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	HAL074046	A. BUILDING: _____ B. WING _____	08/27/2026

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 an annual survey and complaint investigation on 08/18/26 to 08/21/26 and on 08/24/26 to 08/27/26. Complaint investigations were initiated by the Pitt County Department of Social Services on 07/30/26.	D 000		
D 074	10A NCAC 13F .0306 (a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings that are clean, safe, and functional; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the floors, baseboards, bathrooms, and walls in residents' rooms were kept clean and damaged walls were repaired.	D 074		

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D 074	Continued From page 1 The findings are: Observation of Room #318 on 08/19/26 at 1:23pm revealed: -There was a large hole in the wall behind the location that the doorknob would touch the wall. -There was a large red towel stuffed into the hole with half of the towel hanging out of the hole down the wall. -The floor under the dresser had an outline that was the shape of the dresser with dirt and grime that was yellow, brown and black. -The dirt was in the shape of the dresser with darker stains around the edges of the outline under the dresser. Interview with the resident who resided in Room #318 on 08/19/26 at 1:25pm revealed: -Her previous roommate slammed the door and caused the hole in the wall. -She was not sure how long the hole had been in the wall, but her roommate had been gone for a while. -The resident was asked if state surveyors could move her dresser away from the wall to look at the cleanliness in the room. -The resident gave permission for state surveyors to move her dresser away from the wall. Observation of resident Room #319 on 08/18/26 at 3:32pm revealed: -There was dust, dirt, and debris build-up along the baseboards and floor. -There was a dead roach on the floor along the base boards of the wall by the resident's bathroom. Interview with the resident that resided in Room #319 on 08/20/26 at 2:24pm revealed	D 074		

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D 074	Continued From page 2 housekeeping swept and mopped in her room and cleaned the bathroom 3 to 4 times a week. Observation of the bathroom in Room #312 on 08/24/26 at 3:17pm revealed: -There was an area of tile to the right of the toilet that was slightly raised from the floor. -The baseboards were covered with thick brown, yellow and black discoloration. -The tile around the toilet was dirty with discoloration. Observation of Room #124 on 08/24/26 at 3:30pm revealed there was a hole in the wall behind the location that the doorknob would touch the wall. Interview with a housekeeper on 08/26/26 at 11:26am revealed: -She was the only housekeeper on the women's hall on 08/26/26. -Usually there were two housekeepers on the women's hall and two on the men's hall. -Housekeepers were responsible for the overall cleanliness of the facility. -She swept and mopped residents' rooms, cleaned the bathrooms, and dusted the furniture. Interview with the Administrator on 08/27/26 at 6:44pm revealed she expected the facility to be clean so the residents had a safe and comfortable environment.	D 074		
D 079	10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings	D 079		

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D 079	Continued From page 3 (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide a safe and clean environment related to the presence of live and dead cockroaches throughout the facility and unsecured oxygen tanks. The findings are: 1. Review of the local county Public Health Inspection Report for the facility dated 05/19/26 revealed the facility was out of compliance and points were deducted for pest control. Review of the local county Public Health Inspection Report for the kitchen dated 08/31/26 revealed the facility was out of compliance and points were for insects and rodents. Observation of the facility's kitchen on 08/18/26 at 9:15am revealed several insect traps with dead cockroaches throughout the kitchen. Observation of room #133 on 08/19/26 at 1:00pm revealed there were four live cockroaches under the nightstand, and six dead cockroaches under the dresser. Interview with the resident in room #133 on	D 079		

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D 079	Continued From page 4 08/19/26 at 1:00am revealed: -He always had problems with cockroaches in his bedroom. -The cockroaches were the worst at night, they were all over his bedroom. -In the morning he shook his shoes out to make sure there were no cockroaches in them before he put them on. -Pest control came in and sprayed for cockroaches once each month. Observation of room #315 on 08/19/26 at 1:15pm revealed there was one live cockroach and two dead cockroaches under the nightstand. Interview with a resident in room #315 on 08/19/26 at 1:15pm revealed: -She observed cockroaches in her bedroom. -The cockroaches were the worst at night. -Pest control came to the facility to spray for cockroaches. Observation of room #109 on 08/19/26 at 1:20pm revealed there were three dead cockroaches on the floor near the bed. Observation of room #107 on 08/19/26 at 1:45pm revealed there was one dead cockroach on the bed and two dead cockroaches on the floor. Interview with a resident in room #140 on 08/19/26 at 1:40pm revealed: -He observed cockroaches in his bedroom. -He observed cockroaches in the dining room. -The cockroaches used to be much worse. -Pest control came to the facility to spray for cockroaches. Interview with a housekeeper on 08/19/26 at 1:30pm revealed:	D 079		

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D 079	Continued From page 5	D 079		

-The cockroaches were bad in certain rooms.
-Pest control came to the facility to spray for bugs.
-The cockroach problem in the facility was getting better since pest control began spraying more often.

Interview with the Maintenance Director on 08/19/26 at 1:50pm revealed:
-Pest control began coming to the facility about a month ago and was coming to the facility weekly to spray for insects.
-He observed less cockroaches in the facility since pest control began spraying regularly.
-There were some residents that complained that there were cockroaches in their bedrooms.

Interview with the Administrator on 08/19/26 at 2:00pm revealed:
-There was a pest control company that had been spraying the facility monthly.
-She hired a second pest control company on 06/15/26 to come and spray the facility for cockroaches as well.
-She had observed one cockroach in the facility.
-No residents had complained to her about insects in the facility.

Interview with the pest control technician on 08/20/26 at 2:45pm revealed:
-He had observed German cockroaches throughout the facility.
-Some bedrooms had more cockroaches due to unsanitary conditions.
-He came to the facility for an initial treatment to kill all the adult cockroaches, and came back two weeks later to follow-up and kill the newly hatched cockroaches.
-He came to the facility to spray for cockroaches twice each month since his initial treatment.

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D 079	Continued From page 6	D 079		

-He sprayed half of the facility once per month and sprayed the other half of the facility once per month.
-He also asked facility staff about any rooms that were particularly bad and would spray those rooms each time he went to the facility.
-There were less cockroaches observed in the facility since he began treatment.

Interview with the facility's primary care provider (PCP) on 08/21/26 at 10:12am revealed:
-Roaches in the facility could aggravate respiratory issues and cause residents to have more frequent coughing.
-Roaches could exacerbate asthma for residents and disrupt their sleep.
-She wanted the residents to reside in a comfortable facility without worries about cockroaches.

2. Observation of Room #318 on 08/18/26 at 1:23pm revealed:
-There was a resident sitting on the edge of the bed facing the doorway.
-There were 4 oxygen canisters that were upright, unsecured against the other side of the bed.
-The 4 oxygen canisters were lined up beside each other alongside the length of the resident's bed.

Interview with the resident who resided in Room #318 on 08/18/26 at 1:24pm revealed:
-She was not sure who put the oxygen canisters in her room beside her bed.
-She could not remember when the oxygen canisters were placed in her room.

Observation of Room #318 on 08/18/26 at 1:35pm revealed the 4 oxygen canisters were still in the resident's room lined up alongside the

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D 079	Continued From page 7 length of her bed. Interview with the previous Resident Care Coordinator (RCC) on 08/18/26 at 1:40pm revealed staff were expected to keep oxygen canisters in the oxygen storage room in storage racks. Observation of a medication aide (MA) on 08/18/26 at 1:40pm revealed she placed the 4 oxygen canisters in the oxygen storage room in storage racks. Interview with the facility's primary care provider (PCP) on 08/21/26 at 10:12am revealed: -Oxygen canisters should never be unsecured; they should be placed in a storage rack that ensured the oxygen canister could not be turned over accidentally. -There was a risk of the oxygen canisters falling over and exploding which could harm residents. Interview with the Administrator on 08/27/26 at 6:44pm revealed: -Oxygen canisters should be stored in storage racks. -When staff observed an oxygen canister not in a storage rack, they should ensure the oxygen canister was moved and stored in a storage rack. -Oxygen tanks that were not in a storage rack placed residents and staff at risk of a fire.	D 079		
D 080	10A NCAC 13F .0306 (a)(6) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall:	D 080		

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D 080	Continued From page 8 (6) have a supply available in the facility at all times of bath soap, clean towels, washcloths, sheets, pillowcases, blankets, and additional covers such as a bedspread, comforter, or quilt for each resident to use; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to have an adequate supply of towels and washcloths available for residents. The findings are: Review of the facility's Resident Contract revealed: -The facility would provide housekeeping and laundry services. -The facility would provide residents with a washcloth and towel. Review of the current facility census revealed there were 65 residents. Observation of the linen storage on the women's hall on 08/25/26 at 2:14pm revealed: -There were 7 washcloths stacked on a shelf. -There was 1 towel on a shelf. Observation of the linen storage on the men's hall on 08/25/26 at 2:20pm revealed: -There were 7 washcloths stacked on a shelf.	D 080		

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D 080	Continued From page 9 -There were 9 towels on a shelf. Interview with a resident on 08/18/26 at 9:34am revealed there were times when she needed a washcloth and none were available when she asked for one. Interview with a second resident on 08/18/26 at 9:38am revealed: -She did not always have a towel or washcloth available when she needed one. -She asked staff for a towel or washcloth, and usually they brought her one later in the day. Interview with a third resident on 08/18/26 at 9:40am revealed: -There were times that the facility could not provide her with a washcloth and towel. -When she asked for a washcloth or towel, staff told her they were behind on laundry. Interview with a personal care aide (PCA) on 08/25/26 at 1:57pm revealed: -PCAs were responsible for doing laundry for resident's clothing and the facility linens. -PCAs laundered items daily and restocked the linen closet. -She had not had any complaints from residents about the supply of washcloths and towels. Interview with the Administrator on 08/27/26 at 6:44pm revealed the facility should have towels and washcloths available for the residents.	D 080		
D 112	10A NCAC 13F .0311 (c) Other Requirements 10A NCAC 13F .0311 Other requirements (c) The facility shall have heating and cooling	D 112		

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D 112	Continued From page 10 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: Based on observations, record reviews, and interviews the facility failed to have cooling systems such that environmental temperature controls were capable of maintaining temperatures in the facility not to exceed 80 degrees Fahrenheit (F) minimum in the non-heating season in several rooms. The findings are: Review of the current facility census revelaed there were 65 residents. Observation of room #133 on 08/19/26 at 9:50pm revealed: -A resident was observed lying on his bed. -There was a portable wall mounted air conditioning unit in the room. -The air conditioner was set on 60 degrees Fahrenheit (F), wires were exposed and it appeared the unit was not functional. -The air conditioning unit was blowing warm air. -The temperature in the bedroom was 83.1 degrees F. -He had a portable fan in his room.	D 112		

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D 112	Continued From page 11 Second Observation of room #133 on 08/19/26 at 12:10pm revealed the temperature in the bedroom was 85.3 degrees F. Interview with the resident in room #133 on 08/20/26 at 9:50am revealed: -He complained to the Administrator and the Director of Maintenance about his air conditioner not working and they had not followed up. -It was always hot in his room. -He used a portable fan to help stay cool. Observation of room #339 on 08/20/26 at 8:15am revealed: -A resident was observed sitting on her 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 81.7 degrees F. -She had a portable fan in her room. Interview with the resident in room #339 on 08/20/26 at 8:15am revealed: -The air conditioning did not work well in her room. -She used a portable fan to help circulate air throughout the room. -She had not told staff that her room was warm. Observation of room #137 on 08/19/26 at 12:15pm revealed the temperature in the bedroom was 83.1 degrees F. Observation of room #125 on 08/19/26 at 12:17pm revealed the temperature in the bedroom was 81.7 degrees F.	D 112		

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D 112	Continued From page 12 Observation of room #112 on 08/19/26 at 12:20pm revealed the temperature in the bedroom was 82.4 degrees F. Second observation of room #125 on 08/19/26 at 1:55pm revealed the temperature in the bedroom was 82.8 degrees F. Observation of the women's hall on 08/19/26 at 12:23pm revealed the temperature in the hallway was 86 degrees F. Observation of the dining room on 08/19/26 at 12:25pm revealed the temperature in the room was 84 degrees F. Interview with a housekeeper on 08/20/26 at 8:30am revealed: -It was often hot throughout the facility. -Some resident rooms were really warm because the air conditioning units did not work properly. -The facility had been replacing the air conditioning units in some of the resident rooms. -Residents complained to staff about the rooms in the facility being hot. Interview with a personal care aide (PCA) on 08/20/26 at 8:45am revealed: -The hallways in the facility got the hottest. -The air conditioner units in some of the resident rooms did not work properly. -Some rooms got really warm during the day. -No residents had complained to her about their rooms being too hot. Interview with the Director of Maintenance (DM) on 08/20/26 at 9:00am revealed: -He had been the DM at the facility for approximately two months. -He began replacing air conditioner units	D 112		

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throughout the facility as soon as he was hired.
-He had replaced 15 to 20 air conditioner units in the two months since he began to work at the facility.
-The facility was always too hot.
-The hallways in the facility only had portable air conditioner units and were always the warmest.
-Residents rooms were always warm because they left their doors open and the air conditioner units were not strong enough to cool the rooms and the hallways.
-There were three air conditioner units in the dining room.
-The dining room was warm especially when all of the residents were in there.
-It was hotter than 80 degrees F throughout the facility.

Interview with the Primary Care Provider on 08/21/26 at 10:40am revealed she was concerned that if the facility was too warm elderly residents in the facility could become dehydrated and pass out and end up being sent to the hospital.

Interview with the Resident Care Coordinator (RCC) on 08/20/26 at 9:20am revealed:
-She was aware that the facility was supposed to be under 80 degrees F during the warm months of the year.
-The facility had been replacing air conditioning units throughout the facility.
-They had begun replacing air conditioning units in the facility the summer of 2025.
-The hallways and the dining room were above 80 degrees F.
-There were some bedrooms that were above 80 degrees F.
-She was concerned for the residents with breathing issues having to deal with the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 112	Continued From page 14 temperature being above 80 degrees F. Interview with the Administrator on 08/20/26 at 9:35am revealed: -She was aware that the facility was supposed to be under 80 degrees F during the warm months of the year. -The facility did not have a central air conditioning unit. -The facility had replaced about 15 air conditioner units since the summer of 2025. -When residents complained about their rooms being too hot they replaced the air conditioner units in their room. -She attempted to keep the residents out of the hall because it was always the warmest in the hallways.	D 112		
D 118	10A NCAC 13F .0311 (i) Other Requirements 10A NCAC 13F .0311 Other Requirements (i) In licensed facilities without live-in staff, there shall be an electrically operated call system meeting the following requirements: (1) the call system shall connect residents' bedrooms and bathrooms to a location accessible to staff; (2) residents' bedrooms shall have a resident call system activator at the resident's bed; (3) the resident call system activator shall be within reach of a resident lying on the bed; (4) the resident call system activator shall be such that it can be activated with a single action and remain on until deactivated by staff at point of origin; and (5) when activated, the call system shall activate an audible and visual signal in a location accessible to staff.	D 118		

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This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure the electrical call bell system in the Assisted Living (AL) was audible and visible in a location where staff was always available.

The findings are:

Observation of the facility on 08/21/26 at 2:44pm revealed:
-When the call bell in room #307 was pressed there was a dinging sound and the room number was announced which could only be heard inside of the nursing station.
-The room number appeared on a panel located inside the nursing station.

Observation of the facility on 08/21/26 at 9:07am revealed:
-The call bell in room #315 was pressed at 9:07am.
-There was no audible noise that could be heard standing outside of the nursing station.

Interview with the resident in room #315 on 08/21/26 at 9:00am revealed:
-When she pressed her call bell in the past it took a very long time for staff to respond.
-She had pressed her call bell and staff never showed up to check on her.

Observation of the facility on 08/21/26 at 9:45am revealed:
-The call bell in room #301 was pressed at

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D 118	Continued From page 16 9:45am. -At 9:50am there were no staff observed at the nursing station and room #301 was on the panel. -At 9:58am there were no staff observed at the nursing station and room #301 remained on the panel. Observation of the facility on 08/25/26 at 2:43pm revealed: -Survey staff heard a resident in room #324 yelling for help. -Upon entering the room survey staff observed the resident who was partially on the bed attempting to transfer from her wheelchair into her bed. -The resident pressed her call button at 2:45pm. -Room #324 alerted on the call bell panel for approximately three seconds then was cleared automatically without staff clearing it or checking on the resident. -No facility staff came to assist the resident. -The resident was verbally advised by survey staff on how to get into bed properly. Interview with the Administrator on 08/25/26 at 3:00pm revealed: -She did not know why the room number for room #324 only alerted on the panel for a couple of seconds. -When a resident pressed the call button it should have remained on the panel and needed to be manually cleared. Interview with the marketing staff on 08/25/26 at 8:25am revealed: -She was usually at the nursing station throughout the day. -Residents had call bells in their rooms that they pressed if they needed assistance. -When a resident pressed their call button there	D 118		

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was an alert at the nursing station and their room number appeared on the panel.
-When she heard the panel alert in the nursing station, she alerted staff over the intercom which resident room number needed assistance.
-Personal care aides (PCA) and medication aides (MA) walked in the nursing station regularly and could see which rooms pressed their call buttons for assistance.
-Management was attempting to find a better system to allow staff to be alerted when residents needed assistance.
-She was concerned about resident safety due to lack of staff answering call bells.

Interview with a PCA on 08/25/26 at 8:55am revealed:
-Residents pressed their call bells when they needed assistance.
-When residents pressed their call bells there was an alert at the nursing station with the resident room number.
-Any staff member at the nursing station could tell a PCA when a resident needed assistance.

Interview with a second PCA on 08/25/26 at 9:10am revealed:
-Residents had call bells in their rooms that they pressed if they needed assistance.
-The call bell alerted at a panel in the nursing station.
-If there was a staff member at the nursing station then they alerted PCAs which room needed assistance.

Interview with the Resident Care Coordinator (RCC) on 08/21/26 at 2:45pm revealed:
-When a resident pressed their call bell there was an alert at the nursing station that dinged and said the room number and the room number

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remained on the panel.
-Once there was an alert the staff member at the nursing station was supposed to call for the PCA or MA to check on the resident.
-If nobody was in the nursing station when the alert sounded then the room number remained on the panel and whoever walked by and observed the room number should check on the resident.

Interview with the facility's Registered Nurse (RN) on 08/27/26 at 2:15pm revealed:
-Each resident had a call bell in their room they could press for assistance.
-When the call bell was pressed there was an alert at the nursing station with a sound that dinged and said the room number and the room number appeared on a panel.
-If there was not a staff member at the nursing station then staff on the floor could not be made aware of which resident needed assistance.
-The marketing staff member usually sat at the nursing station but she did not go over the intercom and alert staff which room numbers needed assistance.
-She was concerned that residents were not getting the assistance they needed and there could be skin breakdown, if a resident had to wait for incontinent care.
-If a resident had a fall or an injury they needed assistance immediately.

Interview with the Administrator on 08/21/26 at 10:40am revealed:
-When a resident pressed their call bell there was an alert at the nursing station and there was a sound that dinged and announced the room number and the room number appeared on a panel located at the nursing station.
-Staff members did their charting at the nursing station so there was usually someone sitting

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D 118	Continued From page 19 there. -Any staff at the nursing station could alert the PCAs which room number needed assistance.	D 118		
D 176	10A NCAC 13F .0601 (a) Management of Facilities-General Administrato 10A NCAC 13F .0601 Management Of Facilities - General Administrator And Manager Responsibilities (a) Each adult care home shall have an administrator who is certified in accordance with Rule .1701 of this Subchapter. The administrator shall be responsible for the total operation and management of the facility to assure that all care and services are provided to maintain the health, safety, and welfare of the residents in accordance with all applicable local, state, and federal regulations and codes. The administrator shall also be responsible to the Division of Health Service Regulation and the county department of social services for complying with the rules of this Subchapter. The co administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term "administrator" also refers to co administrator where it is used in this Subchapter. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the current Administrator failed to ensure the overall management of the facility to meet and maintain rules related to resident rights, controlled substances, medication administration,	D 176		

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health care, personal care and supervision, housekeeping and furnishings, discharge of residents, resident records, activities, and reporting of incidents and accidents.

The findings are:

Review of the facility's license revealed the license was effective 01/01/26 through 12/31/26 for a capacity of 120 residents.

Review of the facility's census on 08/18/26 revealed there were 65 residents residing in the facility.

Interview with the current Administrator on 08/27/26 at 11:05am revealed:
-She was hired with the company on 06/01/26 and started working as a Regional Director at the facility on 06/01/26.
-She was responsible for oversight of the previous Administrator and the facility.
-The facility had a bank account, and she was unsure if the previous Administrator was listed on that account.
-The previous Administrator had control of the facility mailbox and the bank where the facility had an account.
-She noticed that many residents were behind on their room and board bills.
-The facility had not been paid for room and board for several residents for approximately one year.
-She could not remember the date in June 2026 that she went to the local Social Security office to inquire on how long it would take the facility to become the payee for several residents.
-She was informed it would take approximately one month.
-She completed applications for residents at

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Department of Social Services (DSS) for any residents that qualified for Special Assistance in June or July 2026.

Second interview with the current Administrator on 08/27/26 at 6:44pm revealed:
-Her corporate supervisor wanted to know why the facility had not received many payments on room and board for over a year.
-The corporate supervisor felt it should not take long for payments from the local Social Security office to come to the facility and did not understand why the facility was so far behind in payments for room and board.
-She thought the previous Administrator or the corporate office were not completing the correct paperwork with the local Social Security office.
-When she came to work at the facility on 06/01/26, she was the supervisor of the previous Administrator.
-She realized something was not right with resident's past due balances when the previous Administrator discharged a resident to a skilled nursing facility (SNF), because she had allegedly been taking money from the resident for room and board and there was no documentation that the resident had paid her bill with the facility.

