messages.
-Care outcomes were documented that Emergency Medical Services (EMS) had evaluated Resident #6.
-There was an in-service for Elopement Prevention and Response Inservice dated 07/14/26 signed by 11 facility staff attached to the incident form.

Review of the National Oceanic and Atmospheric Administration (NOAA) and the Weather Channel past weather report for the area the facility was located revealed the temperatures ranged from

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D 270	Continued From page 7 71 to 73 degrees Fahrenheit from 07/13/26 at 11:30pm to 07/14/26 at 2:30am with mostly cloudy conditions. Review of the local 911 call logs dated 07/13/26 to 07/14/26 revealed: -On 07/14/26 at 1:06am, the facility contacted 911 to report a missing resident. -On 07/14/26 at 1:16am and 1:17am, first local law enforcement officers arrive at the facility. -On 07/15/26 at 1:46am, law enforcement officer out with Resident #6 at a local convenience store. The convenience store was 5.5 miles from the facility. -On 07/14/26 at 1:47am, the local emergency medical services (EMS) were dispatched to the scene where Resident #6 had been found with arrival time of 1:56am. Resident #6 refused to be transported by EMS, and EMS cleared the scene at 2:06am. -On 07/14/26 at 2:06am, Resident #6 was enroute back to the facility by facility staff.. Review of emails information dated 07/14/26 at 10:27am and 4:10pm to the local Department of Social Services (DSS) from the Administrator revealed: -The facility incident report dated 07/14/26 for elopement of Resident #6 was sent to the DSS at 10:27am. -The email at 4:10pm revealed Resident #6 was admitted on 07/10/26 and left the facility during the night on 07/13/26. -At approximately 1:05am on 07/14/26, the MA supervisor notified the Administrator that Resident #6 was no longer in the building. The MA supervisor immediately contacted 911 and left a voicemail for the resident's Guardian. -The Administrator and RCC arrived at facility at approximately 1:40am.	D 270		

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D 270	Continued From page 8 -Local law enforcement officers advised that the resident had been located at a local convenience store by law enforcement officers. -Facility staff picked up the resident and safely returned the resident to the facility. -A responding officer advised that the resident had reportedly eloped from a previous facility approximately one year ago. -Based on the circumstances for the current elopement, it appeared the resident exited when someone entered or exited the building without ensuring the door was fully closed and secured behind them. -Staff were re-educated on elopement prevention procedure and have provided additional support and familiar comforts like his preferred coffee from [named convenience store] and additional smoking breaks beyond the normal schedule. -Staff would continue to monitor Resident #6 closely. Interview with Resident #6's Mental Health Provider (MHP) on 07/15/26 at 11:00am revealed: -A referral for mental health evaluation for Resident #6 was made on 07/13/26. -The paperwork was being processed to ensure he was accepted by the practice. -She had not scheduled a visit with Resident #6 for her visit this week due to the pending paperwork. Telephone interview with Resident #6's Primary Care Provider (PCP) on 07/16/26 at 4:35pm revealed: -She saw Resident #6 for an initial visit on 07/15/26 when she was at her routine visit to the facility. -She reviewed facility paperwork and signed his Care Plan dated 07/13/26. -She did not see his SNF discharge summary.	D 270		

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D 270	Continued From page 9 -She received a text message from facility staff during the early morning hours of 07/14/26 informing her Resident #6 was missing from the facility. -She received a text later during the early morning hours of the same morning informing her that Resident #6 had been located, was checked by EMS, and was safely back in the facility. -If Resident #6 was showing signs of exit seeking, the resident should be on more frequent supervision checks by staff. Interview with the Administrator on 07/17/26 from 11:30am to 12:50pm revealed: -She was the Administrator and the ED of the facility. -On 07/13/26, Resident #6 was adjusting to the facility. He was smoking with staff supervision. -There were two MAs reconciling controlled medications around 11:30pm on 07/13/26. One MA reported Resident #6 approached them requesting to go outside to the smoking area to smoke. The staff informed him he would need to wait until the check-off was completed, then he would be taken out onto the smoking patio area. -The doors Resident #6 possibly eloped through were the front right (single door) or left (double doors) or the back door in the middle hall by the vending machine as these were the doors with magnetic locks but they were not alarmed with the siren alarm. Staff routinely entered and exited through the front right or left doors during shift change and used the back door for emptying trash into the dumpster. -She left the facility on 07/13/26 around 5:30pm to 6:00pm. -She received a phone call from the facility informing her Resident #6 was missing from the facility. She was not sure exactly who called or the exact time of the call.	D 270		

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-She arrived at the facility at 1:45am on 07/14/26.
-She remembered police cars and three uniformed officers at the facility when she arrived..
-Shortly after she arrived at the facility, she was informed by one of the officers Resident #6 had been located at a convenience store in a nearby community (5.5 miles away).
-She and staff went to pick the resident up.
-When she arrived at the convenience store, she saw an EMS vehicle and law enforcement cars at the scene.
-Resident #6 did not have any obvious signs of injury.
-He was wearing a pink shirt, gray pants, his athletic style slides, and holding a pack of cigarettes, a cup of coffee and an empty chicken nugget box.
-The resident got in the front seat of a car with the RCC in the other front seat of the car and a MA in the back seat and was returned to the facility around 2:00am on 07/14/26.

