STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(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 conducted a follow-up survey on July 30, 2025 and July 31, 2025	D 000		
D 067	10A NCAC 13F .0305 (h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) in facilities with at least one resident who is determined by a physician or is otherwise observed by staff to be disoriented or exhibits wandering behavior, a continuously sounding device that is activated when the door is opened shall be located on each exit door that opens to the outside. The sound shall be audible in the facility. If a central system of remote sounding devices is provided, the control panel shall be powered by the facility's electrical system, and be in a location accessible by staff to operate the control panel. Notwithstanding the requirements of Rule .0301, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure 7 of 8 exit doors which were accessible to 4 of 7 sampled residents who resided in the facility who were identified as intermittently disoriented (#2, #3, #6 and #7) and two residents diagnosed with dementia (#3, #6) and one resident diagnosed	D 067		

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D 067	Continued From page 1	D 067		

with Alzheimer's Disease (#3) had audible alarms activated when the exit doors were opened to alert staff.

The findings are:

Review of the facility's current license effective 01/01/25 revealed the facility was licensed as an assisted living facility with a capacity of 120 beds.

Review of the facility's census on 07/30/25 revealed there were 82 residents residing at the facility.

A Building Security policy was requested on 07/31/25 at 2:18pm and not provided.

Observation of the outside premises of the front of the facility and the front door on 07/30/25 at 8:00am revealed:
-The facility was located on a busy four lane road with a speed limit of 35 miles per hour (mph).
-There was an entrance gate to enter the facility grounds and anyone wishing to enter had to ring a buzzer and wait for a staff member to open the gate from the inside of the facility.
-There was an exit gate at the front of the facility premises that automatically opened when a vehicle approached to exit the gated area.

Observation of the facility's main front door entrance on 07/30/25 at 8:02am revealed:
-There was a sign on the front door to please ring doorbell.
-There was a doorbell button on the door frame just above the door handle.
-There was a keypad mounted on the brick facade beside the door and frame.
-The front door was unlocked and there was no audible alarm sound when the door was opened.

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D 067	Continued From page 2 -Inside the door was a red octagon shaped exit alarm device at the upper right-hand side of the door. -The key position was turned to the on position. -There was no staff observed monitoring the front entrance. Observation of an exit door located at the middle of the 300 hall of the facility on 07/30/25 at 8:12am revealed: -The door was unlocked. -There was not an audible alarm sound when the door was opened. -Emergency Exit Only (NO EXIT) was on a sign by the door. -There was a red octagon shaped exit door alarm device at the upper right-hand corner of the front exit door. -The key position was turned to the on position but there was no audible alarm. Observation of an exit door located at the back of the 300 hall of the facility on 07/30/25 at 8:15am revealed: -The door was unlocked. -There was not an audible alarm sound when the door was opened. -There was a red octagon shaped exit door alarm device at the upper right-hand corner of the front exit door. -The key position was turned to the on position but there was no audible alarm. Observation of an exit door located at the front of the 300 hall of the facility on 07/30/25 at 8:16am revealed: -The door was unlocked. -There was not an audible alarm sound when the door was opened. -There was a red octagon shaped exit door alarm	D 067		

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D 067	Continued From page 3 device at the upper right-hand corner of the front exit door. -The key position was turned to the on position but there was no audible alarm. Observation of an exit door to facility's smoking area located by the dining room on 07/30/25 at 8:46am revealed: -The door was unlocked. -There was not an audible alarm sound when the door was opened. -There was a red octagon shaped exit door alarm device at the upper right-hand corner of the front exit door. -The key position was turned to the on position but there was no audible alarm. Observation of an exit door located at the middle of the 100 hall of the facility on 07/30/25 at 8:47am revealed: -The door was unlocked. -There was not an audible alarm sound when the door was opened. -There was a red octagon shaped exit door alarm device at the upper right-hand corner of the front exit door. -The key position was turned to the on position but there was no audible alarm. Observation of an exit door located at the front of the 100 hall of the facility on 07/30/25 at 8:50am revealed: -The door was unlocked. -There was not an audible alarm sound when the door was opened. -There was a red octagon shaped exit door alarm device at the upper right-hand corner of the front exit door. -The key position was turned to the on position but there was no audible alarm.	D 067		