Interview with the Business Office Manager (BOM) on 08/25/26 at 2:29pm revealed:
-She began working as the BOM at the facility on 09/01/25.
-The current Administrator was also the Regional Director.
-The previous Administrator left the facility on 07/13/26.
-The current Administrator helped with admissions.
-To her understanding the current Administrator and the previous Administrator set the room and

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D 176	Continued From page 22 board rates for residents. -Approximately 1 ½ weeks prior to the previous Administrator leaving her position at the facility on 07/13/26, the Regional Director who was now the current Administrator explained to the BOM that she was now her supervisor instead of the previous Administrator. -The previous Administrator came to the facility at approximately 11:00pm on 07/12/26 and stayed at the facility until approximately 4:00am on 07/13/26 based on video recordings. -The previous Administrator packed up her office and texted the BOM at approximately 2:00am on 07/13/26 that she left her keys and files in the BOM box, that she was removing her Administrator's license from the wall and placing the Regional Director's license on the wall. -The previous Administrator texted her a photo of Regional Directors/current Administrator license on the wall. Interview with a resident on 08/18/26 at 9:32am revealed: -The facility did not have a good supply of washcloths and towels. -She asked a personal care aide (PCA) for a washcloth and towel several times and was told there were not any clean ones available. -She told the Administrator about the supply shortage of washcloths and towels and there was no improvement. -Last week was the last time she asked a PCA for a washcloth and they were not able to provide her with one. Third interview with the current Administrator on 08/27/26 at 6:44pm revealed: -She was not aware that there was a low supply of washcloths and towels at the facility. -She could not remember a resident or PCA	D 176		

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D 176	Continued From page 23 informing her that there was a low supply of washcloths and towels. Interview with a resident on 08/18/26 at 9:30am revealed: -She did not have a lockable space to keep her belongings in her room safe. -She had asked the Administrator about obtaining a lock for her closet, but nothing had been done yet. Fourth interview with the current Administrator on 08/27/26 at 6:44pm revealed: -She contacted the facility's Maintenance Director last week to ensure all rooms on the female unit had a lockable space. -She was not aware of any complaints of residents having items stolen from their rooms. Fifth interview with the current Administrator on 08/19/26 at 12:30pm revealed: -The medication aides (MAs) should never document a medication was administered if they did not actually administer the medication. -She was not aware that the MAs had made mistakes with documentation on the electronic medication administration records (eMARS). Sixth interview with the current Administrator on 08/21/26 at 2:44pm revealed: -Resident #26 was sent to the hospital on Friday 08/14/26 due to behaviors. -The day prior, Resident #26 had two visitors that were arguing and that seemed to set him off. -On Friday 08/14/26, Resident #26 exhibited threatening and aggressive behavior and was disruptive. -She went to the magistrate's office on 08/14/26 to obtain IVC paperwork for Resident #26 and he was sent to the hospital.	D 176		

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D 176	Continued From page 24 -The hospital overturned the IVC and all she knew was Resident #26 ended up in jail for trespassing. -She received a call from the jail asking if Resident #26 had any health problems. -She received a call from the county jail on Wednesday 08/19/26 that Resident #26 was released on his own recognizance due to his health. -She spoke with the hospice nurse last night and the hospice nurse told her that Resident #26 had called her from jail, but he could not continue hospice services from jail and had been discharged from hospice services. -A family member called over the weekend and spoke with a medication aide (MA) and asked about the process to pick up his clothes. -No one checked to see where Resident #26 was. -She had no idea where Resident #26 was and did not try to locate him. Interview with the Resident Care Coordinator on 08/21/26 at 2:45pm revealed: -She went to check on a resident because she heard her yelling at another resident, not because she pressed her call button. -She was not aware that the call button in the room had been pressed. -When a resident pressed their call button there was an alert at the nursing station that dinged and said the room number and the room number remained on the panel. -Once there was an alert the staff member at the nursing station was supposed to call for the PCA or MA to check on the resident. -If nobody was in the nursing station when the alert sounded then the room number remained on the panel and whoever walked by and observed the room number should check on the resident. -She believed staff members had become	D 176		

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D 176	Continued From page 25 desensitized to the call bell system and stopped checking on residents. -She was concerned because a resident could fall or be injured and press their call button for assistance and staff would not check on them. Seventh interview with the current Administrator on 08/21/26 at 10:40am revealed: -She expected staff to check on residents as soon as possible when a resident pressed their call button. -When a resident pressed their call bell there was an alert at the nursing station and a sound that dinged and said the room number and the room number appeared on a panel. -Staff members did their charting at the nursing station so there was usually someone sitting there. -Any staff at the nursing station could alert the PCAs which room number needed assistance. -After staff checked on the resident that pressed their call button they went to the nursing station and cleared the room number off of the panel. -Staff usually checked on residents when they pressed their call buttons. -Staff should have checked on the residents rooms that were on the panel in the nursing station. -The call bell system did not allow her to print out a history of call bell alerts and time it took to clear the room number. -She was concerned with the health and safety of residents if staff did not answer call buttons. Eighth interview with the current Administrator on 08/24/26 at 10:13am revealed: -She and staff were unable to locate any records of a resident. -She did not think the resident had ever been a resident at the facility.	D 176		

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D 176	Continued From page 26 -She thought the previous Administrator may have packed the resident's chart away somewhere that they were unable to locate. Ninth interview with the current Administrator on 08/24/26 at 10:50am revealed: -She was aware that outing activities should be available for all residents. -She was aware non-ambulatory residents did not go on outings. -She was not equipped to take non-ambulatory residents on outings. -She was working on finding other transportation alternatives so non-ambulatory residents could go on outings. Tenth interview with the current Administrator on 08/24/26 at 11:00am revealed: -Medication that had been discontinued should have been removed from the medication cart by the MA or the RCC and returned to the pharmacy. -The MA or RCC were responsible for completing the discontinued form to be returned to the pharmacy for pick-up. -The RCC was responsible for ensuring all discontinued medications were off the medication cart. Eleventh interview with the current Administrator on 08/25/26 at 8:34am revealed: -When a resident was discharged, she had a discharge meeting with herself and two MAs. -She described the Adult Care Home Resident Discharge Team noted as convened for Resident #26 on the 08/14/26 and 08/21/26 Adult Care Home Notice of transfer/Discharge form as consisting of herself, and two MAs. -She was not aware that the Adult Home Specialist (AHS) with the Department of Social Services (DSS) needed to be included in the	D 176		

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discharge planning and placement of a resident.
-The county DSS AHS was not contacted.
-She was not aware the DSS AHS needed to be included in discharge planning and placement for Resident #26.
-The former RCC located Resident #26 through a mutual friend and took his medications and the discharge paperwork to him she thought on 08/21/26.
-She said Resident #26 was provided with the Adult Care Home Hearing Request Form, but she did not keep a copy of the form, he was given a blank copy that contained the facility name only.
-Since Resident #26 was IVC'd and sent to the hospital she expected hospital staff to assist Resident #26 with placement.
-She did not have a copy of the IVC paperwork for Resident #26.
-She never received a phone call from the hospital staff that Resident #26 was ready for discharge back to the facility.
-The former RCC tried to find Resident #26 on 08/21/26 but was unable to locate him.
-She did have a three way call over the weekend about Resident #26 with the facility's owner and the former RCC and placement was found for Resident #26 at a housing shelter in a neighboring county but Resident #26 refused to go.
-She felt Resident #26 could take care of himself on his own, because the only thing the facility did for Resident #26 was administer his medications.
-She felt Resident #26's discharge was appropriate for the safety of the other residents and staff of the facility.
-Resident #26 had been issued a 30-day notice of discharge in July 2026 for non-payment.
-When a resident was discharged, she never made a copy of the Adult Care Home Hearing Request form when a resident was discharged.

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

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D 176	Continued From page 28 -She did not realize that she needed to maintain a copy in the resident's record. Telephone interview with a previous employee on 08/26/26 at 2:25pm revealed: -She had shared her concern with the Administrator that a resident was often found in 4-5 incontinence briefs when she arrived for her shift. -The resident would be found saturated in urine and bowel through to her bed linens. -She spoke with the Administrator about her concerns but the problem continued. Twelfth interview with the current Administrator on 08/27/26 at 3:52pm revealed: -She was not given any medications when she brought Resident #2 back from the skilled nursing facility (SNF). -She was not aware the Resident #2 was without medications when she returned from the SNF. -If she had known Resident #2 was without her medications, she could have sent staff to the SNF to retrieve Resident #2's medications because the SNF was just across the street. -She expected the residents' medications to be available and administered as ordered by their PCP. -Controlled substance medications were counted each shift. -If the controlled substance count was off, the MAs were to report it to RCC and to her. -There had never been discrepancy with controlled substances reported to her. -The controlled substance logs (CSL) were kept in the facility. -She and the Executive Director were unable to locate a CSL for a resident's morphine sulfate extended release (ER) 30mg but knew it was in the facility somewhere.	D 176		

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D 176	Continued From page 29 Thirteenth interview with the Administrator on 08/24/26 at 10:11am revealed: -She asked the survey team if they could choose another resident's record rather than Resident #7 because she and her staff were unable to locate any information on the resident. -She did not think that Resident #7 had ever been a resident at the facility. -She thought the previous Administrator may have packed the resident's chart away somewhere that they were unable to locate. Fourteenth interview with the Administrator on 08/26/26 at 2:56pm revealed: -She did not know where Resident #7 was located. -She found an obituary for Resident #7 on her cellular telephone. -To the best of her knowledge the resident's family picked him up and took him to a different facility when the previous Administrator was in charge of admissions and discharges. -She assumed that the previous Administrator had shredded all his documentation after he was discharged from the facility since she was not able to find any information on the resident. Non-compliance was identified in the following rule areas: 1. Based on observations and interviews, the facility failed to ensure the floors, baseboards, bathrooms, and walls in residents' rooms were kept clean and damaged walls were repaired. [Refer to Tag 074, 10A NCAC 13F .0306(a)(1) Housekeeping and Furnishings (Standard Deficiency).] 2. Based on observations, interviews, and record	D 176		

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D 176	Continued From page 30 reviews, the facility failed to provide a safe and clean environment related to the presence of live and dead cockroaches throughout the facility and unsecured oxygen tanks. [Refer to Tag 079, 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Standard Deficiency).] 3. Based on observations, interviews, and record reviews, the facility failed to have an adequate supply of towels and washcloths available for residents. [Refer to Tag 080, 10A NCAC 13F .0306(a)(6) Housekeeping and Furnishings (Standard Deficiency).] 4. Based on observations, record reviews, and interviews, the facility failed to have cooling systems such that environmental temperature controls were capable of maintaining temperatures in the facility not to exceed 80 degrees Fahrenheit (F) minimum in the non-heating season in several rooms. [Refer to Tag 112, 10A NCAC 13F .0311(c) Other Requirements (Standard Deficiency).] 5. Based on observations and interviews, the facility failed to ensure the electrical call bell system in the Assisted Living Facility (ALF) was audible and visible in a location where staff was always available. [Refer to Tag 118, 10A NCAC 13F .0311(i) Other Requirements (Standard Deficiency).] 6. Based on record reviews and interviews, the facility failed to ensure the requirements for a notice of discharge and appeal rights were met as soon as practicable related to a resident who was discharged for the safety of the residents in the facility (26). [Refer to Tag 226, 10A NCAC 13F .0702(d) Discharge of Residents (Standard Deficiency).]	D 176		

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D 176	Continued From page 31 7. Based on interviews and record reviews, the facility failed to ensure a safe and orderly discharge for 1 of 1 resident (#26) who was receiving hospice services by failing to convene the Department of Social Services (DSS) discharge team to assist with placement, provide the necessary discharge paperwork and medications to meet his medical needs. [Refer to Tag 229, 10A NCAC 13F .0702(g) Discharge of Residents (Type A1 Violation).] 8. Based on observations, interviews, and record reviews, the facility failed to provide personal care assistance to 7 of 12 sampled residents including a resident who had on three incontinence briefs with skin breakdown (#34), residents with toenails that were long, jagged, had dirt under the nails (#14, #27, #28), and residents who had long, jagged fingernails with dirt and debris underneath their fingernails (#2, #31, #32). [Refer to Tag 269, 10A NCAC 13F .0901(a) Personal Care and Supervision (Type A2 Violation).] 9. Based on observations, interviews, and record reviews, the facility failed to provide supervision for 3 of 8 sampled residents related to a male resident who touched a female resident inappropriately (#25), a resident who had 8 elopements (#15), and a resident that was assessed as an unsafe smoker who had a lighter and cigarettes in his room (#14). [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation).] 10. Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up for 2 of 5 sampled residents (#1, #2) related to a resident with orders for physical and occupational therapy and missed a follow-up	D 176		

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ophthalmology visit (#2) and notifying the primary care provider of blood pressures outside of parameters (#1). [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type B Violation).]

11. Based on observations, interviews, and record reviews, the facility failed to ensure implementation of physician orders to meet the health care needs for 3 of 7 sampled residents related to an order for daily blood pressure checks (#1) and orders for compression garments (#23, #24). [Refer to Tag 276, 10A NCAC 13F .0902(c)(3-4) Health Care (Standard Deficiency).]

12. Based on observations and interviews the facility failed to ensure all residents were offered at least one outing every other month. [Refer to Tag 319, 10A NCAC 13F .0905(f) Activities Program (Standard Deficiency).]

13. Based on observations, interviews, and record reviews the facility failed to provide a personal lockable space for residents on the female unit of the facility. [Refer to Tag 325, 10A NCAC 13F .0906(e) Other Resident Care and Services (Standard Deficiency).]

14. Based on observations, interviews and record reviews the facility failed to ensure 4 of 9 residents (#1, #2, #36, and #38) were free from financial exploitation for their monthly room and board and to ensure residents were treated with respect and consideration of their needs when they requested assistance using their call bells. [Refer to Tag 338, 10A NCAC 13F .0909 Resident Rights (Type A1 Violation).]

15. Based on observations, interviews, and record reviews, the facility failed to ensure

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D 176	Continued From page 33 medications were administered as ordered and in accordance with the facility's policy and procedure for 2 of 5 residents including errors with medications used to treat elevated blood glucose (#1, #2), medications used to treat high blood pressure, and medications used to treat fluid buildup and edema (#1), topical and oral medications used to treat bacterial infections, medications used to treat bi-polar disease and depression, a medication for heart health, a medication used to treat elevated cholesterol, eye-drops used to treat high fluid pressure and inflammation in the eyes, a medication used to treat allergy symptoms, a medication used to treat high phosphate levels in the blood, medication used to treat symptoms of chronic obstructive pulmonary disease, and a vitamin supplement (#2). [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type A1 Violation).] 16. Based on observations, interviews, and record reviews, the facility failed to ensure the accuracy of the electronic medication administration records (eMARs) for 1 of 6 residents (#37) related to a medication used to treat breathing disorders. [Refer to Tag 367, 10A NCAC 13F .1004(j) Medication Administration (Standard Deficiency).] 17. Based on observations, interviews, and record reviews, the facility failed to ensure discontinued medications were stored separately from actively used medications for 1 of 5 sampled residents (#3). [Refer to Tag 387, 10A NCAC 13F .1007(b) Medication Disposition (Standard Deficiency).] 18. Based on observations, interviews, and record reviews, the facility failed to ensure readily	D 176		

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D 176	Continued From page 34 retrievable records that accurately reconciled the receipt and administration of controlled substances for 1 of 6 sampled residents (#26) with an order for a controlled substance used to treat moderate to severe pain. [Refer to Tag 392, 10A NCAC 13F .1008(a) Controlled Substances (Standard Violation).] 19. Based on interviews and record reviews the facility failed to ensure 2 of 5 sampled residents (#2, #38) were provided with receipts for monies received from the residents. [Refer to Tag 418, 10A NCAC 13F .1103(c) Authorized Representative (Standard Deficiency).] 20. Based on interviews and record reviews, the facility failed to maintain records that were readily available for review for 1 of 7 sampled residents (#7). [Refer to Tag 433, 10A NCAC 13F .1201(a) Resident Records (Standard Deficiency).] 21. Based on interviews and record reviews, the facility failed to notify the county Department of Social Services (DSS) for 1 of 6 sampled residents sampled residents (#3). [Refer to Tag 451, 10A NCAC 13F .1212(a) Reporting of Accidents and Incidents (Standard Deficiency).] _____ The Administrator, who was responsible for the total operation and management of the facility failed to ensure care and services were provided to maintain the health, safety, and welfare of the residents. The facility failed to ensure air conditioning to keep the facility under 80 degrees Fahrenheit, a physical environment that was maintained resulting in live and dead cockroaches in the facility, and ensure residents in wheelchairs were provided with outings. The facility failed to maintain a record of Resident #7 who resided in the facility and received	D 176		

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D 176	Continued From page 35 medications from the facility's contracted pharmacy. The Administrator had no knowledge of when he was admitted or discharged from the facility and later found his obituary online. The facility failed to ensure 4 residents were free from exploitation when the previous Administrator failed to provide receipts for payments for room and board they paid resulting in the residents later receiving overdue invoices totaling over $40,000. The facility failed to ensure Resident #26, who had diagnoses of stage four lung cancer and stomach cancer and was under the care of hospice, received a safe and orderly discharge when he was IVC'd to the hospital, determined safe to return and the facility refused to take him back leaving him without a place to stay and without his prescribed hospice medications. The facility failed to provide personal care services to residents including placing 3 incontinence briefs on a resident with skin breakdown and ensuring residents received proper nail care. The facility failed to provide supervision to Resident #15 who had a diagnosis of schizophrenia and was documented as always disoriented who eloped from the facility 8 times and had to be located by law enforcement on multiple occasions. The facility failed to ensure residents received physician referrals for physical therapy and attended ophthalmology appointments and failed to ensure physician notification of blood pressures outside parameters. The facility failed to ensure residents received medications as ordered resulting in a resident being admitted to the hospital with symptoms of shortness of breath and fluid overload. These failures resulted in serious neglect which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/27/26 for	D 176		

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D 176	Continued From page 36 this Violation. THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 26, 2026.	D 176		
D 226	10A NCAC 13F .0702 (d) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (d) The notices of discharge and appeal rights as required in Paragraph (c) of this Rule shall be made by the facility administrator or their designee, at least 30 days before the resident is discharged except that notices may be made as soon as practicable when: (1) the discharge is necessary to protect the welfare of the resident and the facility cannot meet the needs of the resident under Subparagraph (b)(1) of this Rule; or (2) reasons under Subparagraphs (b)(3) and (b)(4) of this Rule exist. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the requirements for a notice of discharge and appeal rights were met as soon as practicable related to a resident who was discharged for the safety of the residents in the facility (#26). The findings are:	D 226		

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D 226	Continued From page 37 Review of the facility's undated Policy on Discharge and Transfer revealed: -The discharge or transfer of a resident by the facility shall meet the following conditions; the discharge or transfer was necessary for the resident's welfare because the resident's needs could not be met by the facility, the resident's health had improved sufficiently so the resident no longer needed the services provided by the facility, the resident's condition was such that he was a danger to himself or posed a direct threat to the health or safety of others, the safety or health of individuals at the facility would otherwise be endangered, the resident or responsible person had failed to pay the costs of services and accommodations according to the resident's contract, or the facility ceased to operate. -If the facility discharged a resident, documentation would be maintained in the resident's record. -If the reason for discharge or transfer was related to the health and safety of the resident or the health and safety of others at the facility, the reason would be supported by the physician and so documented in the resident's record. -Unless a delay in discharge or transfer would jeopardize the health and safety of the resident or others in the home or a resident's condition improved sufficiently to allow for a more immediate discharge or transfer as documented by a physician, thirty (30) days prior to discharging a resident from the facility in all cases in which the facility initiated discharge of a resident, management would take the following steps, notify the resident verbally and in writing of the facility's decision to discharge or transfer the resident, complete the Adult Care Home Notice of Transfer/Discharge form and give the Adult Care Home Notice of Transfer/Discharge form to the	D 226		

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resident the same day it was dated, notify the resident verbally and in writing of the resident's right to appeal to the Division of Medical Assistance the facility's decision to decision of transfer/discharge, give the resident a copy of the Adult Care Hearing Request form simultaneously with the Adult Care Home Notice of Transfer/Discharge, notify the resident's responsible party or contact person in writing of the facility's decision to discharge or transfer the resident, mail or fax a copy of the Adult Care Home Notice of Transfer/Discharge to the resident the same day as dated and given to the resident, notify the resident's responsible party or contact person verbally and in writing of the resident's right to appeal the decision of discharge or transfer to the Division of Medical Assistance, mail or fax a copy of the Adult Home Care Hearing Request to the resident simultaneously with the Adult Home Care Notice of Transfer/Discharge, and a copy of the Adult Care Home Notice of Discharge/Transfer and the Adult Care Hearing Request Form will be mailed or faxed to the legal representative of a resident who has been adjudicated incompetent
-The facility would assist residents with the discharge or transfer process.
-The facility would not discharge a resident who appealed a decision of discharge or transfer from the facility before the final decision resulting from the appeal is rendered except when a delay in discharge or transfer would jeopardize the health or safety of the resident or others in the home or a resident's condition improved sufficiently to allow for a more immediate discharge or transfer as documented by a physician.

Review of Resident #26's current FL2 dated 04/24/26 revealed:
-Diagnoses included malignant neoplasm of the

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lung, chronic obstructive pulmonary disease (COPD), protein calorie malnutrition, dysphagia, iron defiency anemia, major depressive disorder, and emphysema.
-The recommended level of care was assisted living.
-Resident #26 was constantly disoriented.

Review of Resident #26's Resident Register revealed:
-There was an admission date of 04/16/26.
-Resident #26's responsible person was himself.
-There was no contact person listed.
-There was no documentation that Resident #26 had a guardian or power of attorney (POA).
-Under Discharge/Transfer Information, there was no date listed for Notice of Discharge/Transfer, there was documentation the discharge was initiated by the Administrator and reason was documented as "safety".
-The documented date of discharge/transfer was 08/14/26 and 08/21/26.
-The discharge location was documented as "another residence" with the word "friend" handwritten next to it along with an address.
-Resident #26 signed the notice on 08/21/26 indicating he acknowledged the information in the discharge was complete and accurate.

Review of Resident #26's Care Plan dated 09/16/25 revealed:
-Resident #26 resided in assisted living and was oriented with adequate memory.
-The resident enjoyed sitting outside smoking and participated in group activities.
-The resident's family was very supportive.
-The resident received mental health services.

Review of the local police department communications list of events revealed:

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D 226	Continued From page 40 -There was a call on 08/14/26 at 4:24pm described as Disturbance/Dispute; Resident #26 was very belligerent, had a cane, was making threats towards staff, and was standing out front. -The officer spoke with Resident #26, who became loud and cursed but said he would calm down if left alone for the rest of the day. -The officer spoke with staff who agreed to leave Resident #26 alone for the day, and one staff was going to the magistrates office to obtain an involuntary commitment (IVC) order. -There was a call on 08/14/26 at 6:02pm, reporting that Resident #26 had left earlier in the day because someone had alerted him to the IVC paperwork. -Staff were notified to contact the police department back should Resident #26 return to the facility. -There was a call on 08/14/26 at 8:24pm, Resident #26 had returned. Review of Resident #26's staff charting notes for the last six months revealed: -There was an entry on 06/10/26 at 4:30pm by the former Resident Care Coordinator (RCC), that Resident #26 entered another resident's room and they began to have an altercation. -The residents were separated by staff, the primary care provider (PCP) was notified about the incident and the behavioral health provider was also notified. -There was an entry on 06/29/26 at 6:02pm by the former RCC, that Resident #26 was in an altercation with another resident; the resident kicked her in the right leg. -There was an entry on 08/15/26 at 5:53pm by a medication aide (MA), that Resident #26 exhibited aggressive and combative behavior toward the Administrator and facility staff. -Resident #26 was also observed using profanity	D 226		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 226	Continued From page 41 throughout the facility and making threats towards the Administrator. -Due to the resident's escalating behavior and safety concerns, the Administrator initiated an IVC evaluation. -Law enforcement was contacted and responded to the facility. -Resident #26 was picked up by law enforcement and escorted from the facility for further evaluation. -Hospice was notified of the incident as well as the resident's mental health provider. -Resident #26 was his own responsible party. -There was an entry on 08/21/26 at 4:00pm by the Administrator, Resident #26 was contacted and reported that he had secured safe living arrangements with a friend. -Resident #26 left the facility to seek medical care and was subsequently arrested and discharged from the hospital to the county jail. -A family member retrieved and secured his personal belongings, and he received his medications, his physician orders and his treatment plan were reviewed with him. -Based on behaviors and care needs, the facility determined that this placement was not appropriate and could not meet Resident #26's needs while ensuring the safety of others. -Resident #26 was officially discharged safely from the facility. -Hospice services were notified of the discharge. -There was an entry dated 08/21/26 at 7:16pm by the former Resident Care Coordinator (RCC) documenting Resident #26 received his medications and education on medication administration. -Resident #26 signed the discharge paperwork per the Administrator. Review of a letter to Resident #26 from the	D 226		

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facility's current Administrator dated 07/22/26 revealed:
-Resident #26's name was handwritten in the upper left-hand corner of the letter with "file" handwritten beside his name.
-The letter was dated 07/22/26 and the Subject was Notice of Discharge.
-It stated that the letter served as a formal notice of the resident's discharge from the facility.
-The reason for discharge was documented as failure to receive payment for the cost of services and accommodations had not yet been received as required under the residency agreement.
-Resident #26's account remained unpaid since his admission on 04/17/26.
-Resident #26 would be discharged from the facility unless other arrangements had been made for payment and approved in writing by management.
-The letter was signed by the Administrator.
-There was no mention of a 30-day notice in the letter.
-There was no Adult Care Home Notice of Transfer/Discharge form provided with the date of 07/22/26.
-There was no copy of the Adult Care Home Hearing Request form with a discharge date notice of 07/22/26 provided.