Interview with the Business Office Manager (BOM) on 07/17/26 at 12:30pm revealed:
-He had a box of personal belongings, snacks, and a soda.
-The BOM recalled that when signing paperwork at the SNF, the SNF staff said "He is going to throw a fit" when he became aware he was going to the SCU and would not be able to go and come freely from the facility.
-He did not ask the staff what they meant by the statement.

Telephone interview with Resident #6's Guardian on 07/17/26 at 3:40pm revealed:
-Resident #6 was adjudicated incompetent on 09/30/21 and the Department of Social Services (DSS) was his guardian.

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-She had been his guardian since 02/18/26.
-He lived at a SNF from September 2024 until 07/10/26.
-The social worker from Resident #6's SNF called her on 05/18/26 to report that alternative placement was being sought due to Resident #6's history of elopement, and because Resident #6 no longer met SNF criteria. The SNF recommended assisted living (AL) level of care.
-The social worker from the SNF told her that Resident #6 would try to elope when he did not get what he wanted (snacks, cigarettes, etc.), so the SNF was spending facility funds to try and appease him.
-Resident #6 was a long-term resident of the SNF due to diagnoses of chronic kidney disease, type II diabetes and cerebrovascular accident (CVA).
-She found out in the process of trying to find alternative placement for Resident #6 that he had previous elopement incidents from his SNF. She had no previous knowledge of his elopement history.
-She was hesitant to place Resident #6 in an AL facility because of his elopement history.
-She contacted the memory care facility on 06/25/26 to request an in-person assessment of Resident #6 because she knew the facility was secure and she was the guardian for two other wards residing there and had no issues with their care.
-She told the Administrator about Resident #6's history of elopement when the Administrator asked why he was being discharged from the SNF.
-She was made aware of Resident #6 leaving the facility on 07/13/26.
-She received a voicemail message from an officer with the local police department on 07/14/26 at 1:35am and a second voicemail message from the facility's Administrator at

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2:29am on 07/14/26. Both messages requested return calls but provided no other information.
-She tried to call the officer back at approximately 7:40am on 07/14/26 but got no answer.
-She called the Administrator back at 7:45am on 07/14/26 but got no answer.
-The Administrator called her back at 8:09am on 07/14/26 and reported Resident #6 got out of the facility on 07/13/26 because a staff member left a door open during shift change.
-She did not receive any information from the local EMS regarding Resident #6's condition when he was located, but the facility Administrator emailed her on 07/14/26 to let her know that he was assessed by EMS and was transported back to the facility in stable condition.
-Resident #6 communicated with her by using simple one or two word phrases but his responses were mostly curse words and his "yes" or "no" type answers were not always accurate.
-She planned to keep Resident #6 at the SCU facility.

Interview with a MA on 07/17/26 at 4:40pm revealed:
-She was working as the MA on 07/13/26 on second shift (3:00pm to 11:00pm).
-She and the 3rd shift MA were counting the controlled medications at 11:15pm.
-She saw Resident #6 at 11:15pm when he asked to go out to smoke.
-She left the facility around 11:30pm.
-The night shift MA called her to come back to the facility around 1:00am on 07/14/26.
-She arrived about the same time as the Administrator and RCC.
-Several law enforcement officers were at the facility when she arrived around 1:00am.
-Resident #6 had not tried to leave the facility on 07/13/26 during the second shift.

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-He asked to go outside and was upset that he could not leave when he wanted to.
-He made hand gesture several different times, like pointing to his person and then outside, that she understood to be he did not belong here.
-She remained at the facility while the night shift MA went with the Administrator, and RCC went to the local convenience store to pick up Resident #6.
-All doors were locked and alarmed except the two front entrance doors and the one to the dumpster out back that was occasionally used to take out trash.
-The staff clocked in and out for work in a room located close to the front two entrance doors.
-Staff had to enter a code into the magnetic lock keypad to get in and out of the facility.
-Staff did not have to reset a door alarm when entering or leaving the building through the front doors.
-The only way Resident #6 could have gotten out must have been through the front exit doors.

Interview with Resident #6 on 07/17/26 at 4:55pm revealed:
-He could not respond in sentences.
-He answered yes when asked if he walked all the way to the convenience store.
-He answered yes when asked if he went out one of the front doors.
-He answered yes when asked if he had been to the store before and knew the way.
-Resident #6 walked away toward his room and returned with a binder, opened the binder and pointed to a page with names, phone numbers and address and said, "I Know".
-Resident #6 walked away without further interview.

Telephone interview with a second MA on

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D 270	Continued From page 14 07/20/26 at 7:00am revealed: -She was working as the night shift MA when Resident #6 was discovered missing. -The MA scheduled on night shift was the designated supervisor. -Facility staff routinely entered the building at 11:00pm through the front doors, either the double doors or the main entrance door, since the time clock was located in the front near the doors. -The personal care aides (PCAs) were assigned a group of residents, usually 9-10 residents for which they were responsible for supervision during the shift. -The PCAs should go room to room to check on residents at minimum of every 2 hours. -At 12:50am on 07/14/26, the PCA assigned Resident #6 came to her to tell her that the PCA was unable to locate Resident #6 in the facility. -No staff member said anything about Resident #6 not being seen before 12:50am. -She checked the immediate outside premises but did not find Resident #6. -She called the Administrator and the RCC, and then called 911 to report a missing resident. -Local law enforcement officers responded to the facility shortly after the 911 call and conducted a facility and grounds search. -The Administrator and RCC arrived at the facility around 1:30am on 07/14/26. -The second shift MA left around 11:30pm after they had completed the controlled medication shift count. -She did not recall if she saw Resident #6 around 11:00pm. -She could not understand how he got out with the magnetic lock doors that required a code to get out. -He may have followed staff out during the 11:00pm shift changes. -He had not been exit seeking, like walking to a	D 270		

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door and attempting to get out, during any time she worked since his admission on 07/10/26.
-He was a fast walker within the building and had no trouble ambulating.
-He did not speak full sentences but "he would make you understand".
-She learned one of the law enforcement officers that the resident had family in the area where he was located and had gone to the location where he was located during a previous elopement about a year ago.
-The Administrator, RCC and MA supervisor picked up the resident at the convenience store because he refused to get in the police car or EMS vehicle.
-She completed the facility Incident report after the Resident #6 was safely returned to the building.