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D 067	Continued From page 4 Observation of an exit door located at the back of the 100 hall of the facility on 07/30/25 at 8:54am revealed: -The door was unlocked. -There was not an audible alarm sound when the door was opened. -There was a red octagon shaped exit door alarm device at the upper right-hand corner of the front exit door. -The key position was turned to the on position but there was no audible alarm. Review of Resident #2's current FL-2 dated 06/06/25 revealed: -Diagnoses included osteoporosis, type 2 diabetes mellitus, hypertension and hyperlipidemia. -She was intermittently disoriented. -The resident was ambulatory. Review of Resident #3's current FL-2 dated 04/22/25 revealed: -Diagnoses included Alzheimer's Disease, dementia, -He was intermittently disoriented. -The resident was semi-ambulatory. Review of Resident #6's current FL-2 dated 07/01/25 revealed: -Diagnoses included dementia and mild cognitive disorder. -He was intermittently disoriented. -The resident was semi-ambulatory. Review of Resident #7's current FL-2 dated 02/04/25 revealed: -Diagnoses included schizophrenia and diabetes mellitus. -She was intermittently disoriented.	D 067		

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D 067	Continued From page 5 -The resident was semi-ambulatory. Second observation of the main front exit door on 07/30/25 at 11:05am revealed there was an audible alarm when the door was opened. Third observation of the main front entrance door on 07/30/25 at 1:35pm revealed: -The main front entrance door was locked. -The doorbell was pushed, and staff came and opened the door. -While waiting for staff to open the door, a resident that was outside in front of the facility shared the keypad code with the surveyors. -There was an audible alarm when the door was opened. Second observation of the exit door located at the front of the 300 hall on 07/30/25 at 3:11pm revealed the door was unlocked and alarmed when opened. Second observation of the exit door located at the middle of the 300 hall on 07/30/25 at 3:12pm revealed the door was unlocked and alarmed when opened. Second observation of the exit door located at the back of the 300 hall on 07/30/25 at 3:13pm revealed the door was unlocked and alarmed when opened. Second observation of the door to the smoking area on 07/30/25 at 3:15pm revealed the door was unlocked and unalarmed and a staff member was outside with residents present. Second observation of the exit door located at the front of the 100 hall on 07/30/25 at 3:22pm revealed:	D 067		

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D 067	Continued From page 6 -The door was unlocked. -There was not an audible alarm sound when the door was opened. Second observation of the exit door located at the middle of the 100 hall on 07/30/25 at 3:23pm revealed the door was unlocked and alarmed when opened. Second observation of the exit door located at the back of the 100 hall on 07/30/25 at 3:26pm revealed: -The door was unlocked. -There was not an audible alarm sound when the door was opened. Interview with a resident on 07/30/25 at 8:16am revealed: -His room was located by the front exit door of the 300 hall. -He had only been at the facility for about one week and had not heard the exit door by his room alarm. Interview with second resident on 07/30/25 at 3:26pm revealed: -His room was located by the back door of the 100 hall. -He never heard the exit door by his bedroom alarm when opened Interview with a third resident on the 100 hall on 07/30/25 at 3:52pm revealed: -Residents and staff went in and out of the front door to the 100 hall all the time. -He rarely heard the 100 hall doors alarm. -He had heard the main front door alarm in the past few days. Interview with the Business Office Manager	D 067		

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D 067	Continued From page 7 (BOM) on 07/30/25 at 8:08am revealed: -Her office was situated in front of the front entrance door. -She monitored the front door from her office. -Her hours were 8:00am to 4:30pm and she monitored the front door during her works hours. -The front door usually alarmed when opened but she was not sure why the alarm was not working today. Interview with a housekeeper on 07/30/25 at 8:17am revealed: -She thought all the exit doors were usually kept locked. -She thought she last heard the door alarms the day before. Interview with a personal care aide (PCA) on 07/30/25 at 3:56pm revealed: -The main entrance door alarmed all the time. -She was not sure about the exit doors on the 100 and 300 halls. Interview with medication aide (MA) on 07/30/25 at 4:00pm: -She usually heard the main front door alarm. -She thought the other exit doors were kept locked. Interview with a second MA on 07/30/25 at 4:03pm revealed: -The exit doors were supposed to be locked and alarmed. -The MAs were responsible to check the exit doors on their hall each shift. -She knew the mid hall door on the 300 hall was kept unlocked to allow housekeeping to take trash out. Interview with a third MA on 07/30/25 at 4:14pm	D 067		