Request for the Adult Care Home Notice of Transfer/Discharge form and the Adult Care Home Hearing Request form with a discharge date notice of 07/22/26 was made on 08/25/26 at 11:16am and not provided.

Review of Resident #26's Adult Care Home Notice of Transfer/Discharge form dated 08/14/26 revealed:
-The reason for the notice of transfer/discharge was documented as the safety of the resident or

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D 226	Continued From page 43	D 226		

other individuals in this facility was endangered.
-The planned discharge location was documented as the named local hospital.
-The form was signed by the Administrator.
-There was no copy of the Adult Care Home Hearing Request form with a discharge date notice of 08/14/26 provided.

Review of a second Adult Care Home Notice of Transfer/Discharge form for Resident #26 dated 08/21/26 revealed:
-The reason for the notice of transfer/discharge was for the failure to pay the cost of services as specified in the contract.
-The planned discharge location was documented as "c/o friend".
-The form was signed by the Administrator.
-There was no copy of the Adult Care Home Hearing Request form with a discharge date notice of 08/21/26 provided.

Interview with the Administrator on 08/21/26 at 2:44pm revealed:
-Resident #26 was sent to the hospital on Friday 08/14/26 due to behaviors.
-On Friday 08/14/26, Resident #26 exhibited threatening and aggressive behavior and was disruptive.
-She went to the magistrate's office on 08/14/26 to obtain IVC paperwork on Resident #26 and he was sent to the hospital.
-The hospital overturned the IVC and all she knew was Resident #26 ended up in jail for trespassing.
-She received a call from the jail asking if Resident #26 had any health problems.
-She received a call from the county jail on Wednesday 08/19/26 that Resident #26 was released on his own recognizance due to his health.

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D 226	Continued From page 44 -She had no idea where Resident #26 was and did not try to locate him. Telephone interview with the former RCC on 08/24/26 at 4:26pm revealed: -She met Resident #26 at a location near the facility on Saturday 08/22/26, and gave him his medications and had him sign his discharge paperwork. -The Adult Care Home Hearing Request appeal form was not provided as part of Resident #26's discharge paperwork. -Resident #26 signed the medication release form, the last page of the Resident Register, and the Resident Discharge List, indicating he received all personal belongings, all medications, and all discharge paperwork. Telephone interview with Resident #26 on 08/24/26 at 4:35pm revealed: -He was currently staying at a friend's house locally. -He met one of the facility staff at a nearby location over the weekend and received his medications and signed discharge paperwork. -He did not receive the Adult Care Home Hearing Request appeal form. Second interview with the Administrator on 08/25/26 at 8:34am revealed: -Resident #26 was being disruptive on 08/14/26 and the police were contacted and came out on three occasions, when the police arrived, Resident #26 would hide. -When the police came out the first time on 08/14/26, they advised her to apply for an IVC for Resident #26, and they would wait until she returned. -She went to the magistrate's office around 5:00pm on 08/14/26 and it took about 40 minutes	D 226		

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D 226	Continued From page 45 to complete the IVC paperwork for Resident #26. -When she returned to the facility with Resident #26's IVC paperwork , the police were gone and she could hear Resident #26 cursing in the smoking area. -The magistrate called for the police to come back and when the police arrived, Resident #26 was hiding and the police and facility staff could not locate him. -The police returned later and Resident #26 was taken to the hospital on 08/14/26. -The former RCC located Resident #26 and took his medications and the discharge paperwork to him she thought on 08/21/26. -She said Resident #26 was provided with the Adult Care Home Hearing Request Form, but she did not keep a copy of the form, he was given a blank copy that contained the facility name only. -She felt Resident #26's discharge was appropriate for the safety of the other residents and staff of the facility.	D 226		
D 229	10A NCAC 13F .0702 (g) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (g) The facility administrator or their designee shall provide sufficient preparation and orientation to residents to ensure a safe and orderly discharge from the facility as evidenced by: (1) explaining to the resident and responsible person or legal representative and the individual identified upon admission to receive a copy of the discharge notice on behalf of the resident why the discharge is necessary; (2) informing the resident and responsible person or legal representative and the individual identified upon admission to receive a copy of the discharge notice on behalf of the resident about	D 229		

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D 229	Continued From page 46 an appropriate discharge destination that is capable of meeting the needs of the resident; and (A) If at the time of the discharge notice the discharge destination is unknown or is not capable of meeting the needs of the resident, the facility administrator or their designee shall contact the local adult care home resident discharge team as defined in G.S. 131D 4.8(e) to assist with placement; and (B) The facility, at the direction of the administrator or their designee, shall inform the resident, the resident's legal representative, the individual identified upon admission to receive a copy of the discharge notice on behalf of the resident, and the responsible person of their right to request the Regional Long-Term Care Ombudsman to serve as a member of the adult care home resident discharge team; and (3) offering the following material to the resident, the resident's legal representative, or the facility where the resident is to be placed and providing this material as requested prior to or upon discharge of the resident: (A) a copy of the resident's most current FL-2 form required in Rule .0703 of this Subchapter; (B) a copy of the resident's most current assessment and care plan; (C) a list of referrals to licensed health professionals, including mental health; (D) a copy of the resident's current physician orders; (E) a list of the resident's current medications; (F) the resident's current medications; and (G) a record of the resident's vaccinations and TB screening; (4) providing written notice of the name, address and telephone number of the following, if not provided on the discharge notice required in	D 229		

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D 229	Continued From page 47 Paragraph (c) of this Rule: (A) the regional long-term care ombudsman; and (B) Disability Rights North Carolina, the protection and advocacy agency established under federal law for persons with disabilities; (5) providing the resident, responsible person, or legal representative, and the individual identified upon admission who received a copy of the discharge notice on behalf of the resident with the discharge location as determined by the adult care home resident discharge team, if convened, at or before the discharge hearing, if the location is known to the facility. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews, the facility failed to ensure a safe and orderly discharge for 1 of 1 resident (#26) who was receiving hospice services by failing to convene the Department of Social Services (DSS) discharge team to assist with placement, provide the necessary discharge paperwork and medications to meet his medical needs. The findings are: Review of the facility's undated Policy on Discharge and Transfer revealed: -The discharge or transfer of a resident by the facility shall meet the following conditions, the discharge or transfer is necessary for the resident's welfare because the resident's needs could not be met by the facility, the resident's health had improved sufficiently so the resident	D 229		

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no longer needed the services provided by the facility, the resident's condition was such that he was a danger to himself or posed a direct threat to the health or safety of others, the safety or health of individuals at the facility would otherwise be endangered, the resident or responsible person had failed to pay the costs of services and accommodations according to the resident's contract, or the facility ceased to operate.
-The facility would assist residents with the discharge or transfer process.

Review of Resident #26's current FL2 dated 04/24/26 revealed:
-Diagnoses included malignant neoplasm of the lung, chronic obstructive pulmonary disease (COPD), protein calorie malnutrition, dysphagia, iron defiency anemia, major depressive disorder, and emphysema.
-The recommended level of care was assisted living.
-Resident #26 was constantly disoriented.

Review of Resident #26's Resident Register revealed:
-There was an admission date of 04/16/26.
-Resident #26's responsible person was himself.
-There was no contact person listed.
-There was no documentation that Resident #26 had a guardian or power of attorney (POA).
-Under Discharge/Transfer Information, there was no date listed for Notice of Discharge/Transfer.
-The discharge was initiated by the Administrator.
-The reason for the discharge documented as "safety".
-The date of the discharge/transfer was documented as 08/14/26 and 08/21/26.
- The resident was discharged to "Facility" and "another residence" were checked with "friend" handwritten and a street address was

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D 229	Continued From page 49 documented under "new address" . -Resident #26 signed the notice on 08/21/26 indicating he acknowledged the information in the discharge paperwork was complete and accurate. Review of Resident #26's Care Plan dated 09/16/25 revealed: -Resident #26 resided in assisted living and was oriented with adequate memory. -The resident enjoyed sitting outside smoking and participated in group activities. -The resident's family was very supportive. -The resident received mental health services. -He required limited assistance from staff with bathing. -He required supervision from staff with dressing, grooming and personal hygiene. Review of the local police department communications list of events revealed: -There was a call on 08/14/26 at 4:24pm described as Disturbance/Dispute. -Resident #26 was very belligerent, had a cane, making threats towards staff, standing out front. -The officer spoke with Resident #26, he got loud and cursed but said he would calm down if left alone for the rest of the day. -The officer spoke with staff who agreed to leave him alone for the day. -One nurse was going to the magistrates office to obtain an involuntary commitment (IVC) order. -There was a call on 08/14/26 at 6:02pm, reporting Resident #26 had left prior in the day. -Someone had alerted Resident #26 to the IVC paperwork. -Staff were notified to contact the police department when Resident #26 returned to the facility. -There was a call on 08/14/26 at 8:24pm, Resident #26 had returned.	D 229		

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D 229	Continued From page 50 Review of Resident #26's staff charting notes dated 08/21/26 revealed: -There was an entry at 4:00pm by the Administrator, Resident #26 was contacted and reported that he had secured safe living arrangements with a friend. -Resident #26 left the hospital and returned to the hospital seeking medical care and was subsequently arrested and discharged from the hospital to the county jail. -A family member retrieved and secured his personal belongings, and he received his medications, his physician orders and his treatment plan were reviewed with him. -Based on behaviors and care needs, the facility determined that this placement was not appropriate and could not meet his needs while ensuring the safety of others. -Resident #26 was officially discharged safely from the facility to another residence. -Hospice services were notified of the discharge. -There was an entry at 7:16pm by the former Resident Care Coordinator (RCC), Resident #26 received medications and education on medication administration, and Resident #26 signed the discharge paperwork per the Administrator. Review of Resident #26's staff charting notes for the June 2026 revealed: -There was an entry on 06/10/26 at 4:30pm by the former RCC, the resident entered another resident's room and the they began to have an altercation, they were separated by staff, the primary care provider (PCP) was notified about the incident and the behavioral health provider was also notified. -There was an entry on 06/29/26 at 6:02pm by the former RCC, the resident was in an	D 229		

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altercation with another resident, the resident kicked her in the right leg, no injuries, the PCP and behavioral provider were notified.

Review of a letter to Resident #26 from the facility's current Administrator dated 07/22/26 revealed:
-Resident #26's name was handwritten in the upper left-hand corner of the letter with "file" handwritten beside his name.
-The letter was dated 07/22/26 and the Subject was Notice of Discharge.
-It stated that the letter served as a formal notice of the resident's discharge from the facility.
-The reason for discharge was documented as failure to receive payment for the cost of services and accommodations had not yet been received as required under the residency agreement.
-Resident #26's account remained unpaid since his admission on 04/17/26.
-Resident #26 would be discharged from the facility unless other arrangements had been made for payment and approved in writing by management.
-The letter was signed by the Administrator.
-There was no mention of a 30-day notice in the letter.
-There was no Adult Care Home Notice of Transfer/Discharge form provided with the date of 07/22/26.
-There was no copy of the Adult Care Home Hearing Request form with a discharge date notice of 07/22/26 provided.

Review of Resident #26's staff charting notes dated 08/15/26 revealed:
-There was an entry at 5:53pm by a medication aide (MA), the resident exhibited aggressive and combative behavior toward the Administrator and facility staff.

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D 229	Continued From page 52 -The resident was also observed using profanity throughout the facility and making threats towards the Administrator. - Due to the resident's escalating behavior and safety concerns, the Administrator initiated an involuntary commitment evaluation. -Law enforcement was contacted and responded to the facility. -The resident was picked up by law enforcement and escorted from the facility for further evaluation. -Hospice was notified of the incident as well as the resident's mental health provider. -The resident was his own responsible party. -All appropriate notifications were completed, and the incident was documented per facility policy on 08/14/26. Review of Resident #26's Adult Care Home Notice of Transfer/Discharge form dated 08/14/26 revealed: -The reason for the notice of transfer/discharge was documented as "the safety of the resident or other individuals in this facility was endangered". -The planned discharge location was documented as the named local hospital. -There was documentation the facility had convened the adult care home discharge team. -The long-term care ombudsman's name and telephone were listed. -The form was signed by the Administrator. -There was no copy of the Adult Care Home Hearing Request form with a discharge date notice of 08/14/26 provided. Review of a second Adult Care Home Notice of Transfer/Discharge form for Resident #26 dated 08/21/26 revealed: -The reason for the notice of transfer/discharge was documented as failure to pay the cost of	D 229		

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services as specified in the contract.
-The planned discharge location was documented as "c/o friend".
-There was documentation the facility had convened the adult care home discharge team.
-The long-term care ombudsman's name and telephone were listed.
-The form was signed by the Administrator.
-There was no copy of the Adult Care Home Hearing Request form with a discharge date notice of 08/21/26 provided.

Review of Resident #26's Resident Discharge List checklist revealed:
-The form was dated 08/21/26.
-The resident received all personal belongings.
-The resident received all medications.
-The resident received all discharge paperwork.
-The form was signed by Resident #26.
-The form was signed by the Administrator.

Review of Resident #26's Discharge Form revealed:
-The form was dated 08/14/26.
-The discharge to location was documented as the local hospital on 08/14/26, the county jail on 08/19/26 and family friend on 08/21/26.
-There was no refund due.
-There was a handwritten note on the bottom left-hand corner of the form "requested $100.00 refund".
-There was a handwritten note that the resident did not sign/refused.

Review of Resident #26's Medication Leave of Absence form revealed:
-The medication check-out date was documented as 08/21/26.
-Six tablets of Morphine Sulfate (used to treat moderate to severe pain) 30mg, with instructions

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D 229	Continued From page 54 to take one three times a day were documented as signed out. -Thirty-eight capsules of gabapentin (used to treat nerve pain) 75mg, with instructions to take one every 12 hours were documented as signed out. -Eight tablets of oxycodone hcl (used to treat moderate to severe pain) 10mg, with instructions to take one every 4 hours as needed were documented as signed out. -Seventeen pre-filled syringes of morphine sulfate (used to treat moderate to severe pain) 100mg/ml concentrate, with instructions to take 0.25ml every 4 hours as needed were documented as signed out. -Attached to Resident #26's Medication Leave of Absence form were photos of his multi-dose medication packages from the pharmacy, with a start date of 08/16/26 through 08/22/26 which included 84 tablets of acetaminophen (used to treat mild to moderate pain) 325mg, 9 and a half tablets of citalopram (used to treat depression) 20mg, 7 tablets of esomeprazole dr (used to decrease stomach acid) 20mg, 7 tablets of lisinopril (used to treat high blood pressure)10mg, 14 tablets of senna (used to treat constipation) 8.6mg, 7 tablets of amitriptyline (used to treat depression and insomnia) 50mg, and 7 tablets of mirtazapine (used to treat depression) 15mg. -The Medication Leave of Absence form was signed by the former RCC on 08/21/26. -The Medication Leave of Absence form was signed by Resident #26 on 08/21/26 Review of Resident #26's hospital discharge summary dated 08/18/26 revealed: -The resident was in the emergency department from 08/14/26 to 08/18/26. -The chief complaint was documented as an IVC. -Per IVC paperwork, the patient had been aggressive and threatening staff and other	D 229		

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D 229	Continued From page 55	D 229		

residents at the facility, using his cane in a threatening manner to make others submit.
-The resident pushed another resident in the face, verbally assaulted staff for several days and physically assaulted another dependent resident.
-He had diagnoses including schizophrenia and schizoaffective disorder.
-The resident adamantly denied any problems at the facility, he denied suicidal ideation, homicidal ideation, and auditory/visual hallucinations.
-The resident had a past medical history of stage four lung cancer.
-He reported he resided at the assisted living facility and was on hospice for metastatic cancer.
-The staff IVC'd him because they thought he was being aggressive to staff and other residents.
-He did not know exactly why they thought he was being aggressive however he did not think he was.
-Law enforcement came to his room and then left because "they knew I did not do nothing".
-He went to walk around and when he returned more officers were at his room and brought him to the emergency department to be evaluated.
-He did have chronic pain due to his cancer which was unchanged and requested his chronic medications but otherwise was asymptomatic.
-He denied suicidal ideation, homicidal ideation, and visual hallucinations.
-He was chronically ill appearing and in no acute distress.
-Resident #26 signed himself out of the Emergency Department (ED) pending psychiatric evaluation, and was discharged against medical advice (AMA) on 08/18/26 at 3:49pm.

Review of Resident #26's ED note dated 08/19/26 revealed:
-Resident #26 presented to the ED for chest pain since yesterday.

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D 229	Continued From page 56 -He described the pain as constant sharp midline chest pain without radiation that began while at rest yesterday and continued to gradually worsen. -He had associated shortness of breath, numbness/tingling to bilateral upper extremities, nausea, and vomiting. -He had chills and rigors but denied any known fevers, cough, or congestion, -Of note, he had not been able to take his prescribed analgesia regimen for two days due to recent IVC. -Chest pain and shortness of breath may be secondary to lung cancer exacerbated by inability to take prescribed analgesia but less likely. Review of Resident #26's ED note dated 08/21/26 revealed: -The resident presented with concern of chest pain and shortness of breath. -He was recently seen in the ED for similar complaints and had a negative imaging of the chest. -He was recently kicked off hospice and out of his assisted living facility. -He reported that he had not been eating or drinking well due to losing his place in his care facility. -He also reported that he was supposed to wear oxygen and had not been wearing it due to not having a place to live currently. -On exam, he had left upper quadrant abdominal tenderness, he was cachectic (visibly emaciated and frail) appearing. -He was hypotensive (low blood pressure) likely due to poor oral intake given his recent lab work did not show concern for sepsis (reaction to an infection). -He had a pertinent social history of being on hospice but was recently dismissed due to aggressive behavior.	D 229		

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D 229	Continued From page 57 -Because he was discharged from hospice, he was unable to receive his hospice medications. Interview with the Administrator on 08/21/26 at 2:44pm revealed: -Resident #26 was sent to the hospital on Friday 08/14/26 due to behaviors. -The day prior, Resident #26 had two visitors that were arguing and that seemed to set him off. -On Friday 08/14/26, Resident #26 exhibited threatening and aggressive behavior and was disruptive. -She went to the magistrate's office on 08/14/26 to obtain IVC paperwork for Resident #26 and he was sent to the hospital. -The hospital overturned the IVC and all she knew was Resident #26 ended up in jail for trespassing. -She received a call from the jail asking if Resident #26 had any health problems. -She received a call from the county jail on Wednesday 08/19/26 that Resident #26 was released on his own recognizance due to his health. -She spoke with the hospice nurse last night and the hospice nurse told her that Resident #26 had called her from jail, but he could not continue hospice services from jail and had been discharged from hospice services. -A family member called over the weekend and spoke with a medication aide (MA) and asked about the process to pick up his clothes. -No one checked to see where Resident #26 was. -She had no idea where Resident #26 was and did not try to locate him. Telephone interview with the Department of Social Services (DSS) Adult Protective Services (APS) worker on 08/24/26 at 2:56pm revealed: -She received an APS report from the hospital for	D 229		

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Resident #26 on 08/16/26 that Resident #26 had been medically discharged from the hospital but did not have a safe discharge plan because the facility refused to take him back due to aggressive behavior.
-She arrived at the hospital on 08/18/26 and outside the hospital, police had Resident #26 on the ground.
-It was her understanding Resident #26 was combative with staff and left the hospital and returned and was detained by police and that he was currently incarcerated.
-She was not aware that he was no longer incarcerated.
-She still needed to call the county detention center to find out what the charges were against Resident #26 and to try to locate him.
-The APS report came in on Resident #26 on 08/16/26 with a 72-hour response time for caretaker neglect because the facility would not accept him back.

Second telephone interview with the county DSS APS worker on 08/24/26 at 3:18pm revealed she contacted the county detention center and was informed Resident #26 was released from custody on
08/19/26.

Telephone interview with the Social Worker with the local hospital on 08/24/26 at 3:11pm revealed:
-An APS report was made to DSS for Resident #26 because the facility would not accept him back saying they could not care for him.
-She stated she could not share any further information regarding Resident #26.

Telephone interview with Resident #26's hospice nurse on 08/24/26 at 3:20pm revealed:
-Resident #26 was admitted to hospice services

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on 04/28/26 for diagnoses of lung cancer and stomach cancer.
-Resident #26 had a history of behaviors and substance abuse.
-Resident #26 had behaviors at times and she had always told the facility to contact her first.
-If Resident #26 was upset, she could usually talk him down.
-On 8/14/26, she was contacted by Resident #26's friend asking, "did you know the police were here?"
-She was not contacted about Resident #26's behaviors by the facility on 08/14/26.
-She went to the facility and was there from 4:51pm to 5:25pm and the police informed her that the Administrator was on her way to the magistrate's office to obtain IVC papers due to behaviors.
-She asked the Administrator to please consider taking Resident #26 back and was told he would not be accepted back to the facility due to aggressive and threatening behavior and non-payment.
-Resident #26 appeared anxious, apprehensive, and tearful, and had an unsteady gait.
-Resident #26 had a verbal altercation with the Administrator because Resident #26 felt the Administrator had treated him disrespectfully.
-A police officer transported Resident #26 to the hospital once the IVC was approved.
-She received a text from the Administrator at 6:20pm on 08/14/26 that Resident #26 was IVC'd for dangerously aggressive and threatening behavior and could not return to the facility.

Second telephone interview with Resident #26's hospice nurse on 08/25/26 at 12:55pm revealed:
-A referral was received for Resident #26 from the local ED last weekend.
-Resident #26 could not be re-instated to hospice

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services due to testing positive for illegal substances during the 08/14/26 to 08/18/26 ED visit.
-Resident #26 was being held at the hospital pending an APS report for placement on 08/17/26.
-Resident #26 left the hospital against medical advice on 08/18/26 and was arrested on 08/18/26.
-A referral was received on 08/21/26 for Resident #26 from the local ED earlier in the day and a second referral was received for Resident #26 on 08/21/26 from the ED in a neighboring county noting that Resident #26 had been involved in an altercation, but the referrals were denied due to his positive drug screen.

Telephone interview with the DSS Adult Home Specialist (AHS) on 08/25/26 at 9:25am revealed:
-She was not contacted for discharge planning for Resident #26.
-If the Adult Care Home Resident Discharge team was convened on behalf of Resident #26, she was not consulted.
-She was supposed to receive all discharge paperwork for the residents that resided in adult assisted living facilities.
-She was not aware that Resident #26 received an IVC and was discharged from the facility.

Second telephone interview with the DSS AHS on 08/25/26 at 12:36pm revealed:
-She received Resident #26's discharge and IVC information this morning.
-She was not notified prior to 08/25/26 of Resident #26's discharge from the facility.

Telephone interview with the former RCC on 08/24/26 at 4:26pm revealed:
-She met Resident #26 at a location near the

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facility on Saturday 08/22/26, and gave him his medications and had him sign his discharge paperwork.
-The Adult Care Home Hearing Request appeal form was not provided as part of Resident #26's discharge paperwork.
-Resident #26 signed the medication release form, the last page of the Resident Register, and the Resident Discharge List, indicating he received all personal belongings, all medications, and all discharge paperwork.
-Resident #26 was not doing well pain wise and had some difficulty breathing.
-She thought Resident #26 went to the ED for pain and shortness of breath on 08/20/26 and got out on 08/21/26.
-Resident #26 was supposed to be staying with a friend in a neighboring county but that did not work out and he did not say where he was staying.
-Resident #26 was struggling to find somewhere to stay and did not want to go to a homeless shelter.
-Resident #26 asked to return to the facility and she initiated a three-way call with the Administrator and the facility's owner and the Administrator said Resident #26 could not return to the facility.