Telephone interview with a PCA on 07/20/26 at 8:15am revealed:
-She was assigned to care for Resident #6 on 07/13/26.
-She entered the facility on 07/13/26 around 10:50pm through the front main entrance.
-She used the keypad to the door magnetic lock which functioned correctly.
-There was no extra alarm on the front doors, as far as she knew.
-She worked on 07/10/26 when Resident #6 was admitted and not again until night shift on 07/13/26.
-The PCAs start rounds to the residents' rooms at the beginning of their shift.
-She did not see Resident #6 in the common area when she started her shift at 11:00pm.
-Resident #6 was a smoker so he would often went to the secured smoking patio to smoke.
-He was ambulatory and required very little personal care.

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-She was not aware of any additional supervision other than routine 2-hour checks for Resident #6.
-She started her rounds, providing incontinent care, emptying trash, making sure residents were in bed, all the while keeping an eye out for Resident #6.
-When she got to his room around 12:30pm or maybe later, he was not in the room.
-She started searching throughout the facility and asking other staff if they had seen Resident #6.
-She reported to the MA supervisor at 12:50am that she had not been able to find Resident #6 inside the building.
-She carried on her duties attending to the other residents.
-The MA called management to report Resident #6 missing.
-Several law enforcement officers showed up and searched inside and around the outside of the building.

Interview with the facility's Corporate Operations representative on 07/17/26 at 5:15pm revealed:
-If the facility was made aware of previous behaviors that would meet special increased supervision like elopement needs, the corporate support clinical team would be involved with the decision as to if the resident's needs could be met.
-The clinical support team would review previous increased behaviors, medications to treat behavioral issues, and use all factors for determining the admission of a resident.
-The Administrator or RCC would be responsible to advise the clinical support team of any resident with increased elopement risk or previous elopements.
-The clinical support team was not aware of previous elopement behaviors for Resident #6.

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D 270	Continued From page 17 Interview with the Administrator on 07/17/26 at 5:15pm revealed: -Resident #6's Guardian did not inform her that the resident had eloped from a facility previously. -She had no prior knowledge that Resident #6 was at an increased risk for elopement. -That would have influenced the decision to admit the resident to the facility. _____ The facility failed to provide supervision for Resident #6 who had a diagnosis of vascular dementia and FL2 assessment for intermittent confusion and a history of prior elopement, resulting in the resident exiting the facility during the night without staff knowledge and was found by local law enforcement at a convenience store 5.5 miles from the facility. The facility's failure to supervise the resident resulted in serious neglect of a resident and constitutes a Type A1 Violation. _____ The facility provided a plan of protection (POP) in accordance with G.S. 131D-34 on 07/15/26 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED August 19, 2026.	D 270		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) Facilities with a licensed capacity of 7 to 12 residents shall ensure food services comply with Rules Governing the Sanitation of Residential Care Facilities set forth in 15A NCAC 18A .1600 which are hereby incorporated by reference,	D 282		

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D 282	Continued From page 18 including subsequent amendments, assuring storage, preparation, and serving food and beverage under sanitary conditions. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure residents' ice supply was protected from contamination as related to an uncovered ice scoop. The findings are: Observation of the faciliy's kitchen during the initial tour on 07/16/26 at 11:00am revealed: -The kitchen contained one large ice machine that supplied the entire facility. -The scoop for the ice machine was in an uncovered wire rack mounted on the wall beside the ice machine. -The wire rack had chipped paint and was rusted in several areas. -There were scuff marks on the wall behind the rack indicating the ice scoop scraped the wall when being placed in the rack. Interview with a dietary aide on 07/17/26 at 11:45am revealed: -He was unaware that the ice scoop was supposed to be covered when not in use. -He washed the ice scoop daily. Interview with a cook on 07/17/26 at 10:30am revealed:	D 282		

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D 282	Continued From page 19 -The facility did not have a dietary manager. -He was not aware that the ice scoop needed to be covered when not in use. -The ice scoop was washed at least once daily. Interview with the Resident Care Coordinator (RCC) on 07/17/26 at 4:45pm revealed: -She was not aware that the ice scoop needed to be covered when not in use. -Only dietary staff used the ice scoop unless ice was needed for residents after kitchen hours. -She felt the ice scoop should not be exposed to environmental contaminants. Interview with Administrator on 07/17/26 at 4:50pm revealed: -She was not aware the ice scoop needed to be covered when not in use. -Dietary staff and some personal care aides (PCAs) and medication aides (MAs) used the ice scoop daily. -She knew covering the ice scoop was an infection control prevention. -She expected the ice scoop to be washed by hand after each use, run through the dishwasher at least once daily and be kept in a new covered holder at all times when not in use.	D 282		
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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and procedures.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered to hold a long-acting insulin according finger stick blood sugar (FSBS) parameters (#3), and a medication to treat high cholesterol as ordered (#2).