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D 067	Continued From page 8 revealed: -The MAs and PCAs were responsible to check the exit doors daily to make sure they were alarmed and locked. -All the exit doors alarmed. -There was always a PCA on each hall to watch the residents to make sure they did not go out the doors. Interview with the Director of Maintenance (DM) on 07/30/25 at 8:50am revealed: -He was responsible to check the doors daily to make sure the alarms were working. -He checked all the doors daily but did not keep a log of the daily door alarm checks. -He said all the door alarms worked the day before and he was not sure why the door alarms were not working today. Interview with the Administrator on 07/30/25 at 9:04am revealed: -The facility had recently installed brand new door alarms on all the facility exit doors. -All the door alarms worked when she left the facility the previous day at 7:00pm. -She did not know why the door alarms were not working today. -The DM had been contacted to check the door alarms. Second interview with the Administrator on 07/30/25 at 3:47pm revealed: -All exit doors should alarm when opened. -She was not aware that the front and back door on the 100 hall were still unalarmed. -The exit door to the smoking area was not alarmed because there was always to be a staff member present when any resident was in the smoking area.	D 067		

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D 067	Continued From page 9 Observations of the facility's 100 hall on 07/30/25 at 3:51pm revealed the DM was working on the door alarm of the front door of the 100 hall. Third interview with the Administrator on 07/30/25 at 4:15pm revealed: -All exit doors except the exit door to the smoking area should be alarmed. -The smoking area should always have a staff present whenever residents were out there. -All staff were responsible for making sure all doors were alarmed. -All doors were locked from 8:00am to 8:00pm. -There was always a staff member on each hall. -The DM was responsible to check all the doors daily to make sure the door alarms worked. -All door alarms had been recently replaced, and she was not sure why they were not working earlier today. -The DM was the only staff that had a key to disable or enable the door alarms. -The door alarm for the front door of the 100 hall had been repaired this afternoon. -A part was ordered for the back door alarm of the 100 hall, and a staff had been placed by the 100 hall back door to monitor. _____ The facility failed to ensure 7 of 8 of the facility's exit doors were alarmed with an audible sounding device when the doors were opened to prevent 4 residents who were identified as intermittently disoriented and two residents that were diagnosed with dementia, one resident that was diagnosed with Alzheimer's Disease and dementia, from exiting the facility without the staff's knowledge. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in	D 067		

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D 067	Continued From page 10 accordance with G.S. 131D-34 on 07/30/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 14, 2025.	D 067		
D 112	10A NCAC 13F .0311 (c) Other Requirements 10A NCAC 13F .0311 Other requirements (c) The facility shall have heating and cooling systems such that environmental temperature controls shall be capable of maintaining temperatures in the facility at 75 degrees F minimum in the heating season, and not exceed 80 degrees F during the non-heating season. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews the facility failed to have cooling systems such that environmental temperature controls shall be capable of maintaining temperatures in the facility not to exceed 80° minimum in the heating season in several rooms. The findings are: Observation during the 8:00am medication pass on 07/31/25 at 7:37am revealed: -A resident was sitting in the hallway of the 300 Hall near the medication aide and the medication cart. -The resident told the medication aide (MA) that	D 112		

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D 112	Continued From page 11 his room was very hot, and he did not think the AC unit was working correctly. Interview with a housekeeper on 07/31/25 at 8:40am revealed: -It was hot on the men's side of the facility (halls 100 and 200) -Some of the men complained that it was too hot in their rooms. -There were some rooms on the men's side where the air conditioner units were not working properly. -There had been issues with air conditioner units not working throughout the summer. Interview with a medication aide on 07/31/25 at 9:00am revealed: -The air conditioner units on the men side of the facility did not work properly. -Sometimes the air conditioner units worked other times they did not. -Residents complained about how hot it was in the facility. Interview with the Director of Maintenance (DM) on 07/31/25 at 10:05am revealed: -For the last 2 to 4 months the men's side of the facility was often hot. -There were residents that complained that it was too hot in their rooms. -Rooms 205 and 203 got the hottest. -The air conditioner unit in room 205 was set to cool and on high and was not blowing cool air. -In room 203 the air conditioner was set to cool and on high and was not working properly. -He was aware that some of the air conditioning units were not working properly. -He did not know how long the air conditioning units had not been functioning properly. -The facility had new air conditioning units, he	D 112		

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had not gotten around to replacing all of the units that were not working properly.
-He was concerned about the air conditioning unit not working properly in resident rooms because it was a health concern.