Telephone interview with Resident #26 on 08/24/26 at 4:35pm revealed:
-He was currently staying at a friend's house locally.
-He had complications with pain management and breathing and went to the ED on 08/21/26.
-He met one of the facility staff at a nearby location over the weekend and received his medications and signed discharge paperwork.
-He did not receive the appeal/hearing request form.

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D 229	Continued From page 62 -He told the staff he would like to return to the facility, and she made a call and told him he could not return to the facility. -He did not know why he was discharged from the facility without other living arrangements being made. Second interview with the Administrator on 08/25/26 at 8:34am revealed: -Resident #26 had a lot of behaviors over the last month and had a walking cane that he threatened staff and residents with. -Resident #26's behavior started escalating and he would argue with other staff or residents. -Resident #26 would be separated and his behavioral provider was notified when he had increased behaviors. -She was certain hospice was notified about Resident #26's behavior on 08/14/26. -Resident #26 was being disruptive on 08/14/26 and the police were contacted and came out on three occasions, and when the police arrived, Resident #26 would hide. -When the police came out the first time on 08/14/26, they advised her to apply for an IVC for Resident #26, and they would wait until she returned. -She went to the magistrate's office around 5:00pm on 08/14/26 and it took about 40 minutes to complete the IVC paperwork for Resident #26. -When she returned to the facility with Resident #26's IVC paperwork, the police were gone and she could hear Resident #26 cursing in the smoking area. -The magistrate called for the police to come back and when the police arrived, Resident #26 was hiding and the police and facility staff could not locate him. -The police returned later and Resident #26 was taken to the hospital on 08/14/26.	D 229		

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D 229	Continued From page 63 -She described the Adult Care Home Resident Discharge Team noted as convened for Resident #26 on the 08/14/26 and 08/21/26 Adult Care Home Notice of transfer/Discharge form as consisting of herself, and two MAs. -The county DSS AHS was not contacted. -She was not aware the DSS AHS needed to be included in discharge planning and placement for Resident #26. -The former RCC located Resident #26 through a mutual friend and took his medications and the discharge paperwork to him she thought on 08/21/26. -She said Resident #26 was provided with the Adult Care Home Hearing Request Form, but she did not keep a copy of the form, he was given a blank copy that contained the facility name only. -Since Resident #26 was IVC'd and sent to the hospital she expected hospital staff to assist Resident #26 with placement. -She did not have a copy of the IVC paperwork for Resident #26. -She never received a phone call from the hospital staff that Resident #26 was ready for discharge back to the facility. -The former RCC tried to find Resident #26 on 08/21/26 but was unable to locate him. -She did have a three way call over the weekend about Resident #26 with the facility's owner and the former RCC and placement was found for Resident #26 at a housing shelter in a neighboring county but Resident #26 refused to go. -She felt Resident #26 could take care of himself on his own, because the only thing the facility did for Resident #26 was administer his medications. -She felt Resident #26's discharge was appropriate for the safety of the other residents and staff of the facility. -Resident #26 had been issued a 30-day notice of	D 229		

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D 229	Continued From page 64 discharge in July 2026 for non-payment. _____ The facility failed to ensure Resident #26, who had diagnoses of stage four lung cancer and stomach cancer and was under the care of hospice, received a safe and orderly discharge. The facility sent the resident to the hospital for behaviors and refused to readmit him when the Social Worker with the local hospital called to discharge him back to the facility. The resident left the hosptial on 08/18/26 and returned on 08/19/26 for chest pain and 08/21/26 for chest pain and shortness of breath as he did not have his hospice prescribed medications. The resident struggled to find somewhere to stay and ended up having to stay with a friend and was unsure why he was discharged without a place to stay. The facility failed to convene the DSS discharge team to assist with an appropriate placement, provide the resident with required discharge paperwork and served him the notice of discharge at a location close to the facility 1 week after he was refused readmission to the facility. This failure resulted in neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/26/26 for this violation. CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 26, 2026	D 229		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision	D 269		

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D 269	Continued From page 65 (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide personal care assistance to 7 of 12 sampled residents including a resident who had on three incontinence briefs with skin breakdown (#34), residents with toenails that were long, jagged, had dirt under the nails (#14, #27, #28), and residents who had long, jagged fingernails with dirt and debris underneath their fingernails (#2, #31, #32). The findings are: Review of the facility's Resident Contract revealed that the facility would provide assistance with bathing, feeding, dressing, personal hygiene, toileting, grooming, ambulation and other activities of daily living (ADLs) as needed. 1. Review of Resident #34's current FL-2 dated 03/13/26 revealed: -Diagnoses included down syndrome, anxiety disorder, and insomnia. -The resident was semi-ambulatory and there was no information about the resident's orientation. -The resident was incontinent of bowel and bladder. -The resident required assistance with bathing and dressing.	D 269		

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D 269	Continued From page 66 Review of Resident #34's Resident Register revealed: -The resident was admitted to the facility on 02/21/25. -The resident required assistance from staff with dressing, bathing, nail care, toileting, hair/grooming, skin care, mouth care, scheduling appointments, and orientation to time and place. -The resident had significant memory loss and must be redirected. Review of Resident #34's current assessment and care plan dated 03/13/26 revealed: -The resident was wheelchair bound and required extensive assistance with her ADLs. -The resident was incontinent of bowel and bladder. -The resident was sometimes disoriented, was forgetful and needed reminders. -The resident required limited from staff assistance with ambulation. -The resident was totally dependent on staff for eating, toileting, bathing, dressing, grooming, and transferring. Observation of Resident #34 on 08/26/26 at 10:00am revealed: -Resident #34 was sitting on the edge of her bed. -Two PCAs provided assistance to help the resident stand, with the resident resting both hands on the side of her bed and provided incontinence care. -There were three incontinence briefs on the resident. -The resident had a small bowel movement so, the PCAs removed the three incontinence briefs from the resident and cleaned the resident with a moist towelette. -Resident #34 had two areas of skin breakdown on her right buttock area.	D 269		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 67 -There was one open area toward the top of her right buttock that was approximately ¾ of an inch in diameter that was red. -There was a second area of open skin was below the first area of open skin on the right buttock, approximately ¼ of an inch in diameter. -The PCAs placed an incontinence brief on Resident #34 and then proceeded to place two additional incontinence briefs on the resident. -The PCAs placed a protective pad in the resident's wheelchair and assisted the resident to a seated position in her wheelchair. Interview with one PCA on 08/27/26 at 9:35am revealed she completed a skin report yesterday (08/25/26) to the medication aide (MA). Telephone interview with a former facility employee on 08/26/26 at 2:25pm revealed: -She had worked at the facility on second shift but no longer worked there. -She had observed Resident #34 with 4 to 6 incontinence briefs on at a time when she began her shift. -Resident #34 would be soaked with urine through the 4 to 6 incontinence briefs when she began her shift. -There were times that she found the Resident #34 soiled with urine and bowel with 4 to 6 incontinence briefs on and the bed linens were soiled. -The resident developed a rash on her buttock area that she reported to the Administrator several times, however she continued to find the resident in 4 to 6 incontinence briefs when she began her shift. Review of Resident #34 shower sheets from 06/01/26 to 08/20/26 revealed there was no documentation that Resident #34 was provided	D 269		

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	HAL074046	A. BUILDING: _____ B. WING _____	08/27/2026

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 269	Continued From page 68 with a shower from 06/01/26 to 08/20/26. Requests for Resident #34's ADL log for July 2026 and August 2026 on 08/26/26 at 10:35am and 08/27/26 at 11:00am were not provided by the time of survey exit. Request for Resident #34's skin assessments from July 2026 and August 2026 on 08/26/26 at 10:35am and were not provided by time of survey exit. Interview with a PCA on 08/26/26 at 10:20am revealed: -Resident #34 had always required assistance from 2 PCAs for personal care. -PCAs had placed more than one incontinence brief on the resident because she moved so much in her wheelchair. -When the resident moved in her wheelchair the resident's urine or bowel movement would slide out of her incontinence brief and soil the wheelchair protective cover. -She was not aware that she should not place more than one incontinence brief on the resident. Interview with a second PCA on 08/26/26 at 10:24am revealed: -She always had another PCA with her when she provided incontinence care to Resident #34. -She and the other PCA had placed three incontinence briefs on the resident earlier (08/26/26). -They placed more than one incontinence brief on Resident #34 to try to prevent the resident's urine and bowel movement from leaking onto the wheelchair because she moved around in her wheelchair frequently. -She did not realize that she should not put multiple incontinence briefs on the resident.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 269	Continued From page 69 -She had not thought about how the use of several incontinence briefs could cause skin breakdown. Interview with a medication aide (MA) on 08/26/26 at 10:30am revealed: -Residents should never have more than one incontinence brief on at a time. -If a PCA placed more than one incontinence brief on a resident it placed the resident at risk for skin irritation and skin breakdown. Interview with the Resident Care Coordinator (RCC) in training on 08/27/26 at 9:30am revealed: -She came to the facility on Saturday 08/22/26 around 10:00am to 11:00am. -She observed several residents that were outside at the front of the building who had soiled their incontinence briefs. -She asked two PCAs to help get the residents cleaned and in new clothing. -Residents should not be left to sit in urine or feces, because it could cause skin breakdown but was also a dignity issue. Interview with the facility Registered Nurse (RN) on 08/27/6 at 2:21pm revealed: -Residents should only have on one incontinence brief at a time. -PCAs should never double or triple incontinence briefs on a resident because it could cause skin breakdown which could lead to bed sores, infection, and discomfort. Based on observations, interviews, and record reviews Resident #34 was not interviewable. Refer to interview with a MA on 08/26/26 at 10:30am.	D 269		

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D 269	Continued From page 70 Refer to interview with the previous RCC on 08/26/26 at 10:30am. Refer to interview with the Administrator on 08/27/26 at 6:44pm. Refer to interview with the facility's primary care provider (PCP) on 08/21/26 at 10:12am. 2. Review of Resident #14's current FL-2 dated 03/27/26 revealed: -Diagnoses included hypertension, stage 3 chronic kidney disease, chronic obstructive pulmonary disease, and emphysema. -The resident was semi-ambulatory and was intermittently disoriented. -The resident was incontinent of bladder and continent of bowel. -The resident required assistance from staff with bathing and dressing. Review of Resident #14's Resident Register revealed the resident was admitted to the facility on 03/28/24. Review of Resident #14's current assessment and care plan dated 03/27/26 revealed: -The resident was ambulatory with a rollator and had a limited range of motion in his upper extremities. -The resident had occasional bladder incontinence. -The resident was oriented and his memory was adequate. -The resident was independent with toileting and transferring. -The resident required supervision from staff with eating, ambulation, and dressing. -The resident required limited assistance from	D 269		

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D 269	Continued From page 71 staff with bathing and grooming. Observation of Resident #14 on 08/20/26 at 2:39pm revealed: -Resident #14 was lying on his bed. -The resident's toenails were long, jagged, curved over toward the skin, with brown and black debris under his toenails. -The bottom of his left foot had a raised callus area approximately 1 ¼ inch in diameter approximately 2 inches below his great toe. -The raised callus area had a black center, brown and yellow skin surrounding the black area with cracked skin on the outer edges of the raised callus area. -There was also a smaller raised callus area under his fourth toenail adjacent to the larger raised callus area approximately 1 inch in diameter. -The raised callus area had cracked skin around the diameter with a small area of brown skin near the middle. Review Resident #14's shower sheets from 06/01/26 to 08/20/26 revealed: -Resident #14 was provided a shower on 06/10/26. -There was no documentation that Resident #14 was provided with a shower on any other dates. Requests for Resident #14's activities of daily living (ADL) log for July 2026 and August 2026 on 08/26/26 at 10:35am and on 08/27/26 at 11:00am were not provided by the time of survey exit. Request for Resident #14's skin assessments from July 2026 and August 2026 were requested on 08/26/26 at 10:35am and were not provided by time of survey exit.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 269	Continued From page 72 Review of a podiatry visit list provided by the facility on 08/26/26 at 10:35am revealed Resident #14 was not listed as a resident seen by podiatry. Interview with Resident #14's primary care provider (PCP) on 08/21/26 at 10:12am revealed: -She saw the resident's feet during her visit today (08/21/26) and sent a referral for the resident to be seen by the facility's podiatrist for the raised calluses on his right foot and to trim his toenails. -Sometimes the resident refused care but the PCAs should have attempted worked with him to assist with removing dirt from under his toenails. -The resident denied any pain at the calluses on his right foot at her visit today. Refer to interview with a medication aide (MA) on 08/26/26 at 10:30am. Refer to interview with the previous Resident Care Coordinator (RCC) on 08/26/26 at 10:30am. Refer to interview with the Administrator on 08/27/26 at 6:44pm. Refer to interview with the facility's contracted PCP on 08/21/26 at 10:12am. 3. Review of Resident #27's current FL-2 dated 06/04/26 revealed: -Diagnoses included type 2 diabetes, abnormalities of gait and mobility, generalized muscle weakness, and chronic obstructive pulmonary disease. -The resident was semi-ambulatory and there was no information about the resident's orientation. -The resident was continent of bowel and bladder.	D 269		

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D 269	Continued From page 73 Review of Resident #27's Resident Register revealed the resident was admitted to the facility on 06/03/26. Review of Resident #27's undated assessment and care plan revealed: -The resident was oriented. -The resident's memory was forgetful and needed reminders. -There was no documentation of the last page of the care plan to indicate what level of assistance the resident needed for ambulation, eating, toileting, bathing, dressing, grooming, or transferring. Observation of Resident #27 on 08/20/26 at 2:47pm revealed: -Resident #27 was lying on his bed. -The resident's toenails were yellow, long, jagged, curved with black debris under his toenails. -The resident's second and third toenails were curved over touching the skin at the top of the toe underneath. Interview with Resident #27 on 08/20/26 at 2:48pm revealed: -He was not sure when he last had his toenails cleaned or trimmed. -He had some discomfort where his toenails curved over and touched the top of the skin at his toes but had not reported it to anyone. Review of Resident #27's shower sheets from 06/01/26 to 08/20/26 revealed: -Resident #27 was not provided with a shower from 06/01/26 to 08/20/26. -There was no documentation that Resident #27 was provided with a shower on any other dates. Requests for Resident #27's ADL log for July	D 269		

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D 269	Continued From page 74 2026 and August 2026 on 08/26/26 at 10:35am and 08/27/26 at 11:00am were not provided by the time of survey exit. Request for Resident #27's skin assessments from July 2026 and August 2026 were requested on 08/26/26 at 10:35am and were not provided by time of survey exit. Review of a podiatry visit list provided by the facility on 08/26/26 at 10:35am revealed Resident #14 was not listed as a resident seen by podiatry on 06/30/26, 07/14/26, 07/28/26, or 08/11/26. Refer to interview with a medication aide (MA) on 08/26/26 at 10:30am. Refer to interview with the previous Resident Care Coordinator (RCC) on 08/26/26 at 10:30am. Refer to interview with the Administrator on 08/27/26 at 6:44pm. Refer to interview with the facility's primary care provider (PCP) on 08/21/26 at 10:12am. 4. Review of Resident #28's current FL-2 dated 08/14/26 revealed: -Diagnoses included protein calorie malnutrition, malignant neoplasm of the anal canal, and chronic obstructive pulmonary disease. -The resident was ambulatory and there was no information about the resident's orientation. -The resident was incontinent of bladder. -The resident required assistance from staff with bathing. Review of Resident #28's undated Resident Register revealed the resident was admitted to the facility on 06/12/26.	D 269		

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D 269	Continued From page 75 Request for Resident #28's assessment and care plan on 08/25/26 at 2:00pm and 08/26/26 at 10:35am were not provided by the time of survey exit. Observation of Resident #28 on 08/20/26 at 2:39pm revealed: -Resident #28 was sitting on the edge of her bed. -Her right foot was dry with cracked skin. -The first toenail on her right foot was jagged and there were layers of cuticles from the base of her toenail to approximately half way up the toenail. -The second toenail was thick, yellow, long and jagged. -The third toenail was thick, yellow, curved over toward the top of the toe, and there was one cracked area in the nailbed. -Her left foot was dry with cracked skin. -The second toenail was thick, brown and long. -The third toenail was thick and yellow. Interview with Resident #28 on 08/20/26 at 2:41pm revealed: -Her feet were sore sometimes when the skin cracked. -She could not remember if she had been seen by the facility podiatrist or not. -She was not sure when she last received assistance with cleaning and trimming her toenails. Review of Resident #28's shower sheets from 06/01/26 to 08/20/26 revealed: -Resident #28 was not provided with a shower from 06/01/26 to 08/20/26. -There was no documentation that Resident #27 was provided with a shower on any other dates. Requests for Resident #28's ADL log for July	D 269		

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D 269	Continued From page 76 2026 and August 2026 on 08/26/26 at 10:35am and 08/27/26 at 11:00am were not provided by the time of survey exit. Request for Resident #28's skin assessments from July 2026 and August 2026 were requested on 08/26/26 at 10:35am and were not provided by time of survey exit. Review of a podiatry visit list provided by the facility on 08/26/26 at 10:35am revealed Resident #28 was not listed as a resident seen by podiatry. Refer to interview with a medication aide (MA) on 08/26/26 at 10:30am. Refer to interview with the previous Resident Care Coordinator (RCC) on 08/26/26 at 10:30am. Refer to interview with the Administrator on 08/27/26 at 6:44pm. Refer to interview with the facility's primary care provider (PCP) on 08/21/26 at 10:12am. 5. Review of Resident #2's current FL-2 dated 07/31/26 revealed: -Diagnoses included end stage renal disease, reduced mobility, and chronic obstructive pulmonary disease. -The resident was semi-ambulatory and intermittently disoriented. -The resident was incontinent of bowel and bladder. -The resident required assistance from staff with bathing and dressing. Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 07/10/26.	D 269		

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D 269	Continued From page 77 Review of Resident #2's current assessment and care plan dated 07/31/26 revealed: -The resident used a device to assist with ambulation. -The resident was sometimes disoriented, was forgetful and needed reminders. -The resident required supervision from staff with eating and toileting. -The resident required limited assistance from staff with transfers. -The resident required extensive assistance from staff with ambulation. -The resident was totally dependent on staff for bathing, dressing, and grooming. Observation of Resident #2 on 08/24/26 at 3:15pm revealed: -The resident's right hand was the only hand that was visible due to how she was lying in the bed. -Her right thumb had built up dirt, debris and what appeared to be dried food under her fingernail. -Her right second fingernail was long with thick dirt underneath the fingernail. -Her right third fingernail had dirt underneath the fingernail. Interview with Resident #2 on 08/24/26 at 3:17pm revealed: -Staff provided her with a bath and dressed her. -She could not remember the last time staff cleaned under her fingernails. -She liked to look nice and well put together and wished her fingernails looked better. Review of Resident #2's shower sheets from 06/01/26 to 08/20/26 revealed: -Resident #2 was provided with two showers on 06/01/26 and 06/03/26. -Resident #2 was not provided with a shower	D 269		

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D 269	Continued From page 78	D 269		

from 06/04/26 to 08/20/26.
-There was no documentation that Resident #2 was provided with a shower on any other dates.

Requests for Resident #2's ADL log for July 2026 and August 2026 on 08/26/26 at 10:35am and 08/27/26 at 11:00am were not provided by the time of survey exit.

Request for Resident #2's skin assessments from July 2026 and August 2026 were requested on 08/26/26 at 10:35am and were not provided by time of survey exit.

Refer to interview with a medication aide (MA) on 08/26/26 at 10:30am.

Refer to interview with the previous Resident Care Coordinator (RCC) on 08/26/26 at 10:30am.

Refer to interview with the Administrator on 08/27/26 at 6:44pm.

Refer to interview with the resident's primary care provider (PCP) on 08/21/26 at 10:12am.

6. Review of Resident #31's current FL-2 dated 01/13/26 revealed:
-Diagnoses included failure to thrive, below the knee amputation, and encephalopathy.
-The resident was semi-ambulatory and there was no information about the resident's orientation.
-The resident was continent of bowel and bladder.
-The resident required assistance from staff with bathing and dressing.

Review of Resident #31's Resident Register dated 01/22/25 revealed the resident was

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D 269	Continued From page 79 admitted on 01/22/25. Review of Resident #31's current assessment and care plan dated 03/31/26 revealed: -The resident was oriented and his memory was adequate. -The resident required supervision from staff with eating, ambulation and transfers. -The resident required limited assistance from staff with toileting. -The resident was totally dependent on staff for bathing, dressing, and grooming. Observation of Resident #31 on 08/20/26 at 2:50pm revealed: -The resident's right thumbnail was slightly square shaped and jagged. -The resident's second and third fingers had black debris under the fingernails. -The resident's fourth and fifth fingernails were long with black debris under the fingernails. -The resident's second, third and fifth fingers on his left hand had black debris under the fingernails. -The resident's fourth fingernail was long with black debris under the fingernail. Interview with Resident #31 on 08/20/26 at 2:52pm revealed: -He washed his hands during the day, but no one had helped him get the dirt from underneath his fingernails. -He did not feel comfortable cutting his own fingernails and thought the PCAs provided that for him. -He was not sure when anyone had scrubbed under his fingernails. Review of shower sheets from 06/01/26 to 08/20/26 revealed Resident #31 was provided	D 269		

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D 269	Continued From page 80 with a shower on 06/05/26 and 06/20/26. Review of Resident #31's activities of daily living (ADL) log for July 2026 revealed: -There was a section designated for nail care with a description that the resident required assistance with nail care. -Resident #31's nail care was documented as completed on 07/04/26 and 07/11/26 at 8:00am. Review of Resident #31's ADL log for August 2026 revealed: -There was a section designated for nail care with a description that the resident required assistance with nail care. -Resident #31's nail care was documented as completed on 08/08/26 at 8:00am. Refer to interview with a medication aide (MA) on 08/26/26 at 10:30am. Refer to interview with the previous Resident Care Coordinator (RCC) on 08/26/26 at 10:30am. Refer to interview with the Administrator on 08/27/26 at 6:44pm. Refer to interview with the facility's primary care provider (PCP) on 08/21/26 at 10:12am. 7. Review of Resident #32's current FL-2 dated 05/27/26 revealed: -Diagnoses included heart disease, vascular disease, hypertension, and hyperlipidemia. -The resident was semi-ambulatory and intermittently disoriented. -The resident was incontinent of bowel and bladder. -The resident required assistance with bathing and dressing.	D 269		

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	HAL074046	A. BUILDING: _____ B. WING _____	08/27/2026

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

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D 269	Continued From page 81 Review of Resident #32's Resident Register revealed: -The resident was admitted on 11/20/20. -The resident required assistance with dressing and bathing. -The resident was forgetful and needed reminders. Review of Resident #32's current assessment and care plan dated 06/05/26 revealed: -The resident was sometimes disoriented. -The resident was forgetful and needed reminders. -The resident required supervision from staff with eating, toileting, and transfers. -The resident required extensive assistance from staff with ambulation and grooming. -The resident was totally dependent on staff for dressing and bathing. Observation of Resident #32 on 08/20/26 at 2:52pm revealed: -The resident was sitting on his bed with a toothbrush in his left hand. -The resident's fingernails on his left hand were long with black debris under the fingernails. Review of Resident #32's shower sheets from 06/01/26 to 08/20/26 revealed: -Resident #32 was provided with a shower on 06/03/26, 06/20/26, 07/02/26, 07/03/26, and 08/20/26. -There was no documentation that Resident #32 was provided with a shower on any other dates. Review of Resident #32's activities of daily living (ADL) log for July 2026 revealed: -There was a section designated for nail care with a description that the resident required assistance	D 269		