The findings are:

Review of Resident #3's current FL2 dated 06/29/26 revealed:
-Diagnoses included essential hypertension, dorsalgia and Alzheimer's disease with early onset.
-He was intermittently disoriented.
-There was an order for glargine insulin (a long acting insulin) insulin inject 20 units (U) subcutaneously (SQ) at bedtime for diabetes mellitus Type 2.
-There was an order for finger stick blood sugar (FSBS) checks 2 times daily. Hold insulin if blood sugar is less than 150.

Review of Resident #3's physician orders dated 06/01/26 for FL2 verification of a hospital discharge on 05/26/26 revealed:
-There was an order to check FSBS at 8:00am and 8:00pm. Hold insulin if blood sugar was less than 150.
-There was an order for glargine insulin 20 units (SQ) at bedtime.

Review of a subsequent physician order dated 06/11/26 revealed an order to hold insulin if blood sugar was less than 150

Interview with the Resident Care Coordinator

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(RCC) on 07/16/26 at 3:00pm revealed:
-The medication aides (MAs) could document holding insulin in the residents' progress notes as well on the electronic medication administration record (eMAR).
-Breakfast was routinely served around 8:00am.

Review of Resident #3's progress notes from 06/01/26 to 07/16/26 revealed:
-On 06/19/26 at 8:00pm the Resident #3's FSBS was 98 and the glargine insulin was documented held.
-There were no other documented holds for glargine insulin on Resident #3.

Review of Resident #3's June 2026 eMAR revealed:
-There was an entry to check FSBS two times daily at 8:00am and 8:00pm.
-Documented FSBS values at 8:00am ranged from 63 to 312.
-There was an entry to administer glargine insulin U-100 insulin pen inject 20U SQ at bedtime for diabetes mellitus type 2 scheduled for administration at 8:00pm.
-There were 19 opportunities when glargine insulin should have been administered for FSBS values greater than 150.
-On 06/19/26 at 8:00pm, the FSBS value was 98 and the glargine insulin was documented as held.
-There were 8 opportunities when glargine insulin should have been held for FSBS values less than 150 but documented as administered with examples as follows:
-On 06/07/26 at 8:00pm the FSBS value was 139; glargine insulin should have been held but was documented as administered. The FSBS value on 06/08/26 at 8:00am was 125.
-On 06/09/26 at 8:00pm the FSBS value was 135;

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glargine insulin should have been held but was documented as administered. The FSBS value on 06/10/26 at 8:00am was 81.
-On 06/20/26 at 8:00pm the FSBS value was 145; glargine insulin should have been held but was documented as administered. The FSBS value on 06/21/26 at 8:00am was 312.
-On 06/23/26 at 8:00pm the FSBS value was 129; glargine insulin should have been held but was documented as administered. The FSBS value on 06/24/26 at 8:00am was 81.

Review of Resident #1's July 2026 eMAR from 07/01/26 07/14/26 revealed:
-There was an entry to check FSBS two times daily at 8:00am and 8:00pm.
-Documented FSBS values at 8:00am from 07/01/26 to 07/14/26 ranged from 65 to 531.
-There was an entry to administer glargine insulin U-100 insulin pen inject 20U SQ at bedtime for diabetes mellitus type 2 scheduled for administration at 8:00pm.
-Documented FSBS values at 8:00pm from 07/01/26 to 07/14/26 ranged from 134 to 531.
-There were 12 opportunities when glargine insulin should have been administered for FSBS values greater than 150.
-There were 2 opportunities when glargine insulin should have been held for FSBS values less than 150 but documented as administered as follows:
-On 07/05/26 at 8:00pm the FSBS value was 134; glargine insulin should have been held but was documented as administered. The FSBS value on 07/06/26 at 8:00am was 142.
-On 07/07/26 at 8:00pm the FSBS value was 135; glargine insulin should have been held but was documented as administered. The FSBS value on 07/08/26 at 8:00am was 92.

Observation of glargine insulin on hand for

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administration for Resident #3's on 07/16/26 at 3:20pm revealed there was a plastic bag containing a partial glargine insulin pen dispensed on 06/24/26 and labeled as opened on 07/01/26.

Attempted telephone interview with the facility's contracted pharmacy on 07/16/26 at 5:00pm was unsuccessful.

Interview with a medication aide (MA) on 07/16/26 at 4:45pm revealed:
-The facility recently adopted a new eMAR system.
-MAs were trained to obtain FSBS value, document the value on the eMAR, review glargine insulin order for Resident #3, acknowledge the review by documenting administration; then go back into the progress notes and document if the glargine insulin was held for parameters.
-If MAs did not complete the process, then glargine insulin was documented as administered.
-There was no way to know if a MA held glargine insulin unless there was a progress note to documented holding glargine insulin: no note meant glargine insulin was administered.