Interview with the Resident Care Coordinator (RCC) on 07/31/25 at 10:25am revealed:
-The men's hall was the hottest because the laundry room was on that side.
-She had not heard of any residents complaining about the heat in the facility.
-The DM was responsible for ensuring the air conditioning units were working properly.

1. Review of Resident #1's current FL2 dated 03/14/25 revealed:
-Diagnoses included hemiplegia and hemiparesis following cerebral infraction, dependence on renal dialysis, type 2 diabetes with diabetic kidney disease, and chronic obstructive pulmonary disease (COPD).
-There was no information on orientation.

Review of Resident #1's Resident Register revealed an admission date of 02/08/24.

Observation of room #205 on 07/30/25 at 4:30pm revealed:
-Resident #1 was observed sitting on his bed shirtless and noticeable perspiration on his forehead.
-His 02 concentrator was in use.
-There was a portable wall mounted air conditioning unit in the room.
-The air conditioner was set to cool, and fan speed high.
-The air conditioning unit was blowing warm air.
-The temperature in the bedroom was 92.5 degrees F.

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D 112	Continued From page 13 -He did not have a fan in his room. Interview with the Resident #1 on 07/30/25 at 4:30pm revealed: -It was very hot in his room. -He was a dialysis patient and was dependent on oxygen. -The heat in his room made it harder for him to breathe. -It had been hot in his room through the entire summer. -The heat caused him to wake up sweating regularly. -He told the Administrator about the poor functioning AC unit in his room about 1 month ago and the Administrator told the DM to replace Resident #1's AC unit. -The DM told him there was nothing that he could do about his AC unit and the reason his room was so hot was because of the heat level outside. -The DM did not mention replacing Resident #1's AC unit. Interview with the Resident Care Coordinator (RCC) on 07/31/25 at 10:25am revealed: -The air conditioning unit in room 205 did not appear to be working. -She had to leave room 205 because she could not breathe due to the heat. -She was not aware that there were air conditioning units that were not working. -Resident #1 needed a working air conditioning unit in his room because he was on oxygen and dialysis. -Resident #1 needed good air circulation in his room due to his breathing problems. Interview with the Administrator on 07/31/25 at 10:30am revealed: -The air conditioning unit in room 205 was not	D 112		

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ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(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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working properly.
-She was concerned because Resident #1 was on oxygen and had difficulty breathing.

2. Observation of room #124 on 07/30/25 at 4:40pm revealed:
-A resident was observed sitting on his bed.
-There was a portable wall mounted air conditioning unit in the room.
-The air conditioner was set to cool, 60 degrees F, and fan speed high.
-The air conditioning unit was blowing warm air.
-The temperature in the bedroom was 89.2 degrees F.
-He had a portable fan in his room.

Interview with the resident in room #124 on 07/30/25 at 4:40pm revealed:
-It was always too hot in his room.
-The heat in his room made it difficult to breathe.
-He had a portable fan but it did not cool his room enough.
-He was always sweating.
-He had complained to the staff and they did not do anything.

3. Observation of room #134 on 07/30/25 at 4:48pm revealed:
-A resident was observed laying on his bed.
-There was a portable wall mounted air conditioning unit in the room.
-The air conditioner was set to cool, 64 degrees F, and fan speed high.
-The air conditioning unit was blowing warm air.
-The temperature in the bedroom was 88.3 degrees F.
-He did not have a fan in his room.

Interview with the resident in room #134 on 07/30/25 at 4:48pm revealed:

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D 112	Continued From page 15 -It was hot in his room because the air conditioner did not work well. -Staff was told the air conditioner did not work well. -The DM worked on the air conditioner unit sometimes but it did not help. 4. Observation of room #112 on 07/31/25 at 9:15am revealed: -A resident was observed laying on his bed. -There was a portable wall mounted air conditioning unit in the room. -The air conditioner was set to max cool, and fan speed high. -The air conditioning unit was blowing warm air. -The temperature in the bedroom was 86.4 degrees F. -He did not have a fan in his room. Based on observations it was determined the resident in room #112 was not interviewable. 5. Observation of room #108 on 07/31/25 at 9:25am revealed: -A resident was observed laying on his bed. -There was a portable wall mounted air conditioning unit in the room. -The air conditioner display was not working. -The air conditioning unit was blowing warm air. -The temperature in the bedroom was 86.7 degrees F. -He did not have a fan in his room. Based on observations it was determined the resident in room #108 was not interviewable. 6. Observation of room #203 on 07/31/25 at 9:30am revealed: -The resident was not in his bedroom. -There was a portable wall mounted air	D 112		

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conditioning unit in the room.
-The air conditioner was set to cool, 62 degrees F, and fan speed high.
-The air conditioning unit was blowing warm air.
-The temperature in the bedroom was 90.3 degrees F.
-He did not have a fan in his room.