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D 269	Continued From page 82 with nail care. -Resident #32's nail care was documented as completed on 07/04/26 and 07/11/26 at 8:00am. Review of Resident #32's ADL log for August 2026 revealed: -There was a section designated for nail care with a description that the resident required assistance with nail care. -Resident #32's nail care was documented as completed on 08/08/26 at 8:00am. Request for Resident #32's skin assessments from July 2026 and August 2026 were requested on 08/26/26 at 10:35am and were not provided by time of survey exit. Refer to interview with a medication aide (MA) on 08/26/26 at 10:30am. Refer to interview with the previous Resident Care Coordinator (RCC) on 08/26/26 at 10:30am. Refer to interview with the Administrator on 08/27/26 at 6:44pm. Refer to interview with the facility's primary care provider (PCP) on 08/21/26 at 10:12am. _____ Interview with a medication aide (MA) on 08/26/26 at 10:30am revealed: -The PCAs were responsible for cleaning residents fingernails and toenails. -The PCAs could trim toenails if a resident did not have diabetes. -Residents that did not have diabetes should not have toenails get so long that they curved over or caused discomfort. -If a resident had long toenails and had diabetes, the PCA needed to notify the MA or the Resident	D 269		

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D 269	Continued From page 83 Care Coordinator (RCC) so they could make an appointment with the podiatrist. -PCAs should keep residents fingernails clean to prevent skin infections from a resident scratching their skin with dirty fingernails. -Residents with dirty fingernails were at risk of bacteria getting into their skin from scratching which could cause an infection. -Residents should only have one incontinence brief at a time. -PCAs should never put more than one incontinence brief on a resident at time because it could cause skin breakdown. Telephone interview with the previous RCC on 08/26/26 at 8:38am revealed: -Her last day as the previous RCC was 08/25/26. -PCAs were responsible for cleaning residents' fingernails and toenails. -PCAs were supposed to file residents fingernails if they were too long. -If a resident was a diabetic the PCAs could file down their fingernails and/or toenails. -If a PCA noticed that a resident's toenails were too long they were expected to notify the MA who would also notify the RCC. -The facility had a Registered Nurse (RN) who could cut diabetic resident's toenails, or the resident was referred to podiatry services that came to the facility. -There was no excuse for residents having unkept and dirty fingernails and toenails. -The PCAs had dropped the ball and had not provided personal care services that included cleaning a resident's fingernails and toenails. -Residents with dirty, long and/or jagged fingernails were at an increased risk of skin infections if they scratched their skin with dirty fingernails. -The PCAs were expected to document	D 269		

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D 269	Continued From page 84 electronically in the software system which activities of daily living (ADLs) were completed with each resident. Interview with the Administrator on 08/27/26 at 6:44pm revealed: -She was unaware that several residents needed personal care for their fingernails and toenails. -She expected residents to have clean and properly filed fingernails to prevent skin infections. -Residents' toenails should not be long, jagged, dirty or curved over to the skin at the top of their toe. -Toenails in this condition could cause complications with the resident's feet, cause mobility issues and cause discomfort. -The facility had a contracted podiatrist that came to the facility monthly for diabetic residents. -She wanted residents at the facility to look good and feel good. Interview with the facility's primary care provider (PCP) on 08/21/26 at 10:12am revealed: -PCAs provided personal care to residents which included cleaning residents fingernails and toenails. -Some residents were independent with their bathing; however, they still needed to check the residents to ensure they had clean fingernails and toenails. -PCAs should ensure that fingernails and toenails are clean. -Dirty fingernails placed the residents at an increased risk of skin infections if a resident scratched their skin with dirty fingernails which could lead to cellulitis or even sepsis (Sepsis is a life-threatening medical emergency that happens when the body has an extreme response to an infection).	D 269		

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D 269	Continued From page 85 The facility failed to provide personal care services to 7 residents. Resident #34 who was totally dependent on staff for personal care and had two areas of skin breakdown on her buttocks was observed during incontinence care to have 3 incontinence briefs removed and 3 incontinence briefs reapplied which could cause additional skin breakdown and infection. A resident who had toenails that were long, jagged, curved over toward the skin with dirt under his toenails and the bottom of his foot had a raised callus area that was approximately 1 ¼ inch in diameter with a black center (#14), a resident who had toenails that were long that curved and touched the skin on the top of his toe which caused him discomfort (#27), a resident who had cracked sore skin on the top of her feet, with jagged and long toenails, with cuticle layers from the base of her nailbed to half of the nailbed (#28), and two residents who had long fingernails that had dirt under them (#31, #32), and a resident who had thick amounts of dirt, debris, and dried food under some of her fingernails (#2) placing residents at risk of cellulitis and sepsis. This failure placed the residents at substantial risk for serious physical harm and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/26/26 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 26, 2026.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision	D 270		

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D 270	Continued From page 86 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 reviews, the facility failed to provide supervision for 3 of 8 sampled residents related to a male resident who touched a female resident inappropriately (#25), a resident who had 8 elopements (#15), and a resident that was assessed as an unsafe smoker who had a lighter and cigarettes in his room (#14). The findings are: Review of the facility's Resident Contract revealed that the facility would provide 24 hour supervision by capable, qualified, and caring staff. 1. Review of Resident #25's current FL-2 dated 08/21/26 revealed: -Diagnoses included schizophrenia, hypertension, lymphedema, and major neurocognitive disorder (Major neurocognitive disorder is another term for dementia). -The resident was ambulatory and constantly disoriented.	D 270		

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D 270	Continued From page 87 Review of Resident #25's Resident Register revealed the resident was admitted to the facility on 12/22/23. Review of Resident #25's current assessment and care plan dated 08/21/26 revealed: -The resident received mental health services. -The resident was independent with toileting, ambulation, bathing, dressing, grooming, and transfers. -The resident required supervision from staff with eating. Review of an Incident and Accident Report for Resident #25 dated 08/14/26 at 7:00pm revealed: -A female resident reported that Resident #25 came into her room and touched her inappropriately. -Staff called 911 and a police report was completed. -The resident refused to go to the hospital for evaluation. Interview with a female resident on 8/18/26 at 9:05am revealed: -She had resided at the facility for 5 years. -She was friends with Resident #25 and they spent time walking in the facility. -The evening of 08/14/26 Resident #25 came into her room and touched her breasts and buttocks. -Her bedroom door was open and she was awake. -She told him to go and he left her room. -She called the police and completed a police report. -She notified facility staff of the incident. Review of a police incident and investigation report dated 08/14/26 at 7:15pm revealed:	D 270		

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D 270	Continued From page 88 -Dispatch received a telephone call from a staff person at the facility. -An officer responded to a reported sexual assault at the facility and spoke with the female victim. -The resident stated that Resident #25 entered her room while she was wearing a nightgown and laying down on her left hip in the bed. -The resident stated that Resident #25 stood over her with his legs leaning against the bed and began touching her breasts with his open hands in a circular motion. -The resident stated that Resident #25 did the same to her buttocks without her consent. -The resident stated that she told Resident #25 to get out of her room and leave her alone, at which time Resident #25 left her room. -The female resident stated that she did kiss Resident #25 on Monday (08/10/26), but she did not give Resident #25 consent to touch her breasts or buttocks. -The officer made contact with Resident #25 who stated that he pushed another resident in her wheelchair to her room which was located beside the female residents room. -Resident #25 reported that he knocked on the female's door and she told him to come in. -Resident #25 reported that he entered the female resident's room and asked her how dinner was. -The female resident told him that her dinner was okay. -Resident #25 reported that since the female resident was in her nightgown, he told her he was going to leave. -Resident #25 reported that the female resident then asked him for a kiss before he left, and he leaned forward toward her and gave her a brief kiss on the lips before he left her room. -The officer also spoke with staff at the facility	D 270		

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D 270	Continued From page 89 who informed him that Resident #25 had been involved in similar incidents in the past and had repeatedly been instructed not to enter the women's hallway. -Staff also informed him that residents were not allowed to enter the hallways of the opposite sex. -The officer advised Resident #25 not to bother or speak with the female resident until the investigation had been completed. -The officer also advised the female resident not to bother or speak with Resident #25 until the investigation had been completed. Review of a 24 Hour Investigation Report completed by the Administrator revealed: -The incident occurred on 08/14/26 at 8:00pm. -The female resident admitted that she kissed Resident #25, but he later touched her without her consent. - The female resident stated that Resident #25 entered her room on Friday 08/14/26 at "7:00am." -The female resident stated that Resident #25 touched her, but he stopped after she asked him to leave her room. -The female resident stated that she should not have kissed Resident #25. -The female resident had mental anguish with increased anxiety due to the assault by Resident #25 that appeared to be resolved at the time the Administrator interviewed the resident. -The Administrator substantiated the allegation and placed Resident #25 on increased supervision. -The facility staff effective immediately needed to implement supervision measures to ensure the safety, privacy, and well-being of residents. -Staff should provide increased monitoring of Resident #25 during waking hours, with routine visual checks and observation of resident interactions.	D 270		

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D 270	Continued From page 90 -Resident #25 would be redirected promptly if found entering another resident's room without invitation or authorization. Review of 15 minute checks for Resident #25 revealed: -There were no 15 minute checks documented on 08/15/26 at 11:15pm and 11:30pm. -There were no 15 minute checks documented on 08/16/26 from 7:15am to 11:59pm. -There were no 15 minute checks documented on 08/17/26 from 5:00am to 2:45pm. -There were no 15 minute checks documented on 08/18/26 from 7:15am to 10:45pm. -There were no 15 minute checks documented on 08/19/26 from 12:00am to 11:59pm. -There were no 15 minute checks documented on 08/20/26 at 1:15pm or 1:30pm, and from 6:15pm to 8:15pm. -There were no 15 minute checks documented on 08/21/26 from 12:00am to 2:45am, and from 4:00am to 11:59pm. -There were no other 15 minute check documents provided from 08/22/26 at 12:00am to 08/27/26 at 7:45pm. Interview with a medication aide (MA) on 08/26/26 at 10:30am revealed: -Resident #25 and the female resident were close friends. -The former Resident Care Coordinator (RCC) informed her that Resident #25 was on 15 minute checks after he touched a female resident inappropriately in her room on 08/14/26. -The personal care aides (PCAs) were expected to document the 15 minute checks on an increased supervision form. -She checked on Resident #25 as well, however the PCAs kept documentation of the 15 minute checks.	D 270		

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D 270	Continued From page 91 -The PCAs gave their completed 15 minute check list to the MA and the MA would leave it in the previous RCC's box or the PCA would place the list in the previous RCC's box at the end of their shift. Telephone interview with the former RCC on 08/26/26 at 8:38am revealed: -Resident #25 was on 15 minute checks for increased supervision for the duration of his stay at the facility. -PCAs documented on a 15 minute check sheet with their initials and where the resident was located. -PCAs returned their 15 minute check sheets after their shifts to her box. Interview with the facility's primary care provider (PCP) on 08/21/26 at 10:12am revealed: -She was aware that Resident #25 went into a female residents room and touched her inappropriately on 08/14/26. -She had reviewed the Triage note dated 08/14/26. -Resident #25 knew that he was not allowed on the women's hall and should not have knocked on the female resident's door. -Resident #25's actions were inappropriate and she agreed with the former RCC placing the resident on increased supervision. Based on observations, interviews, and record reviews, Resident #25 was not interviewable. Interview with the Administrator on 08/27/26 at 6:44pm revealed she instructed the former RCC to implement 15 minute checks on Resident #25 indefinitely to ensure Resident #4 and other female resident's safety.	D 270		

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D 270	Continued From page 92 2. Review of Resident #15's current FL-2 dated 07/10/26 revealed: -Diagnosis included schizophrenia. -The resident was ambulatory. -The resident was intermittently disoriented. Review of Resident #15's Resident Register revealed the resident was admitted to the facility on 01/31/25. Review of Resident #15's current assessment and care plan dated 06/05/26 revealed: -The resident received mental health services. -The resident liked to be by himself. -The resident was always disoriented. -The resident's memory was documented as adequate but also forgetful and he needed reminders. -The resident was independent with ambulation and transfers. -The resident required supervision from staff with eating and toileting. -The resident required limited assistance from staff with bathing, dressing, and grooming. Review of Resident #15's Incident and Accident (I/A) Report dated 06/08/26 at 8:00am revealed: -Resident #15 was observed leaving the facility premises. -Staff called 911 to bring the resident back to the facility. -There was no documentation of what time the resident was returned to the facility. Review of Resident #15's electronic facility progress note dated 06/08/26 at 4:13pm revealed the resident was observed leaving the premises, police were called, located the resident and returned him to the facility.	D 270		

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D 270	Continued From page 93	D 270		

Review of Resident #15's I/A Report dated 06/11/26 at 7:15am revealed:
-Resident #15 was observed leaving the facility.
-Staff went behind the resident in an attempt to get him to return to the facility.
-Staff and police brought the resident back to the facility.
-There was no documentation of what time the resident was returned to the facility.

Review of a visit note from Resident #15's mental health provider (MHP) dated 06/22/26 revealed:
-The resident had eloped from the facility several times.
-The resident continued to refuse medications.
-The resident was not a danger to himself or others.

Request for an I/A Report for 06/25/26 for Resident #15 was not provided by survey exit.

Review of a facility progress note for Resident #15 dated 06/25/26 at 9:30pm revealed:
-Resident #15 was reported missing and was last seen at 9:00pm sitting in the television room on the men's hall.
-Police were notified and a report was filed.
-Staff also called the hospital in an attempt to locate the resident.
-At the time of the note (9:30pm) the resident had not been located.

Review of a police incident and investigation report dated 06/25/26 at 9:03pm revealed:
-Dispatch received a telephone call from the facility's previous Resident Care Coordinator (RCC) who reported that the resident was missing and facility staff were unable to locate him.
-The officer arrived at the facility and spoke with

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D 270	Continued From page 94 the previous RCC who reported that the resident left the facility at approximately 9:00pm and had not returned. -The previous RCC provided a description of what the resident was last seen wearing. -The previous RCC reported to the officer that the resident had left the facility on multiple occasions in the past and was diagnosed with schizophrenia. -The previous RCC informed the officer of the area near the facility that the resident went to often when he left the facility. -The officer patrolled the area but was unable to locate Resident #15. -The officer entered Resident #15 into the National Crime Information Center (NCIC) as a missing person. Review of a case supplemental report dated 06/26/26 at approximately 10:30pm revealed: -A different officer received a dispatch call in reference to suspicious activity at an intersection approximately 7.8 miles away from the facility. -The caller reported observation of a male wearing the same clothing that was in the description of the NCIC report and thought the individual might be loitering. -The caller observed the male standing at the intersection for "a while." -Local dispatch informed the officer that the description matched the missing person report from the facility last night (06/25/26 at 9:30pm). -The officer made contact with the male and asked if he was okay and if he needed emergency medical assistance. -The male reported he did not but his family member would be picking him up. -The male then told the officer his name which matched the missing person report. -The officer told Resident #15 that he had to take	D 270		

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him back to the facility.
-Resident #15 at first verbally resisted stating he could not go back there because "they have no food."
-Resident #15 continued to say if the officer took him there, that he would sue the officer and the local police department.
-Resident #15 was cooperative in regards to willingly get into the officer's vehicle.
-Once Resident #15 was in the back seat of the patrol car, he calmed down and proceeded to talk to himself.
-The officer escorted Resident #15 back into the facility.

Review of Resident #15's I/A Report dated 07/17/26 at 6:05pm revealed:
-Resident #15 was unable to be located on 3rd shift rounds.
-The local police were called and informed the resident was missing.
-The resident returned to the facility at 6:41am on 07/17/26.

Review of an I/A Report dated 07/19/26 at 6:36am revealed:
-Staff reported that Resident #15 got out of the facility gate and eloped.
-There was no documentation of what date and time the resident returned to the facility.

Review of an I/A Report dated 07/25/26 at 6:20am revealed:
-Staff reported that the resident got out of the facility gate.
-Staff asked the resident to come back more than once, but the resident refused.
-There was no documentation of what date and time the resident returned to the facility.

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D 270	Continued From page 96 Review of a police incident and investigation report dated 07/25/26 at 6:17am revealed: -The officer responded to the facility for a report of a missing person. -Resident #15 had managed to leave the facility on multiple occasions this year; he had walked away from the facility on 07/06/26, 07/17/26, and 07/19/26. -The officer patrolled the area near the facility and quickly located Resident #15. -When the officer got out of his vehicle, Resident #15 attempted to walk away but was cooperative with the officer and sat in the back of the police vehicle. -Resident #15 was talking to himself in a somewhat manic manner, "was caked in a layer of filth, he smelled like feces." -He returned Resident #15 to the facility and spoke with the medication aide (MA) on duty that reported the resident missing. -The officer asked about the resident's cleaning services for personal care and staff informed him that the resident had refused showers and medications. -The officer asked about the facility policies in place to help the resident in difficult situations, including had the facility considered an involuntary commitment (IVC) of the resident to help stabilize him. -The MA gave the officer the former RCC's contact number so he could speak with her about his concerns. Review of Resident #15's I/A Report dated 08/02/26 revealed: -There was no documentation of a time other than "am" was circled. -The report was completed by the Regional Director/Administrator. -The resident left the facility between 15 minute	D 270		

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D 270	Continued From page 97 watch and new placement secured. Review of a visit note from Resident #15's mental health provider (MHP) dated 06/22/26 revealed: -The resident had eloped from the facility several times. -The facility was attempting to find a different placement for the resident. -Resident #15 continued to refuse medications. -The resident was not a danger to himself or others. Review of a visit note from Resident #15's MHP dated 07/20/26 revealed: -The resident continued to elope from the facility. -The resident continued to refuse his medications. -The resident was not a danger to himself or others. Interview with a medication aide (MA) on 08/18/26 at 9:10am revealed: -Staff had to keep an eye on Resident #15 because he would wander in the facility parking lot frequently. -She was not aware of any increased supervision for Resident #15 other than staff keeping an eye on him. Second interview with a MA on 08/26/26 at 10:30am revealed: -She was not aware that Resident #15 had ever been on increased supervision. -It would have been difficult for staff to provide increased supervision for Resident #15 due to limited staff. -She was never told by anyone that Resident #15 was on increased supervision. -Staff generally tried to keep an eye out for Resident #15, the same as they did for any	D 270		

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D 270	Continued From page 98 resident. Telephone interview with the former RCC on 08/26/26 at 8:38am revealed: -Resident #15 had been discharged to a group home but she could not remember the date he was discharged. -When Resident #15 was a resident at the facility he was supposed to be on 30 minute checks for 72 hours after each elopement. -The PCAs had a form to document every 30 minutes where they observed the resident and were expected to monitor the resident's location every 30 minutes to ensure his safety. Review of 15 minute checks for Resident #15 revealed: -There was a cover sheet with instructions for the 15 minute safety observation record. -Staff were to place the date at the top of the form. -Instructions included that staff were to visually observe the resident at least once every 15 minutes and document each observation in the table (form) below and the observation must be a direct visual check. -Remote camera monitoring did not satisfy the 15 minute observation requirement. -Staff were to enter the exact time of their observation, the individual's physical location, behavioral status code, initials, and any relevant clinical comments -Late entries must be marked with an asterisk and explained in the comments column. -Staff were not to "prefill" entries in advance. -If the resident was out of the facility for a community outing or medical appointment, staff were expected to document the resident's location accordingly. -A supervisor was to review and co-sign the 15	D 270		

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D 270	Continued From page 99 minute check form at the end of each shift. -Resident #15 eloped on 06/08/26, 06/11/26, 06/25/26, and 07/17/26. -There were no 15 minute checks for Resident #15 from 06/08/26 to 07/18/26. -Resident #15 eloped on 07/25/26 and there was no documentation of 15 minute checks until 07/26/26. Interview with Resident #15's MHP on 08/25/26 at 10:57am revealed: -Resident #15 had refused pill form medication, injections, and even patches. -She had attempted all forms of medication administration in an attempt to successfully medicate the resident since he had numerous refusals of his medications. -Most days the resident was calm and would stay in the television room watching television. -At times he became restless and would wander in the facility and staff reported he frequently left the facility grounds when he was able to sneak away. -There was often a female resident that sat with him in the television room often. -The female resident was very religious and would tell the resident that he was free and he could go referring to free in a spiritual sense. -She thought that the resident interpreted that he was free to leave the facility. -Staff reported that several times after sitting with the female resident he would run for the front door in an attempt to leave the facility grounds. -Staff notified her when the resident eloped from the facility. -She had not instructed staff with a specific plan to ensure the resident's safety, other than to monitor the resident for increased agitation, irritability, or elopements.	D 270		

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D 270	Continued From page 100 Interview with Resident #15's primary care provider (PCP) on 08/21/26 at 10:12am revealed: -Resident #15 had a history of elopements. -He had been observed walking in the parking lot on several occasions waiting for the front gate to open. -The front gate was supposed to serve as a deterrent to prevent residents from leaving the facility property, however Resident #15 would wait for the gate to open and then go walking. -On occasion there would be a staff member sitting at the front door to prevent Resident #15 from going into the parking lot, even though there was a front door alarm, Resident #15 would still wander in the parking lot. -Staff had increased his supervision at times but she was not aware of a certain frequency or schedule of Resident #15 being under increased supervision. -She was aware that at one time there was discussion of getting Resident #15 a private sitter to prevent elopements but did not recall the resident ever having a private sitter. -She wanted the facility to implement increased supervision for the resident, to check on the resident every 30 minutes to ensure his safety, but she was not sure what the facility staff was able to provide regularly with increased supervision. Interview with the Administrator on 08/27/26 at 6:44pm revealed: -Resident #15 was placed on 15 minute checks to help prevent additional elopements. -She expected staff to perform and document all 15 minute checks on the resident. -Resident #15 was discharged to a group home. 3. Review of the facility's Resident Contract revealed that the facility did not allow smoking	D 270		

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D 270	Continued From page 101 anywhere on the premises. Review of the facility's undated smoking policy revealed: -It was not the intent of the facility to encourage smoking. -The facility believed that smoking was dangerous to the health of the resident, however they recognized that resident's had the right to choose. -Designated smoking areas were to be posted at the facility. -The designated smoking area was on the outdoor patio. -Residents were expected to use the designated smoking area to smoke. -Smoking was prohibited inside the facility and doing so would initiate discharge from the facility. -Staff were to supervise residents who smoked and needed supervision as determined by an initial and ongoing assessment. -For the safety of all residents, the facility reserved the right to confiscate all smoking materials if a resident failed to abide by smoking policies until the resident was discharged from the facility. Review of Resident #14's current FL-2 dated 03/27/26 revealed: -Diagnoses included hypertension, stage 3 chronic kidney disease, chronic obstructive pulmonary disease, and emphysema. -The resident was semi-ambulatory and was intermittently disoriented. -The resident was incontinent of bladder and continent of bowel. -The resident required assistance from staff with bathing and dressing. Review of Resident #14's Resident Register	D 270		

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D 270	Continued From page 102 revealed the resident was admitted to the facility on 03/28/24. Review of Resident #14's current assessment and care plan dated 03/27/26 revealed: -The resident was ambulatory with a rollator and had a limited range of motion in his upper extremities. -The resident had occasional bladder incontinence. -The resident was oriented and his memory was adequate. -The resident was independent with toileting and transferring. -The resident required supervision from staff with eating, ambulation, and dressing. -The resident required limited assistance from staff with bathing and grooming. Observation of Resident #14's on 08/20/26 at 2:42pm revealed: -The resident was lying on his bed. -There was a full size black lighter on his comforter beside three vape devices. Interview with Resident #14 on 08/20/26 at 2:43pm revealed: -He had quit smoking and only vaped now. -He had a lighter on his comforter on his bed because he still had four short cigarettes left to smoke. -He kept his short cigarettes underneath the seat cushion of his rollator. Observation of Resident #14's rollator on 08/20/26 at 2:44pm revealed: -There was one approximately half of a cigarette lying outside of the cigarette case. -There were three half cigarettes inside the cigarette case.	D 270		