Telephone interview with Resident #3's Primary Care Provider (PCP) on 07/16/26 at 5:15pm revealed:
-Resident #3 was not ordered glargine insulin prior to a hospital discharge in June 2026.
-She approved Resident #3's glargine insulin order after reviewing his hospital discharge summary in June 2026.
-She added parameters to the administration of glargine insulin to help ensure the resident did have his blood sugar go to low (below 60-65) while she was helping adjust his dosage. FSBS values below 65 place the resident at risk for

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D 358	Continued From page 24 hypoglycemic symptoms like sweating, confusion, and even loss of consciousness for extremely low FSBS values. -The facility's MAs sent her frequent text or left messages related to the facility's residents' health care changes or parameters, including Resident #3. -She wanted his glargine insulin held if FSBS values were below 150 as a precaution while she monitored his glargine insulin dosage. -She did not know the facility was administering Resident #3's glargine insulin when they should have been holding it for FSBS values below 150 as ordered. -Since the resident had not had extremely low FSBS values following the administration of Lantus when FSBS value was less than 150 and the next morning's FSBS values were checked, and Resident #3 had and he had not experienced noticeable adverse signs of hypoglycemia, she did not see harm in the incorrectly administered glargine insulin. -The MAs should administer glargine insulin as ordered. Later interviews with the RCC on 07/16/26 at 4:18pm and 5:25pm revealed: -The MAs could document holding Resident #3's glargine insulin on the facility's progress notes through exception to administration documentation even if there was documented administration on the eMAR. -There was documentation in Resident #3's progress notes on 06/19/26 at 8:00pm glargine was administered but a note on the progress notes for holding glargine insulin for low blood sugar. -There were no other documented holds in Resident #3's progress notes for June 2026 or July 2026 (except 06/19/26).	D 358		

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-The facility was responsible for entering orders into the eMAR system: She entered the order routinely.
-She was responsible for auditing residents' eMAR once monthly.
-Her audits were routinely to ensure that medications ordered matched the entry in the eMAR system and the eMAR had no missed or blank administration times.
-She did not know Resident #3 had documented administration of glargine insulin in June 2026 and July 2026 outside the parameters ordered and no information for holding the glargine insulin in the progress notes because she had not audited Resident #3's progress notes compared to the eMARs.

Interview with the Corporate Regional Nurse (CRN) on 07/17/26 at 5:19pm revealed:
-MAs were responsible for reading residents' eMAR completely.
-Resident #3's entry on the eMAR for check FSBS twice a day, hold insulin for FSBS less than 150, and glargine insulin 20 units at bedtime was a bit confusing.
-She would change the eMAR entry to check FSBS twice a day, and glargine insulin 20 units at bedtime, hold for FSBS less than 150 for clarity.
-She reviewed Resident #3's progress notes and was not able to find additional documentation Resident #3's glargine insulin was held for FSBS less than 150.

Interview with the Administrator on 07/17/26 at 5:28pm revealed:
-The RCC was responsible for checking that medications administered were correct and complete.
-He was not aware that Resident #3's glargine insulin was administered incorrectly according to

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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
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documentation on the resident's eMAR and progress notes.

Based on observations, interviews, and record review it was determined Resident #3 was not interviewable.
2. Review of Resident #2's current FL2 dated 12/08/25 revealed:
-Diagnoses included hypertension, vascular dementia, type II diabetes,
-There was an order for atorvastatin calcium 20mg 1 tablet daily at bedtime.

Review of Resident #2's signed physician orders dated 06/08/26 revealed there was an order for atorvastatin calcium 20 mg 1 tablet daily at bedtime.

Review of Resident #2's May 2026 eMAR revealed:
-There was an entry for atorvastatin 20mg 1 tablet daily at bedtime scheduled at 08:00pm.
-There was documentation that atorvastatin 20mg was administered daily.

Review of Resident #2's June 2026 eMAR revealed:
-There was an entry for atorvastatin 20mg 1 tablet daily at bedtime scheduled at 08:00pm.
-There was documentation that atorvastatin 20mg was administered daily.

Review of Resident #2's July 2026 eMAR dated 07/01/26-07/14/26 revealed:
-There was an entry for atorvastatin 20mg 1 tablet daily at bedtime scheduled at 08:00pm.
-There was documentation that atorvastatin 20mg was administered daily.

Observation of medications on hand for Resident

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D 358	Continued From page 27 #2 on 07/16/26 at 11:38am revealed there was no atorvastatin calcium available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 07/16/26 at 3:07pm revealed: -Resident #2 had an active order for atorvastatin calcium 20mg 1 tablet daily at bedtime. -The last 3 dispense dates for the atorvastatin calcium were 06/18/26 (quantity of 7), 06/25/26 (quantity of 7) and 07/02/26 (quantity of 3). -Only 3 tablets of the atorvastatin were dispensed on 07/02/26 because the original prescription had expired. -Pharmacy staff entered medication orders on the facility's eMAR which interfaced with the facility's electronic medical records system, but facility staff must accept and verify orders once this was completed. -Medications were distributed to the facility weekly in multi-dosing packets. Telephone interview with Resident #2's Primary Care Provider (PCP) on 07/16/26 at 4:48pm revealed: -She was aware of Resident #2's order for atorvastatin calcium daily. -She was not aware the original prescription had expired or that the pharmacy had only sent 3 tablets on 07/02/26. -No one from the facility or from the pharmacy had requested a new prescription for the atorvastatin calcium. -Resident #2 had another provider until May 2026. -She was not concerned about Resident #2 missing multiple doses of the atorvastatin calcium because her cholesterol levels on 04/08/26 were "perfect".	D 358		