Interview with the resident in room #203 on 07/31/25 at 9:30am revealed:
-It was too hot in his room.
-It was always hot in his room.

Interview with the Administrator on 07/31/25 at 10:30am revealed:
-She was not aware that there were several air conditioning units in the facility that were not working properly.
-The facility had new air conditioner units in storage.
-The DM was responsible for ensuring the air conditioning units were working properly.

Interview with the Primary Care Provider on 07/31/25 at 3:14pm revealed:
-She was not aware that there were air conditioning units that were not working in the facility.
-She saw Resident #1 on 07/29/25 and was not aware his air conditioning unit was not working.
-She had concerns about Resident #1's air conditioner not working because he was on oxygen for COPD, she was worried about him going into respiratory distress due to the heat.
-Residents room should be in the 70's and no higher than the low 80's in the summer months.
-She was concerned for the risk of heat strokes for residents whose rooms were too hot.

Attempted phone interview with Resident #1's

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D 112	Continued From page 17 dialysis provider on 07/31/25 at 2:52pm was unsuccessful. _____ The facility failed to maintain temperatures at or below 80° in the summer months in several rooms throughout the facility. High temperatures caused risk of respiratory distress and heat stroke for residents. This failure was detrimental to the health, safety and welfare of residents and constitutes a Type B Violation. _____ The facility provided a plan of protection on July 31, 2025, in accordance with G.S. 131D-34 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED September 14, 2025.	D 112		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure referral and follow-up to meet the acute health care needs of 1 of 7 sampled residents (#6) related to failing to inform a primary care provider (PCP) of a 12% weight loss in two months. The findings are: Review of the facility's undated Policy on Weight Management revealed:	D 273		

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D 273	Continued From page 18 -The facility is committed to maintaining residents' optimal health by monitoring weight as an essential component of nutritional and overall health status. -Significant weight changes will be promptly addressed to prevent complications such as malnutrition, dehydration or fluid overload in accordance with NC DHSR standards. -A significant weight change was defined as a 5% change over 30 days, a 7.5% change in 90 days, a 10% change in 180 days or unplanned weight loss/gain not due to a physician-prescribed intervention or resident's voluntary change in eating habits. -Routine monitoring, residents shall be weighed monthly unless more frequent monitoring is warranted. -Weighing will occur at the same time of day, using the same scale, and under consistent conditions. -All weights must be recorded in the resident's health record. -Any significant changes will be flagged and communicated to the nurse or attending physician. -If a significant or unexplained weight change is observed, notify the physician or nurse practitioner, conduct a comprehensive evaluation (appetite, fluid intake, medications, illness, psychological status), consult the dietitian to reassess dietary needs, review medications that might affect weight, implement an intervention plan (dietary changes, meal support, physical activity, etc). -The care plan will be updated to reflect weight management strategies and interventions, and staff will monitor compliance and response to interventions regularly. -Residents and/or family members will be informed of significant weight changes and	D 273		

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involved in care planning, if appropriate.
-Staff will receive annual training on weight monitoring procedures and recognizing signs of malnutrition and fluid imbalance, in accordance with NC DHSR guidelines.
-Weight trends will be reviewed monthly as part of the facility's Quality Assurance and Performance Improvement (QAPI) program.

Review of Resident #6's current FL-2 dated 07/01/25 revealed diagnoses included hypertension, diabetes mellitus, hyperlipidemia, cerebrovascular accident, mild cognitive disorder, hyperlipidemia, vitamin B12 deficiency, mild depression and dementia.

Review of Resident #6's previous FL-2 dated 12/31/24 revealed diagnoses included hypertension, diabetes mellitus, hyperlipidemia, cerebrovascular accident, mild cognitive disorder, hyperlipidemia, vitamin B12 deficiency, and mild depression.