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D 270	Continued From page 103 Observation of the designated smoking area outside on 08/27/26 at 3:00pm revealed: -Resident #14 was not outside smoking at the time of observation. -There were 7 residents outside in the designated smoking area without any staff present. Review of a Smoking Assessment for Resident #14 dated 05/14/25 revealed: -The purpose of the assessment was to determine the independence of residents who smoked. -The facility had the right to monitor all cigarettes, cigars, and lighters. -The facility also reserved the right to become a smoke free environment. -Matches or refillable lighters were not allowed in the facility. -There were 12 yes or no questions on the assessment. -Question #1 was could the resident light their own cigarette; yes Resident #14 could light his own cigarette. -Question #2 was could the resident handle his own cigarette without dropping it; yes Resident #14 could handle his own cigarette without dropping it. -Question #3 was the resident on oxygen, no Resident #14 was not on oxygen. -Question #4 could the resident express safety in regards to the risks of smoking and oxygen, no Resident #14 could not express safety related to the risks of smoking and oxygen. -Question #5 did the resident understand that they could not smoke in their room, bed, or bathroom, or in the hallway, no Resident #14 did not understand that he could not smoke in his room, bed, bathroom, or the hallway. -Question #6 did the resident understand that	D 270		

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D 270	Continued From page 104 before giving a cigarette to another resident he must ask staff to ensure that resident was not a supervised smoker, no Resident #14 did not understand. -Question #7 was how many cigarettes did the resident smoke a day, Resident #14 smoked 5 cigarettes a day. -Question #8 was if the resident was oriented to person, time, and place, no Resident #14 was not oriented to person, time, and place. -Question #9 was if the resident could verbalize the request for smoking materials, yes Resident #14 could verbalize request for smoking materials. -Question #10 was could the resident repeat to the staff where they could and could not smoke, no Resident #14 could not repeat to staff where they could and could not smoke. -Question #11 was based on the assessment was the resident capable of smoking in the designated smoking area independently, no Resident #14 was not capable of smoking in the designated smoking area independently. -Question #12 was to list any concerns, Resident #14 was not compliant and sometimes he smoked in his room. -The resident and previous Resident Care Coordinator (RCC) signed and dated the assessment. Review of a Smoking Assessment for Resident #14 dated 05/31/26 revealed: -There were 12 yes or no questions on the assessment. -Question #1 was could the resident light their own cigarette; no Resident #14 could not light his own cigarette. -Question #2 was could the resident handle his own cigarette without dropping it; yes Resident #14 could handle his own cigarette without	D 270		

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D 270	Continued From page 105 dropping it. -Question #3 was the resident on oxygen, no Resident #14 was not on oxygen. -Question #4 was could the resident express safety in regards to the risks of smoking and oxygen, yes Resident #14 could express safety related to the risks of smoking and oxygen. -Question #5 was the resident able to understand that they could not smoke in their room, bed, or bathroom, or in the hallway, no Resident #14 did not understand that he could not smoke in his room, bed, bathroom, or the hallway. -Question #6 asked if the resident understood that before giving a cigarette to another resident he must ask staff to ensure that resident was not a supervised smoker, yes Resident #14 did understand to ask staff before giving another resident a cigarette. -Question #7 was how many cigarettes did the resident smoke a day, Resident #14 smoked 2 cigarettes a day. -Question #8 was if the resident was oriented to person, time, and place, yes Resident #14 was oriented to person, time, and place. -Question #9 was could the resident verbalize the request for smoking materials, yes Resident #14 could verbalize request for smoking materials. -Question #10 was could the resident repeat to the staff where they could and could not smoke, yes Resident #14 could repeat to staff where they could and could not smoke. -Question #11 was based on the assessment was the resident capable of smoking in the designated smoking area independently, no Resident #14 was not capable of smoking in the designated smoking area independently. -Question #12 was to list any concerns, there were no concerns listed for Resident #14. -The resident should be placed on a list of supervised smokers if the resident refused to	D 270		

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comply with the smoking policy in any way.
-There was an explanation that Resident #14 refused to give staff his smoking materials because he said he was capable of smoking on his own.
-The resident refused to sign and date the smoking assessment, it was signed and dated by the previous RCC.

Interview with the former Resident Care Coordinator (RCC) on 08/20/26 at 3:15pm revealed:
-Resident #14 was not supposed to have a lighter or cigarettes in his possession.
-Resident #14 had been caught smoking in his room one time before so he was not allowed to have a lighter or cigarettes in his room.
-The residents' lighter and cigarettes were supposed to stay on the medication cart.
-She was going to remove the lighter and cigarettes from his room and place them on the medication cart.
-All the MAs should have known that Resident #14's lighter and cigarettes were supposed to be kept on the medication cart.

Telephone interview with the previous RCC on 08/26/26 at 8:38am revealed:
-Resident #14 was not supposed to have lighters or cigarettes in his room due to his smoking assessment; because he was deemed to be an unsafe smoker.
-In the past Resident #14 was supposed to be supervised when he smoked outside to ensure his safety and the safety of others.

Interview with a medication aide (MA) on 08/20/26 at 3:00pm revealed:
-Resident #14 was able to keep his own lighter and cigarettes.

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D 270	Continued From page 107 -Staff were not responsible for keeping the residents' lighter or cigarettes on the medication cart. -Resident #14 was allowed to go outside to the smoking area whenever he felt like it. -She was not aware that Resident #14's cigarettes and lighter had to be kept on the medication cart. Interview with a second MA on 08/26/26 at 10:30am revealed: -Resident #14 required one on one supervision in the past when he went to the smoking area outside to smoke. -She was not sure how long it had been that the one on one supervision of Resident #14 in the smoking area stopped. -MAs were expected to keep Resident #14's lighter and cigarettes on the medication cart and the resident had to come ask for his smoking supplies. -She was not sure when, however, the owner of the facility informed her that Resident #14 did not need one on one supervision when smoking outside anymore. -There was one incident when Resident #14 left the smoking area and was observed trying to put a fire out near the crotch of his pants in front of the receptionist area. -Resident #14 was not injured, however she felt he still needed one on one supervision when he went outside to smoke. -Resident #14 was not supposed to have possession of a lighter or cigarettes, his smoking items were supposed to be kept on the medication cart or at the receptionist's desk. Interview with Resident #14's mental health provider (MHP) on 08/25/26 at 10:57am revealed: -She was not aware that Resident #14 had a	D 270		

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lighter and cigarettes in his room.
-The resident was alert and oriented x3, very smart, and knew he should not have a lighter or cigarettes in his room.
-She thought that the personal care aides (PCAs) or MAs kept a check on the resident's room to ensure he did not have a lighter or cigarettes in his room.

Interview with Resident #14's primary care provider (PCP) on 08/21/26 at 10:12am revealed:
-Resident #14 had a smoking assessment completed that identified him as an unsafe independent smoker, and he had a history of smoking in his room.
-His cigarettes and lighter should be kept on the medication cart to ensure the safety of the resident and of other residents.
-Some residents had to keep their cigarettes and lighters at the front receptionist area and had to ask for a cigarette and their lighter when they wanted to smoke.
-The facility placed residents at risk by not keeping Resident #14's cigarettes and lighter on the medication cart or at the front receptionist area.
-No resident should have a lighter or cigarettes in their room if they were deemed an unsafe smoker.
-There was a risk that Resident #14 could catch something on fire which put him and other residents at risk.
-There was a time that the Administrator did not allow residents to keep their own lighter and cigarettes.
-In the past residents' lighters and cigarettes had to stay on the medication cart or in the front office with the receptionist.

Interview with the Administrator on 08/27/26 at

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D 270	Continued From page 109 6:44pm revealed: -Resident #14 was not allowed to keep his own lighter and cigarettes because he was not a safe smoker. -Resident #14's lighter and cigarettes were supposed to stay on the MA cart, and the resident had to ask for his lighter and a cigarette. -All residents were supervised in the designated smoking area outside. -Staff were specifically assigned to supervise all residents when they went outside to smoke. -She was not sure how staff missed that Resident #14 had a lighter and cigarettes in his room. _____ The facility failed to provide adequate supervision for 3 residents (#14, #15, #25). The facility failed to provide supervision to Resident #25 who was not allowed on the womens hall and went into a female residents room and touched her inappropriately on her breasts and buttocks. Resident #15 who had a diagnosis of schizophrenia and was documented as always disoriented eloped from the facility 8 times requiring law enforcement to locate the resident on multiple occasions, once his whereabouts were unknown for more than 24 hours. Resident #14 was assessed to be an unsafe smoker, required supervision while smoking, was not to have smoking materials in his possession and was found with a lighter and cigarettes in his room. This failure resulted in neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/20/26 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 26, 2026.	D 270		

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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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up for 2 of 5 sampled residents (#1, #2) related to a resident with orders for physical and occupational therapy and missed a follow-up ophthalmology visit (#2) and notifying the primary care provider of blood pressures outside of parameters (#1). The findings are: Review of the facility's undated Documentation of Health Services policy revealed: -There shall be written documentation of each visit to a physician or other healthcare professional. -The healthcare professional will be asked to document notes regarding visits including any care instructions deemed necessary. -Documentation would include date and signature of person making entry to the record. -Implementation of instructions given would begin immediately. -Any documentation made during the visit would be reviewed with the Administrator or designated supervisor following the visit, not to exceed 8 hours. -Documentation would be maintained in the resident's record at the facility.	D 273		

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D 273	Continued From page 111 1. Review of Resident #2's current FL-2 dated 07/31/26 revealed: -Diagnoses included end stage renal disease, reduced mobility, bi-polar disease, and chronic obstructive pulmonary disease (COPD). -Her level of care was documented as domiciliary (rest home) and other, assisted living facility (ALF). a. Review of Resident #2's handwritten physician order sheet dated 04/24/26 revealed: -There was an order for physical therapy (PT) to evaluate and treat for gait training, strengthening, balance, and falls prevention. -The order was signed by Resident #2's primary care provider (PCP) on 04/24/26. Review of a communication from Resident #2's PCP office dated 04/28/26 revealed: -The communication was dated 04/28/26 and was from the Care Coordinator from Resident #2's PCP office. -The note was a PT and Occupational Therapy (OT) referral had been sent to a named local home health provider. Review of PT/ OT notes for Resident #2 revealed: -The most recent entry was dated 09/16/25 and noted PT services were discontinued. -There were no further PT/OT notes provided. Telephone interview with a representative from the named local home health provider on 08/21/26 at 8:43am revealed: -A referral was received for Resident #2 for PT/OT services on 04/28/26. -Resident #2's referral was not accepted due to the home health provider not accepting Resident #2's insurance.	D 273		

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D 273	Continued From page 112 Interview with the former Resident Care Coordinator (RCC) on 08/21/26 at 10:44am revealed: -When the resident's PCP wrote an order for a referral, the referrals coordinator from the PCP's office sent the actual referral. -The PCP's referral coordinator notified her where the referral was sent and when she did not hear back about the referral or appointment date, she reached out to that provider. -She usually waited 3 to 4 days after notification of where the referral was sent to follow-up on the referral and appointment. -It was her responsibility to follow up on referrals. -She thought the PT/OT provider came out to see Resident #2, but she could not find any notes or documentation of PT/OT visits. Interview with Resident #2's PCP on 08/21/26 at 11:22am revealed: -She often ordered PT for residents when they were new to the facility. -Resident #2 had a fall on 04/21/26 and she ordered PT/OT to evaluate and treat at that time. -Outside referrals were sent from her office and her office notified the facility where the referrals were sent. -She was not aware that Resident #2 did not receive PT/OT as ordered in April 2026. -She saw Resident #2 today 08/21/26 and placed an order today for a PT/OT evaluation. -She expected the facility to follow-up on referrals for the residents. Review of Resident #2's hospital after summary dated 07/02/26 revealed: -The reason for the visit was cellulitis. -There were orders to pause insulin glargine (long-acting insulin to treat elevated blood sugar)	D 273		

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and insulin lispro (rapid-acting insulin to treat elevated blood sugar).
-Under other instructions, Home Health and PT services had been arranged through a named local home care provider and a phone number was provided.

Telephone interview with a representative with the Home Health/PT provider on 08/21/26 at 8:46am revealed:
-The last referral received for Resident #2 was in May 2025.
-There was no record of a PT referral received in July 2026.
-There was no documentation of contact from the facility for PT services for Resident #2 since May 2025.

Interview with the former RCC on 08/21/26 at 10:44am revealed:
-Either she or the facility's Registered Nurse (RN) were responsible for reviewing all hospital after visit summaries, or discharge summaries for orders.
-She was not aware of an order for Home Health/PT for Resident #2 on her 07/02/26 hospital after visit summary.

Interview with Resident #2's PCP on 08/21/26 at 11:22am revealed:
-She was not aware that PT had been ordered for Resident #2 after her 07/02/26 hospital visit.
-She was not contacted by the facility regarding a PT referral for Resident #2 in July 2026.
-The residents could always benefit from PT to assist with mobility.
-She saw Resident #2 today 08/21/26 and placed an order today for a PT/OT evaluation.
-She expected the facility to follow-up on referrals for the residents.

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D 273	Continued From page 114 Interview with the RCC-in-training on 08/27/26 at 8:59am revealed: -She was new to the position of RCC. -If the resident's PCP made a referral to an outside provider, the PCP's office sent the referral. -The PCP's office notified the RCC via email where the referral was sent and it was the RCC's responsibility to follow up on the referral. -When a resident returned from a hospitalization, emergency department visit or an outside provider appointment, whoever transported the resident was responsible for giving the paperwork to the RCC. -The RCC or RN reviewed all hospital paperwork and paperwork from outside provider appointments to ensure orders and referrals were processed. Interview with the Administrator on 08/27/26 at 3:52pm revealed: -The RCC reviewed all paperwork for the residents such as hospital discharge and after visit summaries and paperwork given at outside provider appointments. -The RCC was responsible for making sure all appointments for the residents were scheduled and kept. -The PCP's office sent referrals for outside providers for the residents and it was the RCC's responsibility to follow-up and make sure referrals were completed. b. Review of Resident #2's ophthalmology visit notes dated 04/27/26 revealed: -The following issues were addressed; macular edema (fluid build-up in the center of the retina), iritis (inflammation of the colored part of the eye), secondary right, and Epiretinal membrane (a thin	D 273		

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layer of scar-tissue that forms on the surface of the retina over the macula) of both eyes.
-The resident was to return to the office for a dilated exam.
-The resident's next appointment was 05/29/26 at 2:20pm.

Ophthalmology visit notes for Resident #2's 05/29/26 visit were requested on 08/21/26 at 8:24am and were not provided by the survey exit date.

Interview with Resident #2 on 08/21/26 at 2:24pm revealed she had not seen her ophthalmologist for a couple months.

Telephone interview with a receptionist at Resident #2's ophthalmology office on 08/20/26 at 1:48pm revealed;
-Resident #2 was last seen in the office on 04/27/26.
-Resident #2 had a follow appointment on 05/29/26 and the appointment was cancelled by the resident and rescheduled to 06/16/26.
-The 06/16/26 appointment was documented as a no-show.
-She had no documentation of any contact from the facility regarding Resident #2's follow-up appointment.

Interview with the Transportation Coordinator on 08/25/26 at 9:56am revealed:
-She transported residents to their appointments.
-When she transported a resident to an appointment, any paperwork received was given to her and if there were orders she faxed the info to the pharmacy and gave the paperwork to the Resident Care Coordinator (RCC).
-If the resident was given a return appointment she put it on her calendar and on the big calendar

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in the RCC's office.
-She thought she took Resident #2 to her appointment on 04/27/26 but was not sure about the follow-up appointment the resident was supposed to have on 05/29/26.

Second interview with the Transportation Coordinator on 08/25/26 at 4:11pm revealed:
-She contacted Resident #2's ophthalmology office and was told Resident #2 had cancelled the 05/29/26 follow-up visit and it was rescheduled to 06/16/26.
-She was not aware that Resident #2 had an appointment with ophthalmology on 06/16/26.

Interview with the former RCC on 08/21/26 at 10:44am revealed:
-The Transportation Coordinator transported the residents to their appointments and brought back any paperwork regarding new orders, return appointment or referrals.
-The Transportation Coordinator could fax orders to the pharmacy and was to place the paperwork in the RCC office.
-Either she or the facility's RN reviewed all appointment paperwork, hospital after visit summaries, or discharge summaries.
-The Transportation Coordinator kept up with the residents' appointments and kept the appointment calendar updated.
-She was not aware of a follow-up ophthalmology appointment for Resident #2.

Interview with the Administrator on 08/27/26 at 3:52pm revealed:
-The RCC reviewed all paperwork for the residents such as hospital discharge and after visit summaries and paperwork given at outside provider appointments.
-The RCC was responsible to make sure all

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D 273	Continued From page 117 appointments for the residents were scheduled and kept. Attempted telephone interview with Resident #2's ophthalmologist on 08/20/26 at 1:48pm and on 08/24/26 at 10:48am was unsuccessful. 2. Review of Resident #1's current FL-2 dated 07/09/26 revealed diagnoses included hypertensive heart, chronic kidney disease, muscle weakness, and syncope. Review of Resident #1's signed physician order dated 07/09/26 revealed there was an order to check the resident's blood pressure daily and call if the blood pressure was greater than 140/90. Review of Resident #1's July 2026 electronic medication administration record (eMAR) revealed: -There was an entry to check the resident's blood pressure daily at 10:30am and call the physician if the blood pressure was greater than 140/90. -On 07/14/26 at 10:30am the resident's blood pressure was 182/98. -On 07/15/26 at 10:30am the resident's blood pressure was 167/100. -On 07/29/26 at 10:30am the resident's blood pressure was 162/101. -On 07/30/26 at 10:30am the resident's blood pressure was 152/107. Review of Resident #1's August 2026 eMAR revealed: -There was an entry to check the resident's blood pressure daily at 10:30am and call the physician if the blood pressure was greater than 140/90. -On 08/03/26 at 10:30am the resident's blood pressure was 168/101. -On 08/07/26 at 10:30am the resident's blood	D 273		

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pressure was 156/99.
-On 08/14/26 at 10:30am the resident's blood pressure was 149/96.

Review of Resident #1's record revealed there was no documentation that the resident's primary care provider (PCP) was notified when the resident's blood pressure was greater than 140/90.

Interview with a medication aide (MA) on 08/20/26 at 11:24am revealed:
-When she notified Resident #1's PCP of a blood pressure greater than 140/90, she forgot to document the notification on a facility progress note.
-She was sure she had notified Resident #1's PCP when his blood pressure was greater than 140/90 but had no documentation of communication with the PCP.
-She knew she needed to do better with her documentation in facility progress notes, because if it was not documented it was not completed.
-She often got busy during her medication pass and forgot to document that she notified the resident's PCP.

Interview with the Resident Care Coordinator (RCC) on 08/20/26 at 1:55pm revealed:
-MAs were expected to follow PCP orders and to notify the PCP if Resident #1's blood pressure was greater than 140/90.
-The resident was at an increased risk of stroke or heart attack when his blood pressure went too high.
-The PCP needed to know when the resident's blood pressure was greater than 140/90 to ensure the resident's safety and the PCP may want to change a medication.
-She was not aware that MAs had not notified the

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PCP that the resident's blood pressure was greater than 140/90.
-The MAs should have notified the PCP and documented the notification in the facility progress note.

Interview with the facility's PCP on 08/21/26 at 10:12am revealed:
-She had been Resident #1's PCP in the past but he had recently started seeing a physician at the local Veterans Clinic.
-The MAs needed to follow the order to notify her if the resident's blood pressure was greater than 140/90.
-The MAs also needed to inform the resident's new physician at the Veteran's Clinic that his blood pressure was greater than 140/90.
-When there were parameters with orders, the physicians expected to be notified when the resident's blood pressure was greater than 140/90.
-She or the physician with the Veteran's Clinic may have wanted to change a medication to help control the resident's high blood pressure.
-The resident was at an increased risk of stroke, heart attack, or dehydration due to an increased blood pressure.

Interview with the Administrator on 08/27/26 at 6:44pm revealed:
-MAs were expected to document any communication with resident's physicians.
-MAs knew that if something was not documented it was not completed.
-The MAs should have notified Resident #1's physician when his blood pressure was greater than 140/90 so the physician could make changes to medications if needed.
-When the MAs failed to notify Resident #1's physician of his blood pressure being greater

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D 273	Continued From page 120 than 140/90 they placed the resident at an increased of a stroke or heart attack. Attempted telephone interview with Resident #1's physician at the Veterans Clinic on 08/24/26 at 9:29am was unsuccessful. _____ The facility failed to ensure referral and follow-up for two sampled residents (#1, #2), including a resident that had a follow-up ophthalmology appointment that was not kept and the same resident with orders for Physical Therapy on two separate occasions that was never scheduled placing her at risk for falls (#2), and by failing to notify a resident's PCP of blood pressure readings outside of parameters placing him at increased risk of stroke and heart attack. (#1). The failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/21/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 11, 2026.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this	D 276		

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D 276	Continued From page 121 Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure implementation of physician orders to meet the health care needs for 3 of 7 sampled residents related to an order for daily blood pressure checks (#1) and orders for compression garments (#23, #24). The findings are: 1. Review of Resident #1's current FL-2 dated 07/09/26 revealed diagnoses included hypertensive heart, chronic kidney disease, muscle weakness, and syncope. Review of Resident #1's signed physician order dated 07/09/26 revealed there was an order to check the resident's blood pressure daily and to call the physician if the blood pressure was greater than 140/90. Review of Resident #1's July 2026 electronic medication administration record (eMAR) revealed: -There was an entry to check the resident's blood pressure daily at 10:30am and call the physician if the blood pressure was greater than 140/90. -There was no blood pressure documented at 10:30am on 07/09/26 to 07/13/26, 07/16/26, 07/18/26 to 07/20/26, 07/23/26, 07/25/26 to 07/27/26, and 07/31/26. -There were no exceptions documented on the eMAR for 07/09/26 to 07/13/26, 07/16/26, 07/18/26 to 07/20/26, 07/23/26, 07/25/26 to 07/27/26, and 07/31/26. -The resident's blood pressure was not taken 14 times in July 2026.	D 276		

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D 276	Continued From page 122 Review of Resident #1's August 2026 eMAR revealed: -There was an entry to check the resident's blood pressure daily at 10:30am and call the physician if the blood pressure was greater than 140/90. -There was no blood pressure documented at 10:30am on 08/01/26 to 08/02/26, 08/05/26, 08/10/26 to 08/12/26, and 08/15/26 to 08/16/26. -There were no exceptions documented on the eMAR from 08/01/26 to 08/02/26, 08/05/26, 08/10/26 to 08/12/26, 08/15/26 to 08/16/26. -The resident's blood pressure was not taken 8 times in August 2026. Interview with a medication aide (MA) on 08/20/26 at 11:24am revealed: -She was surprised that she had not taken Resident #1's blood pressure so many times in July 2026 and August 2026 on the eMAR. -It was probably an oversight that she forgot to obtain the resident's blood pressure. -Sometimes the resident's blood pressure cuff battery went dead, but there was a supply on the cart to replace the battery. -She should have ensured that the resident's blood pressure was taken daily because it was a physician's order. Interview with the former Resident Care Coordinator (RCC) on 08/20/26 at 1:55pm revealed: -She was not aware that Resident #1's blood pressure was not documented as taken several times in July 2026 and August 2026. -MAs were expected to follow the physician orders and the MAs should have taken resident's blood pressure daily. -The physician needed to know what the resident's blood pressure was daily so she could	D 276		

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D 276	Continued From page 123	D 276		

monitor for any changes she may want to make with the resident's medication.

Interview with the facility's primary care provider (PCP) on 08/21/26 at 10:12am revealed:
-She had been Resident #1's PCP in the past, but he had recently started seeing a physician at the local Veterans Clinic.
-She expected the MAs to document the resident's blood pressure daily as ordered so his blood pressure could be monitored to see if there were any medication changes that were needed.