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D 358	Continued From page 28 Interview with a (MA) on 07/15/26 at 4:55pm revealed: -She was aware of Resident #2's atorvastatin calcium order. -She was aware of the pharmacy sending only 3 tablets on 07/02/26. -She was not aware that the atorvastatin calcium prescription had expired. -Medication cart audits were completed every Monday during the new cycle fill of medications. -Another MA completed the cart audit for Resident #2. -She was not aware that atorvastatin calcium was being documented as administered on 07/05/26-07/14/26. Interview with a second MA on 07/16/26 at 4:28pm revealed: -She was aware of Resident #2's atorvastatin calcium order. -She was not aware that the pharmacy had sent only 3 tablets on 07/02/26. -MAs were responsible for ordering medications. -Cart audits were completed weekly and she would write down when a medication was missing, contact the pharmacy and pharmacy staff would tell her if a new prescription was needed. -MAs were responsible for contacting the PCP for a new prescription but the pharmacy would do this on occasion. -She was supposed to request a new prescription for the atorvastatin but forgot to do so. -She documented that the atorvastatin calcium was administered on 07/05/26-07/14/26. Interview with the Resident Care Coordinator (RCC) on 07/16/26 at 4:37pm revealed: -She was aware of Resident #2's order for atorvastatin calcium.	D 358		

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D 358	Continued From page 29 -She was not aware the original prescription had expired or that the pharmacy had only sent 3 tablets on 07/02/26. -MAs were responsible for reordering medications and contacting PCPs for new prescriptions. -Cart audits were completed weekly by MAs who would record their findings and interventions, and submit a report to her. -Pharmacy staff entered all medication orders, but they must be approved by her. -She could change medication administration times only or open entry boxes for medications parameters. -She did not request a new prescription for the atorvastatin calcium because the MA was responsible for doing so. Interview with the Administrator on 07/16/26 at 4:50pm revealed: -She was aware of Resident #2's order for atorvastatin calcium. -She was not aware that the prescription had expired. -She was not aware that an MA did not order the atorvastatin calcium or that an MA had documented administration on 07/05/26-07/14/26. -MAs were responsible for ordering medications and completing medication audits daily on each shift and submit their reports to her. -The RCC audited medications and eMARs every 30 days and when updating care plans. -Audit reports were presented daily during standup meetings. -She expected MAs to order medications, request new presciptions when needed and administer medications as ordered. Based on observations and interviews, Resident #2 was not interviewable.	D 358		

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D 358	Continued From page 30 Attempted telephone interview with Resident #2's Responsible Party (RP) on 07/16/26 at 1:35pm was unsuccessful.	D 358		
D 461	10A NCAC 13F .1304 Special Care Unit Building Requirements 10A NCAC 13F .1304 Special Care Unit Building Requirements In addition to meeting all applicable building codes and licensure regulations for adult care homes, the special care unit shall meet the following building requirements: (1) For facilities licensed prior to April 1, 2025, the following shall apply: (a) Plans for new or renovated construction or conversion of existing building areas shall be submitted to the Construction Section of the Division of Health Service Regulation for review and approval. (b) If the special care unit is a portion of a facility, it shall be separated from the rest of the building by closed doors. (c) Unit exit doors may be locked only if the locking devices meet the requirements outlined in the N.C. State Building Code for special locking devices. (d) Where exit doors are not locked, a system of security monitoring shall be provided. (e) The unit shall be located so that other residents, staff and visitors do not have to routinely pass through the unit to reach other areas of the building. (f) At a minimum the following service and storage areas shall be provided within the special care unit: staff work area, nourishment station for the preparation and provision of snacks, lockable	D 461		

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space for medication storage, and storage area for the residents' records.
(g) Living and dining space shall be provided within the unit at a total rate of 30 square feet per resident and may be used as an activity area.
(h) Direct access from the facility to a secured outside area shall be provided.
(i) A toilet and hand lavatory shall be provided within the unit for every five residents.
(j) A tub and shower for bathing of residents shall be provided within the unit.
(k) Use of potentially distracting mechanical noises such as loud ice machines, window air conditioners, intercoms and alarm systems shall be minimized or avoided.
(2) For facilities licensed on or after April 1, 2025, the following shall apply:
(a) A special care unit that is part of an adult care home shall meet licensure rules for adult care homes contained in Rules .0301-.0311 of this Subchapter with the following exceptions: .0305(e)(3), .0305(f)(1), .0305(f)(4), .0305(h)(3), .0305(k), and .0305(l).
(b) The unit, if part of an adult care home, shall be separated from the rest of the facility by walls and closed doors.
(c) The unit, if part of an adult care home, shall be located so that other residents, staff, and visitors will not have to pass through the unit to reach other areas of the facility.
(d) Unit exit doors shall be locked with locking devices meeting the requirements outlined in the North Carolina State Building Code for special locking arrangements.
(e) Unit exit doors shall have a sounding device that is activated when the door is opened per Rule .0305(h)(4) of this Subchapter.
(f) Operable exterior windows shall be equipped with mechanisms to limit window openings to no

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less than four inches and no greater than six inches to minimize the chance of elopement.
(g) There shall be direct access from the unit to a secured outside area located on the same level as the unit.
(h) Fences used to enclose the secured outside area shall be at least six feet high and shall be constructed to prevent residents' ability to climb over the fence.
(i) The following service and storage areas shall be provided within the special care unit:
(i) a staff work area;
(ii) a staff bathroom;
(iii) a nourishment station for the preparation and provision of snacks. The nourishment station shall be provided with a sink trimmed with valves that can be operated without hands. If the sink is equipped with blade handles, the blade handles shall not be less than four and one half inches in length. If the sink faucet depends on the building electrical service for operation, the faucet must have an emergency power source or battery backup capability. If the faucet has battery operated sensors, the facility shall have a maintenance policy to keep extra rechargeable or non-rechargeable batteries on premises for the faucets;
(iv) lockable space for medication storage;
(v) storage area for the residents' records;
(vi) separate storage room or area shall be provided for the storage of soiled linens; and
(vii) a housekeeping closet, with mop sink or mop floor receptor.
(j) The living room and dining room/dining area may be sized per Rules .0305(b) and .0305(c) of this Subchapter or may be combined for a minimum of 30 square feet per resident. The combined space may be used as an activity area.
(k) The unit shall have a central bathing area