Review of Resident #6's signed physicians order sheet dated 06/06/25 revealed there was an order to check and document weight monthly.

Review of Resident #6's May 2025 electronic medication administration record (eMAR) revealed
-There was an entry to check and document weight monthly scheduled for 7:00am to 3:00pm.
-His weight was documented as 190 lbs. on 05/21/25.

Review of Resident #6's June 2025 eMAR revealed
-There was an entry to check and document weight monthly scheduled for 7:00am to 3:00pm.
-His weight was documented as 200 lbs. on

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D 273	Continued From page 20 06/18/25. Review of Resident #6's July 2025 eMAR revealed -There was an entry to check and document weight monthly scheduled for 7:00am to 3:00pm. -His weight was documented as 177.8 lbs. on 07/16/25. There was no documentation provided of primary care provider (PCP) notification of Resident #6's 5% weight gain from 05/21/25 to 06/18/25. There was no documentation provided of PCP notification of Resident #6's 12% weight loss from 06/18/25 to 07/16/25. Interview with Resident #6 on 07/31/25 at 2:35pm revealed: -He thought he had probably lost about 20 lbs. over the past few months. -He used to weigh 200 lbs. and had been trying to lose a little weight. Interview with a medication aide (MA) on 07/31/25 at 2:01pm revealed: -All residents were weighed at least monthly around the 1st of the month. -Some residents were weighed more frequently if there was an order to do so. -The personal care aides (PCAs) weighed the residents and reported the weight to the MAs and they recorded the resident's weight on their eMAR. -The residents' weights were reviewed by the Resident Care Coordinator (RCC). -The MAs did not compare the residents' current weight to their previous month's weight. -If she noticed that a resident seemed to be losing weight, she might look at the resident's	D 273		

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previous month's weight.
-Resident #6's dementia was worsening, and she thought that may be responsible for his weight loss, but she had not thought to compare his current weight to his previous weight.

Interview with the RCC of the Men's Hall on 07/31/25 at 2:25pm revealed:
-All residents were weighed at least monthly around the first of the month.
-The PCAs obtained the residents' weight and reported it to the MAs, who entered the weights in the eMAR.
-The resident's weights were given to the RCC to enter on the resident's face sheet.
-The residents were weighed monthly to monitor for weight loss, weight gain and to see if they were holding on to fluid.
-She did not compare the residents' current month's weight to their previous month's weight.
-She had never been instructed to compare the resident's weights month to month.
-There was no one that she knew of that compared the residents' month to month weights unless it was the licensed health professional (LHPS) nurse who came to the facility quarterly.

Resident #6 was re-weighed on 07/31/25 at 2:35pm at the surveyor's request and his weight was observed and documented as 168.2.

Second interview with the MA on 07/31/25 at 2:39pm revealed:
-She was not sure if the scale used for weighing the residents had to be calibrated.
-She did not know how to calibrate the scale used to weigh the residents.
-She thought an outside company came and calibrated the scale monthly.
-There was a green sticker on the back of the

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D 273	Continued From page 22 scale that indicated the scale had been calibrated on 05/23/25 and was next due in 05/2026. Interview with the Administrator on 07/31/25 at 4:20pm revealed: -The PCAs or the MAs weighed all residents at least monthly. -The MAs documented the residents' weights on their eMAR. -The MAs also notified the RCC of the residents' weight and made sure the weight was entered accurately. -If a resident's weight differed by 5 lbs. or more, the resident should be re-weighed to make sure the weight was accurate. -If there was still a 5 lb. difference in the resident's weight, she expected the resident's PCP to be notified by either the MA or the RCC. -She expected both the MAs and the RCC to compare the residents' current weight to their previous month's weight to monitor for changes. -She thought the scale used to weigh the residents was calibrated quarterly. Interview with Resident #6's PCP on 07/31/25 at 3:17pm revealed: -She treated Resident #6 for diabetes, hypertension and dementia among other things. -She was not notified of Resident #6's weight change from May 2025 to June 2025 or from June 2025 to July 2025. -The weight change documented for Resident #6 was significant. -If she had been made aware of Resident #6's weight change, she would have evaluated the resident and reviewed his medications to determine if there was a cause there and then would consider testing to rule out things such as types of metabolic issues or cancer. -She expected to be notified by the facility if a	D 273		

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D 273	Continued From page 23 resident had a weight change of 5 to 6 lbs. in one month.	D 273		