Interview with the Administrator on 08/27/26 at 6:44pm revealed:
-She was not aware that MAs had missed taking the resident's blood pressure several times in July 2026 and August 2026.
-MAs were supposed to follow physician orders.
-MAs knew that if it was not documented it was not completed.

Attempted telephone interview with Resident #1's physician at the Veterans Clinic on 08/24/26 at 9:29am was unsuccessful.

2. Review of Resident #23's current FL-2 dated 01/13/26 revealed:
-Diagnoses included dementia, muscle wasting, and malignant neoplasm of the prostate.
-He was semi-ambulatory.
-He required personal care assistance with bathing and dressing.

Review of Resident #23's signed physician order dated 01/26/26 revealed an order for knee-high compression socks (used to improve circulation), apply in the morning and remove at bedtime.

Observation of the Resident #23 on 08/19/26 at

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D 276	Continued From page 124 7:36am revealed Resident #23 was not wearing any type of socks. Review of Resident #23's August 2026 electronic medication administration record (eMAR) from 08/01/26 to 08/19/26 revealed: -There was an entry for knee-high compression socks, apply every morning, remove at bedtime scheduled at 7:00am and 8:00pm. -Knee-high compression socks were documented as applied at 7:00am on 08/01/26 through 08/19/26. -Knee-high compression socks were documented as removed at 8:00pm on 08/01/26 through 08/18/26. -Knee-high compression socks were documented as applied by the third shift MA at 7:00am on 08/19/26. Telephone interview with a pharmacist with the facility's contracted pharmacy provider on 08/19/26 at 10:39am revealed: -Resident #23 had an active order for compression socks to be applied in the morning and removed at night as of 05/28/25. -Resident #23's order for compression socks was profiled only and the compression socks never dispensed by their pharmacy. Interview with Resident #23 on 08/19/26 at 9:05am revealed: -He thought his compression socks were being washed. -He had several pairs of compression socks. -Staff did not assist him with the compression socks and did not put his compression socks on this morning. -He usually put the compression socks on himself. -He wore his compression socks the other day	D 276		

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D 276	Continued From page 125 but had not worn them since. Interview with the MA on 08/19/26 at 10:14am revealed: -The personal care aides (PCAs) were responsible for applying the residents' compression socks. -Resident #23 was not able put on his compression socks. -She had not noticed that Resident #23 was not wearing his compression socks during the morning medication pass. Observation of Resident #23 on 08/19/26 at 10:14am revealed: -The resident was sitting in his wheelchair in his room. -He was not wearing compression socks or any type of socks. Interview with a PCA on 08/19/26 at 10:16am revealed: -The third shift PCA was responsible for putting on the residents' compression socks. -She did not work third shift, so she did not apply Resident #23's compression socks. -She could only locate one compression sock for Resident #23 in his room. -She thought maybe Resident #23's compression socks were in the laundry. -She checked the laundry and could not locate compression socks for Resident #23. -She would order more compression socks for Resident #23. Interview with the former Resident Care Coordinator (RCC) on 08/21/26 at 4:28pm revealed if a resident had orders for compression socks/hose, the MAs were responsible for applying and making sure the resident wore their	D 276		

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compression socks/hose.

Interview with the Administrator on 08/19/26 at 12:30pm revealed:
-The MAs were responsible for applying the residents' compression socks/hose.
-The residents often refused their compression socks/hose.
-If a resident was able to put their own compression socks/hose on, it was the MAs responsibility to make sure they were wearing them.
-The MAs were responsible for making sure the residents were wearing compression socks/hose if they were ordered.

Interview with Resident #23's primary care provider (PCP) on 08/21/26 at 11:22am revealed:
-Resident #23 had chronic edema (swelling) in his legs.
-Resident #23 could not apply or remove his compression socks without assistance.
-Resident #23 could experience continued or increased swelling in his lower extremities without the compression socks.
-She expected staff to apply Resident #23's compression socks as ordered.

3. Review of Resident #24's current FL-2 dated 06/05/26 revealed:
-Diagnoses included schizoaffective disorder, hypertension, and gastroesophageal reflux disease.
-He required personal care assistance with bathing and dressing.

Review of Resident #24's signed physician order dated 06/05/26 revealed:
-There was an order for thigh-high compression hose (used to improve circulation), apply hose

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every morning.
-There was an order for thigh-high compression hose, remove hose at bedtime.

Observation of Resident #24 on 08/19/26 at 7:43am revealed the medication aide (MA) did not apply or offer to apply thigh-high compression hose to Resident #24.

Review of Resident #24's August 2026 electronic medication administration record (eMAR) from 08/01/26 through 08/19/26 revealed:
-There was an entry for thigh-high compression hose, apply every morning scheduled for 8:00am.
-There was a second entry for thigh-high compression hose, remove hose at bedtime, scheduled for 8:00pm.
-Thigh-high compression hose were documented as applied at 8:00am on 08/01/26 through 08/19/26.
-Thigh-high compression hose were documented as removed at bedtime at 8:00pm on 08/01/26 through 08/18/26.
-Thigh-high compression hose were documented as applied at 8:00am on 08/19/26 by the first shift MA.

Telephone interview with a pharmacist with the facility's contracted pharmacy on 08/19/26 at 10:39am revealed:
-She did not see an active order for thigh-high compression hose for Resident #24.
-Thigh-high compression hose had never been dispensed from the pharmacy for Resident #24.

Observation of Resident #24 on 08/19/26 at 9:09am revealed:
-He was lying on his bed reading.
-He was wearing ankle high white socks.
-He was not wearing thigh-high compression

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hose.

Interview with Resident #24 on 08/19/26 at 9:09am revealed:
-He could put his own thigh-high compression hose on.
-Staff never applied or assisted him with the thigh-high compression hose.
-He pulled a pair of thigh-high compression hose out of his dresser drawer to show the surveyor and returned them to the dresser drawer.

Interview with the MA on 08/19/26 at 10:14am revealed:
-The personal care aides (PCAs) were responsible for applying the residents' compression hose.
-Third shift frequently applied compression hose.
-Resident #24 could apply his own compression hose.
-Resident #24 did not like to wear his compression hose and they were probably applied earlier today and he took them off.
-Resident #24 would not wear his compression hose.
-She had not noticed Resident #24 was not wearing his compression hose.

Interview with a PCA on 08/19/26 at 10:16am revealed:
-The third shift PCA was responsible for putting on the residents' compression hose.
-She did not work third shift, so she did not apply Resident #24's compression hose.
-She was not aware Resident #24 had orders for compression hose.

Interview with the former Resident Care Coordinator (RCC) on 08/21/26 at 4:28pm revealed if a resident had orders for compression

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D 276	Continued From page 129 socks/hose, the MAs were responsible for applying and making sure the resident wore their compression socks/hose. Interview with the Administrator on 08/19/26 at 12:30pm revealed: -The MAs were responsible for applying the residents' compression socks/hose. -The residents often refused their compression socks/hose. -If a resident was able to put their own compression socks/hose on, it was the MAs responsibility to make sure they were wearing them. -The MAs were responsible for making sure the residents were wearing compression socks/hose if they were ordered. Interview with Resident #24's primary care provider (PCP) on 08/21/26 at 11:22am revealed: -Resident #24 had a history of chronic lower extremity edema (swelling). -Resident #24 could probably apply and remove his compression hose. -Resident #24 could experience continued or increased swelling in his lower extremities without the compression hose. -She expected staff to apply Resident #24's compression hose as ordered.	D 276		
D 319	10A NCAC 13F .0905 (f) Activities Program 10A NCAC 13F .0905 Activities Program (f) Each resident shall have the opportunity to participate in at least one outing every other month. Residents interested in being involved in the community more frequently shall be encouraged to do so.	D 319		

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D 319	Continued From page 130 This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure all residents were offered at least one outing every other month. The findings are: Review of the facility's calendar on 08/20/26 revealed the activities scheduled on 08/20/26 were snack time at 10:00am, shopping time from 10:00am to 2:00pm, tattoo party from 2:00pm to 3:00pm, snack time at 3:30pm and at 8:00pm, and walking time at 5:00pm. Observation of the facility on 08/20/26 revealed there was no resident outing from 10:00am to 2:00pm. Interview with a resident on 08/19/26 at 1:38pm revealed: -He had not seen transport used for outings. -He would love to go on an outing. Interview with a second resident on 08/19/26 at 1:20pm revealed: -She used a wheelchair to ambulate. -She had not gone on an outing since she had been at the facility in August 2025. -She would love to go out to eat if the facility would take her. Interview with a third resident on 08/19/26 at 1:30pm revealed: -The facility did not transport him anywhere for fun. -He would like to go out to eat and shopping.	D 319		

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D 319	Continued From page 131 -No one had invited him to go out of the facility for activities. Interview with a fourth resident on 08/18/26 at 1:48pm revealed: -He used a wheelchair to ambulate. -He had been trying to go shopping all week. -He had not gone out to a restaurant to eat with the facility. -He would love to go out to eat on occasions. -He was told it was hard to transport him because of his leg amputation, and they could not transfer him. Interview with the primary care provider (PCP) on 08/21/26 at 10:10am revealed: -She was aware that the facility was responsible to take residents who wished to go out on outings. -She was aware ambulatory residents went out on outings and non-ambulatory residents did not. -It was important to take residents on outings for their wellbeing. Interview with the Activity Director on 08/20/26 at 9:40am revealed: -She became the Activity Director in November 2025. -She completed the Activity Director's certification course on 07/27/26. -She drove the residents on outings and was often the only staff on the outing. -No one in a wheelchair wished to go on an outing and the residents sent her to purchase personal items and food. -If a resident had a doctor's appointments on the day of an outing, the outing would be cancelled and rescheduled at another time. -There was no outing on 08/20/26 due to the transportation staff transported a resident to a	D 319		

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D 319	Continued From page 132 doctor's appointment during the scheduled outing event. -She was responsible for developing and posting the activity calendar. Telephone interview with the Administrator on 08/24/26 at 10:50am revealed: -She was aware there should be outing activities. -She was aware non-ambulatory residents did not go on outings. -She was not equipped to take non-ambulatory residents on outings. -She was working on finding other transportation alternative so non-ambulatory residents could go on outings. -The Activity Director was responsible for developing and posting the activity calendar.	D 319		
D 325	10A NCAC 13F .0906(e) Other Resident Care and Services 10A NCAC 13F .0906 Other Resident Care and Services (e) Personal Lockable Space. (1) Personal lockable space shall be provided for each resident to secure his personal valuables. One key shall be provided free of charge to the resident. Additional keys shall be provided to residents at cost upon request. It is not the home's obligation to pay for additional keys; and (2) While a resident may elect not to use lockable space, it shall still be available in the home since the resident may change his mind. This space shall be accessible only to the resident and the administrator or supervisor-in-charge. The administrator or supervisor-in-charge shall determine at admission whether the resident desires lockable space, but the resident may change his mind at	D 325		

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D 325	Continued From page 133 any time. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to provide a personal lockable space for residents on the female unit of the facility. The findings are: Review of the facility's Resident Contract revealed that the facility would provide a personal lockable space as required to secure the resident's valuables and the facility would not be held responsible for valuables left with the resident. Interview with a resident in room #324 on 08/18/26 at 9:34am revealed: -She did not have a lockable space in her room. -It would be nice to have a lockable space to be able to protect her belongings. -She had not had anything stolen from her at the facility. Observation of room# 324 on 08/18/26 at 9:35am revealed there was no lockable space in the resident's room. Interview with a resident in room #325 on 08/18/26 at 9:36am revealed she did not have a lockable space in her room. Observation of room #325 on 08/18/26 at 9:37am	D 325		

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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
D 325	Continued From page 134 revealed there was no lockable space in the resident's room. Interview with a resident in room #326 on 08/18/26 at 9:40am revealed there was not a lockable space in her room. Observation of room #326 on 08/18/26 at 9:41am revealed there was no lockable space in the resident's room. Interview with a resident in room #226 on 08/18/26 at 9:43am revealed she did not have a lockable space to keep her personal belongings in her room. Observation of room #226 on 08/18/26 at 9:45am revealed she did not have a lockable space in her room. Interview with a resident in room #320 on 08/18/26 at 9:55am revealed she did not have a lockable space in her room. Observation of room #320 on 08/18/26 at 9:57am revealed there was no lockable space in the room. Interview with the Maintenance Director on 08/19/26 at 1:52pm revealed he was installing locks on the closet doors on the female unit this week. Interview with the Administrator on 08/27/26 at 6:44pm revealed: -She contacted the facility's Maintenance Director last week to ensure all rooms on the female unit had a lockable space. -She was not aware of any complaints of residents having items stolen from their rooms.	D 325		

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D 325	Continued From page 135 -It was important for residents to have access to a personal lockable space in their room because it would help the residents feel more comfortable leaving their room and feel they had increased privacy.	D 325		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews the facility failed to ensure 4 of 9 residents (#1, #2, #36, and #38) were free from financial exploitation for their monthly room and board and to ensure residents were treated with respect and consideration of their needs when they requested assistance using their call bells. The findings are: 1. Review of Resident #1's current FL-2 dated 07/09/26 revealed diagnoses included hypertensive heart, chronic kidney disease, muscle weakness, and syncope. Review of Resident #1's resident contract dated 04/17/25 revealed that beginning "April" the resident would be charged $1,449.00 per month for room and board. Review of an invoice from the facility dated 06/22/26 revealed:	D 338		

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D 338	Continued From page 136 -Resident #1's past room and board was $14,416.16 -There were no late fees listed. -The resident's total outstanding balance was $14,416.16. Interview with Resident #1 on 08/27/26 at 2:51pm revealed: -The previous Administrator told him that he had $10,000.00 in his checking account and that he needed to withdraw the $10,000.00 and close his checking account. -He was not sure how the Administrator knew how much money he had in his checking account and was not sure why he needed to close his checking account. -The previous Administrator informed him that he owed $6,000.00 for his room and board at the facility. -The resident went to the bank and withdrew $6,000.00 in cash. -He gave the previous Administrator $6,000.00 cash about 1-2 months ago that he saw her put in a green lock box in a drawer in her desk. -He received a receipt from the previous Administrator for the $6,000 he paid in cash and gave the receipt to his family member who was present when he paid the $6,000.00. -He received an invoice in June 2026 for over $14,000.00 and did not understand how he had such a large account balance that was due. -He did not understand how he could have an outstanding balance when he paid $6,000.00 in cash to the previous Administrator. -He was upset that the previous Administrator stole from him. -He felt that the previous Administrator took advantage of him when she did not apply the $6,000.00 cash to the outstanding balance she told him that he had.	D 338		

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D 338	Continued From page 137 Telephone interview with Resident #1's family member on 08/20/26 at 10:30am revealed: -The previous Administrator told the resident that he had $10,000.00 in his checking account. -Resident #1 told her that the previous Administrator told him to withdraw $10,000.00 from his checking account, pay her $6,000.00 for his room and board and to close his checking account. -Resident #1 told her that the previous Administrator told him once he paid $6,000 to her, that social security would take care of the remainder of his balance for his room and board. -She was not sure how the previous Administrator knew how much money Resident #1 had in his checking account. -Resident #1 told her that the previous Administrator was the only person with a key to the facility mailbox and she was the only person who opened the mail. -Shortly after Resident #1 paid $6,000.00 in cash to the previous Administrator, the resident received an invoice that he owed the facility approximately $14,000.00 for room and board. -The resident contacted his family member that was a witness to his payment of $6,000.00 in cash to the previous Administrator and told her he received an invoice that he owed the facility $14,000.00 and did not understand how he had an outstanding balance. -She and another family member did not understand how the resident had an invoice for $14,000.00. -She and another family member met with the Business Office Manager (BOM) in July 2026 to ask about the $6,000.00 cash the resident paid the previous Administrator and why it had not been credited to the resident's account. -The BOM was not aware that Resident #1 had	D 338		

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paid $6,000.00 to the previous Administrator until she and another family member met with her and they inquired about the resident having an outstanding balance of approximately $14,000.00.
-The BOM explained to them that there was no credit of $6,000.00 on the resident's account.
-The BOM explained to them that the last credit she could find on the resident's account was in April 2025.
-She and another family member spoke with a detective with the local police department who was investigating similar financial issues for other residents at the facility.

Attempted telephone interview with another family member of Resident #1's on 08/20/26 at 1:44pm was unsuccessful.

Refer to interview with the BOM on 08/25/26 at 2:29pm.

Refer to interview with the current Administrator on 08/27/26 at 11:05am.

Refer to second interview with the current Administrator on 08/27/26 at 6:44pm.

2. Review of Resident #2's current FL-2 dated 07/31/26 revealed diagnoses included end stage renal disease, reduced mobility, and chronic obstructive pulmonary disease.

Review of Resident #2's resident contract dated 07/10/26 revealed that beginning 07/10/26 the resident would be charged $1,432.00 per month for room and board.

Review of an invoice from the facility dated 06/22/26 revealed:

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D 338	Continued From page 139 -Resident #2's past room and board was $12,243.06. -The late fees for the resident were $35.00. -Room and board for July 2026 was $1,004.00. -The resident's total outstanding balance was $13,282.06. Review of a Resident #2's typed statement revealed: -The resident paid $800.00 a month to reside at the assisted living facility and social services paid the remainder of her balance. -On the 1st and on the 3rd of the month she received a check. -On the 1st she paid $200.00 cash to the previous Administrator. -When she paid the previous Administrator, she observed that the previous Administrator placed the $200.00 cash into a lock box until she paid the rest of the $600.00 cash when she was paid on the 3rd. -The document was signed by Resident #2, a witness and the Administrator on 07/13/26. Interview with Resident #2 on 08/27/26 at 1:46pm revealed: -The previous Administrator had possession of her debit card. -A staff member or the transportation staff would take her to the bank each month. -She used her debit card to withdraw $600.00 to $800.00 a month in cash. -She gave the cash to the previous Administrator for her room and board. -She had paid the previous Administrator $600.00 to $800.00 per month since she had resided at the facility. Interview with the Business Office Manager (BOM) on 08/25/26 at 2:29pm revealed:	D 338		

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D 338	Continued From page 140 -Whenever she asked the previous Administrator about Resident #2's bill being paid, the previous Administrator told her not to worry about it, that she had already talked to the Social Security office and that the resident's money was in a trust account and was on hold for the facility room and board bill with the facility as the direct payee. -She and the current Administrator went to the local Social Security office on 07/09/26 to ask about Resident #2's social security account. -The representative from social security informed her and the current Administrator that Resident #2's Social Security funding went directly to Resident #2. -The previous Administrator discharged Resident #2 to a skilled nursing facility (SNF) on 07/09/26. -When the BOM and current Administrator returned to the facility on 07/09/26 from the Social Security office the Administrator realized that Resident #2 was not in the building. -The current Administrator asked various staff where Resident #2 was and a staff member told her that the previous Administrator took the resident to a SNF because she had become incontinent. -The previous Administrator did not want the current Administrator or the BOM to know that she discharged Resident #2 to a SNF. -The current Administrator went to the SNF, spoke with Resident #2 and brought her back to the facility as a resident. -Resident #2 told the current Administrator that she got paid twice a month on the 1st and 3rd of each month and the money was deposited into her account. -She would go to withdraw money to take cash payments to the previous Administrator on the 1st and 3rd of each month, and she assumed the money she paid her was for her room and board.	D 338		

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D 338	Continued From page 141 Interview with the current Administrator on 08/27/26 at 11:05am revealed: -She went to the local Social Security office on 07/09/26 and when she returned to the facility, she noticed that Resident #2 was not at the facility. -When she asked where the resident was, she was informed that the previous Administrator had discharged her to a SNF due to urinary incontinence. -She went to the SNF to talk with the resident who told her that she still wanted to work on saving money so her case manager would be able to help her locate independent living. -She reported that she had paid the previous Administrator on the 1st and 3rd of each month cash for room and board. -Evidently the previous Administrator had packed up the resident's belongings and destroyed any receipts that the resident had in her room. -She told the previous Administrator on 07/10/26 that "this is too big for me, I'm gonna have to call the police." -The previous Administrator denied that Resident #2 paid her any cash. Refer to interview with the BOM on 08/25/26 at 2:29pm. Refer to interview with the current Administrator on 08/27/26 at 11:05am. Refer to second interview with the current Administrator on 08/27/26 at 6:44pm. 3. Review of Resident #38's current FL-2 dated 07/24/26 revealed diagnoses included type 2 diabetes, chronic obstructive pulmonary disease, hypertension, congestive heart failure, and cerebral infarction.	D 338		

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D 338	Continued From page 142 Request for Resident #38's resident contract on 08/27/26 at 11:00am was not provided by the end of the survey. Review of an invoice from the facility dated 06/22/26 for Resident #38 revealed: -The resident's past room and board was $4,171.43 -There were no late fees listed. -Room and board for July 2026 was $1,194.00. -The resident's total amount outstanding was $5,365.43. Interview with Resident #38 on 08/27/26 at 3:00pm revealed: -He was not sure if his family member had been able to cancel his debit card or get it back in her possession. -He thought his debit card was used to obtain a money order to pay his room and board. -He was upset that he received an invoice that he owed the facility money because he had paid $1,100.00 each month to the previous Administrator for his room and board. -He felt taken advantage of and was upset that the previous Administrator betrayed his trust. Telephone interview with Resident #38's family member on 08/27/26 at 1:16pm revealed: -Her family member resided at the previous assisted living facility (ALF) where the previous Administrator was the Administrator. -She believed that her family member was coerced into moving to the new ALF when the previous Administrator started working there. -She felt that her family member had been coerced into giving the previous Administrator his debit card because he trusted her. -She had spoken with the previous Administrator	D 338		

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several times and asked for a ledger of her family members' payments for room and board.
-The previous Administrator told her that she had provided the resident with receipts, the ledger, and invoice of amount owed to the facility and refused to provide her with copies of the information.
-Her family member reported to her that the previous Administrator told him that his room and board had increased, she requested information from the previous Administrator and never received the information about the increase.
-The previous Administrator informed the resident that his room and board were increased after he had been at the facility for 2 months and he did not understand why there was an increase.
-The previous Administrator informed the resident's family member that she used her own personal money to bring his room and board bill up to date; she could not remember the date.
-The previous Administrator had possession of the resident's debit card and his personal identification number (PIN) number.
-When she obtained a copy of the resident's bank statements she noticed there were numerous purchases at gas stations, a smoke shop, fast food restaurants and other places that she knew her family member did not make the purchases.
-When she reviewed the bank statements from her family member's checking account, she noticed that $1,100 was deducted each month but was not credited to the resident's room and board.

Interview with the Activity Director on 08/27/26 at 4:05pm revealed:
-The previous Administrator directed her to obtain a money order for Resident #38 with his debit card in the amount of $1,100.00 on 03/25/26.
-She obtained the money order for $1,100.00 and

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gave the money order to the previous Administrator.
-On 03/31/26 the Business Office Manager (BOM) asked her if she obtained a money order for Resident #38 on 03/25/26.
-The BOM informed her that the previous Administrator reported that she had not received a money order from Resident #38 for the month of March 2026.
-The previous Administrator directed her to obtain a second money order for Resident #38 on 04/02/26 for $1,100.00.
-She obtained a money order with the resident's debit card that the previous Administrator gave her.
-She returned to the facility and gave the previous Administrator a money order for $1,100.00 and returned the resident's debit card to her.
-She took a photograph of both money orders and had the BOM sign her notebook that she obtained a money order for Resident #38 on 04/02/26.
-She told the previous Administrator that she would not go to get a money order for Resident #38 again.