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D 461	Continued From page 33 meeting the following: (i) a door of three feet minimum width; (ii) a roll-in shower designed to allow the staff to assist a resident in taking a shower without the staff getting wet. The roll-in shower shall be designed and equipped for unobstructed ease of shower chair entry and use. If a bathroom with a roll-in shower designed and equipped for unobstructed ease of shower chair entry adjoins each resident bedroom in the facility, the central bathing area is not required to have a roll-in shower; (iii) a bathtub, a manufactured walk-in tub or a similar manufactured bathtub designed for easy transfer of residents into the tub. Bathtubs shall be accessible on three sides. Manufactured walk-in tubs or a similar manufactured bathtub shall be accessible on at least two sides. Staff shall not be required to reach over or through the tub faucets and other fixture fittings to assist the resident in the tub; (iv) a toilet and a lavatory trimmed with valves that can be operated without hands. If the lavatory is equipped with blade handles, the blade handles shall not be less than four and one half inches in length. If the lavatory faucet depends on the building electrical service for operation, the faucet must have an emergency power source or battery backup capability. If the faucet has battery operated sensors, the facility shall have a maintenance policy to keep extra rechargeable or non-rechargeable batteries on premises for the faucets; and (v) individual cubicle curtains shall enclose each toilet, bathtub, manufactured walk-in tub or similar manufactured bathtub, and shower. (l) If each resident bedroom has direct access to a bathroom equipped with a shower meeting the requirements of Rule .0305(e)(7)(B) of this	D 461		

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D 461	Continued From page 34 Subchapter, the shower required by this rule is not required to be provided in the unit. (m) Fire extinguishers required by Rule .0308(a) of this Subchapter shall be secured in a manner acceptable to the local Fire Marshal to prevent access by residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 3 of 11 entrance/exit doors of the Special Care Unit (SCU) facility, accessible to residents, were locked and equipped with a continuous sounding device that activated when the door was opened for the safety of all residents in the SCU which included one resident (Resident #6) who was intermittently disoriented and ambulatory who eloped from the facility without staff knowledge. The findings are: Review of the facility's license effective for 01/01/26 revealed: -The facility was licensed for 85 residents. -The license was effective until 12/31/2026. -The facility was licensed as a special care unit (SCU). Review of the facility census dated 07/15/26 revealed there were 52 residents residing at the facility. Observation during the initial entry of the facility on 07/15/26 at 8:45am revealed:	D 461		

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-The facility had a ramp leading to the main entrance.
-The main entrance had a foyer area accessible by a single door. The door was not locked.
-Inside the front door was a foyer area with a visitor sign-in register.
-Next, there was a single door for area entry into the facility.
-A second door inside the reception foyer door gained access into the facility's memory care unit. This door was locked and had a keypad.
-There was a doorbell for requesting entry located beside the second door inside the reception area.
-Upon ringing the doorbell, a staff member responded immediately.
-The staff member was observed entering numbers into a keypad and opened the facility's interior entrance door.
-There was no audible sound when the door was opened.

Review of Resident #6's current FL2 dated 07/03/26 revealed:
-Diagnoses included vascular dementia, major depressive disorder, and aphasia following cerebrovascular disease (09/20/24).
-He was intermittently disoriented.
-He was ambulatory.
-His current level of care was skilled nursing facility.
-His recommended level of care was memory care.

Review of Resident #6's Resident Register revealed:
-The resident was admitted on 07/10/26 (Friday).
-Resident #6's assistance needs required was blank for documentation.
-His personal habits included smoking.
-The Resident Register was signed by the

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D 461	Continued From page 36 Guardian on 07/09/26. Review of Resident #6's Personal Care Physician Authorization and Care Plan with an assessment date of 07/13/26 revealed: -There was no documentation of wandering behaviors. -He was sometimes disoriented, and forgetful-needed reminders. -Activities of daily living (ADL) were documented as independent for transferring and ambulation. Review of Resident #6's Incident report dated 07/14/26 revealed: -The incident was an elopement, with time the incident occurred was documented for 1:00am and the report completed at 2:15am. -The incident was described as an elopement without injury. -The statement from staff involved was that during the shift change, a resident eloped from the facility. Emergency services (911) called. Observation or Resident #6 on 07/15/26 between 2:15pm and 5:00pm revealed he ambulated independently throughout the front of the building and to the smoking area. Observation of Resident #6 at various times on 07/16/26 and 07/17/26 from 9:15am and 5:00pm revealed he ambulated independently throughout the front of the building and to the smoking area. Telephone interview with Resident #6's Primary Care Provider (PCP) on 07/16/26 at 4:35pm revealed: -The facility was a SCU and all residents had cognitive impairment to be placed at the facility. -The facility was responsible for ensuring the safety of the residents.	D 461		

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D 461	Continued From page 37 -The doors of a SCU were secured with a keypad code. Observation of the facility's exterior doors on 07/17/26 at 2:58pm revealed: -There were eleven doors that exited to the outside/exterior of the building and one (1) door that exited into an enclosed patio area designated as the smoking area. -Each outside/exterior door had a red alarm box affixed to the top of the door. -The red alarm box had a key slot with indication of on (alarmed) and off (disarmed). -Eight of the outside/exterior doors had red alarm boxes with the alarm set to the activated position. -There were 3 outside/exterior doors which had the red alarm box in the off position as follows; the single outside/exterior doors from the main entrance into the facility and from the back of the building through the area of the vending machine that led to the dumpster area; and one set of double glass doors in the front entrance foyer that led to the parking areas. Observation of the red alarm box operation on the front entrance/exit doors on 07/17/26 at 3:00pm revealed: -The Director of Maintenance (DOM) assisted the surveyor with observing the red alarm box test of the front entrance doors. -The red alarm box was not deactivated when the magnetic lock keypad was used to open the single front entry door. -The DOM used a key to set the red alarm box to the activated position on the single door in the entrance foyer. -The red alarm box emitted a piercing high tone when the door was opened and continued until a key was used to deactivate the alarm (silence the alarm).	D 461		

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-The red alarm box on the double door entrance/exit doors to the left in the front entrance foyer and keypad were tested in the same manner.
- The red alarm box emitted a piercing high tone when either of the front entry/exit double doors were opened and continued until the DOM used a key to deactivate the alarm (silence the alarm).

Interview with the DOM on 07/17/26 at 3:15pm revealed:
-Medication aides (MAs) had a key to activate or deactivate the red box door alarms on the keys to the medication carts.
-All doors except the front entrance/exit doors and the door at the back of the building used by staff to take out trash were alarmed 24 hours a day on seven days a week.
-The only time those 3 alarms would be activated was if the magnetic lock keypad system was not operating properly.
-Staff entered and exited the facility through the doors in the front of the building, either the door from the main entrance or the double doors located from the front foyer, both located inside the facility's magnetic lock and keypad doors.
-He was unaware all entrance/exit doors should have sounding alarms always activated, including the doors at the front entrance area and the back door close to the dumpster.
-He tested all red box alarms and changed batteries periodically if needed.

Interview with the Administrator on 07/17/26 at 3:30pm revealed:
-The red box alarms were not deactivated through the magnetic lock door closure keypad. They must be activated and deactivated with a separate key at the red box alarm.
-The front single and double doors, and the back

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door near the dumpster had never been alarmed. Staff and providers used the front doors to access and egress the building. The door at the dumpster was used by staff to carry trash to the dumpster.
-She thought the magnetic lock keypad system was sufficient for securing the SCU front doors and the back door at the dumpster.
-The red box alarms within the facility had been in place for more than 4 years.
-The door alarms were routinely checked by the DOM once a week and documented on a log.
-The MA supervisors have keys to the red box alarms on the medication carts keys to activate and reset the door alarms in the event an entrance/exit door keypad is opened without authorization.
-The volume of the door alarm would disturb SCU residents and possibly trigger unwanted behaviors.

Interview with a MA supervisor on 07/17/26 at 4:00pm revealed:
-The MA had a key to deactivate and reset the red box alarms on the facility's doors.
-She had been instructed on the procedure for activating and deactivating the door alarms during some of her orientation or training but not sure of the exact timeframe.
-She had not had a door alarm go off since she had been working at the facility.
-The front entrance/exit doors near the entrance and where staff clocked in to work were had never been alarmed, just keypad entry.

Interview with a MA on 07/17/26 at 4:40pm revealed:
-All doors were locked and alarmed except the 2 front entrance doors and the one to the dumpster out back that was occasionally used to take out

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041072	A. BUILDING: _____ B. WING _____	R 07/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON OAKS	3004 DEXTER AVENUE GREENSBORO, NC 27407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 461	Continued From page 40	D 461		

trash.
-The staff clocked in and out for work in a room located close to the front 2 entrance doors.
-Staff had to enter a code into the magnetic lock keypad to get in and out of the facility.
-Staff did not have to reset a door alarm when entering or leaving the building through the front doors.

Telephone interview with a personal care aide (PCA) on 07/20/26 at 8:15am revealed:
-She routinely entered the facility through the front main entrance.
-She used the keypad to the door magnetic lock which functioned correctly.
-There was no extra alarm on the front doors, as far as she knew.
-Resident #6 was a smoker so he would often go to the secured smoking patio to smoke.
-He was ambulatory and required very little personal care.

Interview with the facility's Corporate Operations representative on 07/17/26 at 5:15pm revealed:
-The facility had secured doors using the magnetic lock system.
-The only way to get in and out of the building was using the keypad to open the maglock doors with a code.
-She thought the magnetic locking doors accessible only with a keypad code was adequate security for the SCU.

[Refer to Tag D0270, NCAC 13F .0901(b) Personal Care and Supervision]

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The facility failed to ensure a secure system of monitoring the SCU doors with a continuous sounding alarm when the doors were opened related to 3 of 11 sounding devices that were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041072	A. BUILDING: _____ B. WING _____	R 07/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 461	Continued From page 41 de-activated, placing the residents all of which had diagnoses of dementia or cognitive impairment, including one resident who eloped from the facility without staff knowledge (#6), at risk for the residents' safety. This failure was detrimental to the 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 07/17/2026. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 03, 2026.	D 461		