Interview with the BOM on 08/25/26 at 2:29pm revealed:
-The previous Administrator informed her in March 2026 that Resident #38 needed to pay his room and board.
-The previous Administrator gave the Activity Director the resident's debit card and she went to a local grocery store to obtain a money order for the resident's room and board.
-The Activity Director told her that she took the money order to the previous Administrator.
-Later the previous Administrator informed the resident, BOM and the Activity Director that she never received the money order for his room and

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board.
-The previous Administrator explained that she never received a money order because the Activity Director used the wrong PIN and the bank was issuing the resident a new debit card and a new PIN.
-The previous Administrator directed the Activity Director to go back to the local grocery store and to get another money order for the resident's room and board.
-The Activity Director took photographs of the money order and delivered the money order to the previous Administrator.
-The Activity Director made a note in her notebook that the previous Administrator had asked her to obtain a second money order for Resident #38 and asked the BOM to sign her notebook.
-She asked the resident how he paid for his room and board and he told her the previous Administrator had his debit card and that the previous Administrator returned his debit card to him the evening of 07/12/26.

Refer to interview with the BOM on 08/25/26 at 2:29pm.

Refer to interview with the current Administrator on 08/27/26 at 11:05am.

Refer to second interview with the current Administrator on 08/27/26 at 6:44pm.

4. Review of Resident #36's current FL-2 dated 07/10/26 revealed diagnoses included type 2 diabetes, hypertension, and major depressive disorder.

Request for Resident #36's resident contract on 08/25/26 at 2:00pm and 08/27/26 at 11:00am was

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D 338	Continued From page 146 not provided by survey exit. Review of an invoice from the facility dated 06/22/26 revealed: -Resident #36's past room and board was $10,111.32 -There was a late fee of $35.00. -The resident's room and board for July 2026 was $1,014.00 -The resident's total outstanding balance was $11,157.32. Review of Resident #36's typed statement revealed: -The resident was transported to the bank every month by a staff member. -She cashed her check at the bank and obtained a money order for $900.00. -She took the money order to the previous Administrator, and the previous Administrator completed the money order. -The previous Administrator told her that she still owed money. -She explained that she had receipts and she did not owe as much money as the invoice had listed. -The document was signed by the resident, a witness and the current Administrator on 07/13/26. Review of a typed document with Resident #36's signature revealed: -"I (Resident #36) understand that I have backpay of $9,543.72 that I will make arrangement on to take care of to clear my balance to Alpha Care One." -The resident signature was below the statement with a typed date of 05/10/26. -There was a note that the document was "signed on 07/12/26."	D 338		

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	HAL074046	A. BUILDING: _____ B. WING _____	08/27/2026

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

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D 338	Continued From page 147 Interview with the Business Office Manager (BOM) on 08/25/26 at 2:29pm revealed: -She and the current Administrator reviewed receipts made out to Resident #36 and found that there were 4 deposits at $900.00 each that were credited to the resident's account. -Resident #36 told her and the current Administrator that she was woken up by the previous Administrator early in the morning on 07/13/26 and told her that she owed money for her room and board and that she would have to leave if she was not able to pay the money owed. -The previous Administrator had the resident sign a piece of paper that the resident owed money to the facility and needed to agree to a payment plan in order to pay her unpaid balance to the facility. -Resident #36 told her that she wanted to be discharged to another assisted living facility. -The current Administrator found the statement of the payment plan that the previous Administrator got Resident #36 to sign. -Resident #36 told the current Administrator that when the previous Administrator woke her up, she was confused and did not understand why she had to sign that she owed the facility because she had always paid her room and board on time. Interview with the current Administrator on 08/27/26 at 11:05am revealed Resident #36 had some receipts that she had paid the previous Administrator for room and board, and she did not receive credit for the money she paid. Attempted telephone interview with Resident #36 on 08/25/26 at 10:34am was unsuccessful. Attempted telephone interview with Resident #36's family member on 08/26/26 at 2:20pm was unsuccessful.	D 338		

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D 338	Continued From page 148 Refer to interview with the BOM on 08/25/26 at 2:29pm. Refer to interview with the current Administrator on 08/27/26 at 11:05am. Refer to second interview with the current Administrator on 08/27/26 at 6:44pm. _____ Interview with the Business Office Manager (BOM) on 08/25/26 at 2:29pm revealed: -She began working as the BOM at the facility on 09/01/25. -The current Administrator was also the Regional Director. -The previous Administrator left the facility on 07/13/26. -The current Administrator helped with admissions. -When the previous Administrator was at the facility, the BOM was not allowed to complete admission packages, and the previous Administrator completed the required documentation for admissions. -The previous Administrator would tell the BOM that she had already contacted the regional office and all financial information for the new resident had been completed. -To her understanding the Administrator and the previous Administrator set the room and board rates for residents. -She was not aware how much each resident paid for their room and board; because the previous Administrator would not share that information with her. -The previous Administrator also kept information on any residents that received personal care service funding. -She was not allowed to check the mailbox for the	D 338		

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facility, only the previous Administrator had access to the mailbox key.
-The previous Administrator gave the BOM anything that she felt needed to be kept in a file in the BOM's office.
-The previous Administrator would open all mail and would place a sticky note on the information from the mailbox that needed to be filed.
-Residents normally received $90.00 a month after deductions were made for pharmacy expenses.
-The previous Administrator would go to the bank where the facility had an account and withdraw $3,000.00 to $4,000.00 for residents' personal funds each month.
-The previous Administrator would return from the bank, go into her office, shut the door, divide the resident's cash and place the money in an envelope with the resident's name written on the outside of the envelope.
-Once the previous Administrator had money in envelopes for residents, she would call the BOM to her office and give her the envelopes to disperse to residents.
-Residents had to sign a form with the previous Administrator for the money they received.
-The previous Administrator kept a lock box in her office in a desk drawer, and she was the only individual who had access to the lock box.
-To her knowledge there were not any residents that complained that they were supposed to get more money each month.
-Approximately 1 ½ weeks prior to the previous Administrator leaving her position at the facility on 07/13/26, the Regional Director who was now the current Administrator explained to the BOM that she was now her supervisor instead of the previous Administrator.
-The previous Administrator came to the facility at approximately 11:00pm on 07/12/26 and stayed

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at the facility until approximately 4:00am on 07/13/26 based on video recordings.
-The previous Administrator packed up her office and texted the BOM at approximately 2:00am on 07/13/26 that she left her keys and files in the BOM box, that she was removing her Administrator's license from the wall and placing the Regional Director's license on the wall.
-The previous Administrator texted her a photo of Regional Directors/ current Administrator license on the wall.

Interview with the current Administrator on 08/27/26 at 11:05am revealed:
-She was hired with the company on 06/01/26 and started working as a Regional Director at the facility on 06/01/26.
-She was responsible for oversight of the previous Administrator and the facility.
-The facility had a bank account, and she was unsure if the previous Administrator was listed on that account.
-She noticed that many residents were behind on their room and board bills.
-The facility had not been paid for room and board for several residents for approximately one year.
-She could not remember the date in June 2026 that she went to the local Social Security office to inquire on how long it would take the facility to become the payee for several residents.
-She was informed it would take approximately one month.
-The previous Administrator went to the bank near the first of the month and put residents' personal funds into envelopes after any outstanding balance from the pharmacy was deducted.
-The previous Administrator and the BOM gave the envelopes with money to the residents.

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D 338	Continued From page 151 -She completed applications for residents at Department of Social Services for any residents that qualified for Special Assistance in June or July 2026. -The previous Administrator had control of the facility mailbox and the bank where the facility had an account. -The previous Administrator would pay the BOM and the front desk receptionist for 80 hours every 2 weeks but limited the time that they were allowed to work at the facility. Second interview with the current Administrator on 08/27/26 at 6:44pm revealed: -Her corporate boss wanted to know why the facility had not received many payments on room and board for over a year. -The corporate boss felt it should not take long for payments from the Social Security office to come to the facility and did not understand why the facility was so far behind in payments for room and board. -She thought the previous Administrator or the corporate office were not completing the correct paperwork with the Social Security office. -When she came to work at the facility on 06/01/26, she was the supervisor of the previous Administrator. -She realized something was not right with resident's past due balances when the previous Administrator discharged a resident to a skilled nursing facility (SNF), because she had allegedly been taking money from the resident for room and board and there was no documentation that the resident had paid her bill with the facility. -She notified the local police department to request assistance with investigating the possible misappropriation of funds from residents at the facility.	D 338		

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D 338	Continued From page 152 2. Observation of the facility on 08/21/26 at 2:44pm revealed when the call button in room #307 was pressed there was a dinging sound and the room number was announced which could only be heard inside of the nursing station and the room number appeared on a panel. Interview with the resident in room #315 on 08/21/26 at 9:00am revealed: -When she pressed her call bell in the past it took a very long time for staff to respond. -She had pressed her call bell and staff never showed up to check on her. -Awhile ago she pressed her call bell because she needed assistance because she was feeling suicidal. -Staff never came to her room to assist her. -She was worried about her safety because she may have an accident and press the call bell for help and staff members would not show up. Observation of the facility on 08/21/26 at 9:07am revealed: -The call bell in room #315 was pressed at 9:07am. -At 9:13am, there was a medication aide (MA) observed in the 300 hall passing medications and the Administrator was also in the hallway. -At 9:16am, there were two staff members observed in the nursing station where the call bells alert and room #315 was on the panel. -There was no audible noise that could be heard standing outside of the nursing station. -At 9:18am, the Resident Care Coordinator (RCC) came to room #315 because the resident was in her doorway yelling at another resident. -At 9:20am, room #315 remained on the screen in the nursing station as needing assistance. -At 9:37am, room #315 remained on the screen at the nursing station; no staff member provided	D 338		

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D 338	Continued From page 153 assistance. Observation of the facility on 08/21/26 at 9:45am revealed: -The call bell in room #301 was pressed at 9:45am. -At 9:50am, there was no staff observed at the nursing station and room #301 was on the panel. -At 9:58am, there were no staff observed at the nursing station and room #301 remained on the panel. -At 10:15am, one staff member was observed at the nursing station and room #301 remained on the panel. Interview with the resident in room #301 on 08/21/26 at 9:42am revealed she never had to press her call button for assistance because she was very independent. Observation of the facility on 08/21/26 at 10:04am revealed: -At 10:05am, there were three staff members observed at the nursing station, the Administrator, the Executive Director (ED) and an MA. -At 10:14am, room #320 was still on the panel at the nursing station. Observation of the nursing station on 08/21/26 at 10:58am revealed there were four staff members at the nursing station and rooms #320 and #301 were still on the panel. Observation of the nursing station on 08/21/26 at 1:00pm revealed there was one staff member at the nursing station and rooms #320 and #301 were still on the panel. Observation of the facility on 08/25/26 at 2:43pm revealed:	D 338		

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D 338	Continued From page 154 -Survey staff observed a resident in room #324 yelling for help. -Upon entering the room survey staff observed the resident. -The resident was partially on the bed attempting to transfer from her wheelchair into her bed. -No staff came to assist the resident. -The resident was verbally assisted by survey staff to get into her bed properly. -She pressed her call button at 2:45pm. -Room #324 alerted on the panel for approximately three seconds then was cleared without staff clearing it or checking on the resident. Interview with the resident in room #324 on 08/21/26 at 9:42am revealed that staff were not going to come because they did not answer the call buttons when she pressed it. Interview with the Administrator on 08/25/26 at 3:00am revealed: -She did not know why the room number for room #324 only alerted on the panel for a couple seconds. -When a resident pressed the call button it should have remained on the panel and needed to be manually cleared. Interview with a marketing staff on 08/25/26 at 8:25am revealed: -She was usually at the nursing station throughout the day. -Residents had call buttons in their rooms that they pressed if they needed assistance. -When a resident pressed their call button there was an alert at the nursing station and their room number appeared on the panel. -There were supposed to be two staff members in each hall to assist residents.	D 338		

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D 338	Continued From page 155 -When she heard the panel alert in the nursing station, she alerted staff over the intercom which resident room number needed assistance. -Personal care aides (PCAs) and MAs walked in the nursing station regularly and could see which rooms pressed their call buttons for assistance. -Staff members should check resident room immediately when they pressed their call buttons. -Management was attempting to find a better system to allow staff to be alerted when residents needed assistance. -She was concerned about resident safety due to lack of staff answering call bells. Interview with a PCA on 08/25/26 at 8:55am revealed: -Residents pressed their call buttons when they needed assistance. -When residents pressed their call buttons there was an alert at the nursing station with the resident room number. -Staff were supposed to walk their assigned hall and check in on all the residents regularly. -Any staff member at the nursing station could tell a PCA when a resident needed assistance. -She was not sure how long residents waited for assistance when they pressed their call button. -She was concerned about resident well-being if staff did not respond to call buttons quickly. Interview with a second PCA on 08/25/26 at 9:10am revealed: -Residents had call buttons in their rooms that they pressed if they needed assistance. -The call bell alerted at a panel in the nursing station. -If there was a staff member at the nursing station then they alerted PCAs which room needed assistance. -Staff should respond to call bells within two to	D 338		

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D 338	Continued From page 156 three minutes. -It was important to the health and safety of residents for staff to respond to residents call bell immediately. -The resident's room number remained on the panel in the nursing station until staff manually cleared it in the system after they checked on the resident. -Some days staff were really busy and were not able to check on the residents that pressed their call buttons right away. Interview with the RCC on 08/21/26 at 2:45pm revealed: -She went to check on the resident in room #315 because she heard her yelling at another resident, not because she pressed her call button. -She was not aware that the call button in room #315 had been pressed. -When a resident pressed their call button there was an alert at the nursing station that dinged and said the room number and the room number remained on the panel. -Once their was an alert the staff member at the nursing station was supposed to call for the PCA or MA to check on the resident. -If nobody was in the nursing station when the alert sounded then the room number remained on the panel and whoever walked by and observed the room number should check on the resident. -She believed staff members had become desensitized to the call bell system and stopped checking on residents. -She was concerned because a resident could fall or be injured and press their call button for assistance and staff would not check on them. Interview with the Administrator on 08/21/26 at 10:40am revealed:	D 338		

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D 338	Continued From page 157 -She expected staff to check on residents as soon at it was feasible when a resident pressed their call button. -When a resident pressed their call bell there was an alert at the nursing station and a sound that dinged and said the room number and the room number appeared on a panel. -Staff members did their charting at the nursing station so there was usually someone sitting there. -Any staff at the nursing station could alert the PCAs which room number needed assistance. -After staff checked on the resident that pressed their call button they went to the nursing station and cleared the room number off of the panel. -Staff usually checked on residentswhen they pressed their call buttons. -Staff should have checked on the residents rooms that were on the panel in the nursing station. -The call bell system did not allow her to print out a history of call bell alerts and time it took to clear the room number. -She was concerned with the health and safety of residents if staff did not answer call buttons. Interview with facility's Registered Nurse (RN) on 08/27/26 at 2:15pm revealed: -Each resident had a call button in their room they could press for assistance. -When the call button was pressed there was an alert at the nursing station with a sound that dinged and said the room number and the room number appeared on a panel. -If there was not a staff member at the nursing station then staff on the floor could not be made aware of which resident needed assistance. -The marketing staff member usually sat at the nursing station but she did not go over the intercom and alert staff which room numbers	D 338		

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D 338	Continued From page 158 needed assistance. -Staff should have checked on each resident at least every two hours. -She was concerned that residents were not getting the assistance they needed and there could be skin breakdown if a resident had to wait for incontinent care. -If a resident had a fall or an injury they needed assistance immediately. -Staff not answering call buttons could also lead to residents having mental anguish and issues with overall health and well-being. Interview with the facility's contracted primary care provider (PCP) on 08/21/26 at 10:40am revealed: -If a resident pressed their call button for assistance, then staff should check on them within five minutes. -Injury or death could occur if staff was not assisting residents who were calling for help. _____ The facility failed to ensure residents were free from financial exploitation by the previous Administrator for payment of their room and board. Resident #1 was instructed by the previous Administrator to withdraw $10,000.00 from his checking account and to close his checking account, she instructed the resident to pay her $6,000.00 in cash and did not credit the money to his account resulting in an overdue invoice for $14,416.16. Resident #2 paid the previous Administrator $800.00 a month for room and board, which was not credited to the resident's account resulting in an overdue invoice of $13,282.06. Resident #3 paid $1,100.00 two times but was not credited for the $2,200.00 resulting in an overdue invoice of $5,365.43. Resident #4 paid the previous Administrator $900.00 a month for room and board, was woken	D 338		

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D 338	Continued From page 159 up by the previous Administrator early in the morning and asked to sign a payment agreement when she was sleepy and confused. The residents account was not credited $900.00 per month which resulted in an overdue invoice for $9,543.72. This failure resulted in exploitation of residents and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on August 27, 2026. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 26, 2026.	D 338		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered and in accordance with facility policy for 2 of 5 residents including errors with medications used to treat elevated blood glucose (#1, #2), medications used to treat high blood pressure, fluid buildup and edema	D 358		

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 _____	08/27/2026

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

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D 358	Continued From page 160 (#1), topical and oral medications used to treat bacterial infections, medications used to treat bi-polar disease and depression, a medication for heart health, a medication used to treat elevated cholesterol, eye-drops used to treat high fluid pressure and inflammation in the eyes, a medication used to treat allergy symptoms, a medication used to treat high phosphate levels in the blood, medication used to treat symptoms of chronic obstructive pulmonary disease, and a vitamin supplement (#2). The findings are: Review of the facility's undated Medication Administration policy revealed: -Medications, both prescription and non-prescription, would be administered in accordance with the prescribing practitioner's orders. -Medications would be administered within one hour before or one hour after prescribed or scheduled time unless an emergency precludes the administration. -In the event of medication errors and adverse reactions to medications the facility staff would notify a physician or appropriate health professional and their supervisor, document any orders received by the physician or health professional and actions taken by the facility to comply with the order. -Charting would identify if documentation errors, unavailability of medications or resident's refusal of medication may have led to the error. 1. Review of Resident #2's current FL-2 dated 07/31/26 revealed: -Diagnoses included end stage renal disease, reduced mobility, bi-polar disease, and chronic obstructive pulmonary disease (COPD).	D 358		

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D 358	Continued From page 161 -Her level of care was documented as domiciliary (rest home) and other, assisted living facility (ALF). Interview with the former RCC on 08/20/26 at 2:47pm revealed: -There was no admission paperwork received when Resident #2 returned from the skilled nursing facility (SNF) on 07/10/26. -She sent Resident #2's previously signed physician order sheet to the pharmacy when she returned from the SNF and had Resident #2's primary care provider (PCP) sign a new FL-2 and physician's order sheet on 07/31/26. -She did not think Resident #2 returned from the SNF with her medications. Telephone interview with the former RCC on 08/26/26 at 8:42am revealed: -She was out of the facility for 2-3 days when Resident #2 returned from the SNF. -She was notified by one of the medication aides (MAs) that Resident #2 did not have her medications. -She knew Resident #2 was without her medications for several days. -Resident #2 should never have been accepted back to the facility without her medications. -She worked for days to get Resident #2's medications back in the facility. Interview with the Administrator on 08/20/26 at 2:53pm revealed: -She was at the facility and noticed Resident #2 was placed in a staff member's vehicle. -She asked where Resident #2 was going and was told Resident #2 had been "skilled up" by the previous Administrator for incontinence and was transferred to a SNF. -She immediately went to the SNF and discussed	D 358		

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D 358	Continued From page 162	D 358		

with the Admissions Coordinator at the SNF that Resident #2 was not appropriate for admission to the SNF.
-She brought Resident #2 back to the facility the same day.
-She did not think Resident #2's medications were sent back with her from the SNF.
-She was not aware that Resident #2 did not receive her 8:00am medications on her dialysis days.
-Staff should have contacted Resident #2's PCP about her 8:00am scheduled medications on her dialysis days.

Interview with the Administrator on 08/27/26 at 3:52pm revealed:
-She was not given any medications when she brought Resident #2 back from the SNF.
-She was not aware the Resident #2 was without medications when she returned from the SNF.
-If she had known Resident #2 was without her medications, she could have sent staff to the SNF to retrieve Resident #2's medications because the SNF was just across the street.
-She expected the residents' medications to be available and administered as ordered by their PCP.

a. Review of Resident #2's signed physician's order dated 05/29/26 revealed an order for insulin lispro (a rapid acting insulin used to treat elevated blood glucose levels) 100unit/ml, inject 5 units subcutaneously three times daily with meals, hold for blood sugar less than 100.

Review of Resident #2's hospital after visit summary (AVS) dated 07/02/26 revealed:
-The resident was admitted from 06/23/26 to 07/02/26.
-The primary diagnosis was cellulitis.

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D 358	Continued From page 163 -There was an order to pause insulin lispro. Review of Resident #2's hospital discharge summary dated 07/24/26 revealed: -Chief complaint/Reason for admission was dyspnea (shortness of breath). -Her insulin was held on discharge as she did not require any insulin while inpatient. -Additional history gathered was that she had not been receiving home medications for the past 2 weeks due to medication mix-up that occurred after her last discharge between a SNF and her ALF. -With resumption of her medications as well as diuresis her symptoms improved requiring no further interventions. -Her type 2 diabetes was managed with insulin, and she was discharged on insulin, insulin lispro 5 units subcutaneously three times a day with meals. -She was stable for discharge on 07/24/26. Review of Resident #2's signed physician order sheet dated 07/31/26 revealed an order for insulin lispro 100unit/ml, inject 5 units subcutaneously three times daily with meals, hold for blood sugar less than 100. Review of Resident #2's hospital discharge summary dated 08/16/26 revealed: -Her admitting diagnoses were abdominal pain, constipation, and acute metabolic encephalopathy. -Her chief complaint and admitting diagnosis were constipation and colitis. -Her insulin lispro was decreased from 5 units three times a day with meals to 2 units three times a day with meals. Review of Resident #2's telephone triage note	D 358		

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D 358	Continued From page 164 dated 08/20/26 revealed: -There was a note that since surveyors were in the facility, the facility staff requested to change the administration time for insulin lispro for Tuesday, Thursday, and Saturday at 6:00am and on Monday, Wednesday, Friday at 8:00am. -A response was received to the times as requested, please place in book for primary care provider (PCP) to follow-up, notify triage of any acute changes. Review of Resident #2's June 2026 electronic medication administration record (eMAR) revealed: -There was an entry for insulin lispro 100unit/ml pen, inject 5 units subcutaneously three times daily with meals, hold for blood sugar less than 100, scheduled at 8:00am, 12:00pm, and 5:00pm. -There was a note the resident was out of the facility from 06/29/26 through 07/02/26. -Insulin lispro was documented as not administered at 8:00am on 06/02/26, 06/06/26, 06/09/26, 06/11/26, 06/13/26, 06/16/26, 06/18/26, and on 06/23/26 with the exception documented as out of facility on each occasion. -Insulin lispro was documented as not administered at 12:00pm on 06/02/26, 06/09/26, 06/13/26, and on 06/16/26 with the exception documented as out of facility on each occasion. -There was no documentation insulin lispro was administered at 12:00pm on 06/23/26, there was no exception and the space for initials, finger stick blood sugar (FSBS) and injection were blank. -The resident missed 12 doses of insulin lispro in June 2026. Review of Resident #2's July 2026 eMAR revealed:	D 358		

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D 358	Continued From page 165 -There was an entry for insulin lispro 100unit/ml pen, inject 5 units subcutaneously three times daily with meals, hold for blood sugar less than 100, scheduled at 8:00am, 12:00pm, and 5:00pm with a stop date of 07/09/26. -There was a note the resident was out of the facility from 06/29/26 to 07/02/26. -There was a second note that insulin lispro was suspended on 07/02/26 through 07/31/26, on hold per discharge summary and was held on 07/01/26 through 07/08/26. -There was second entry for insulin lispro 100unit/ml pen, inject 5 units subcutaneously three times daily with meals, hold for blood sugar less than 100, scheduled at 8:00am, 12:00pm, and 6:00pm. -Insulin lispro was not documented as administered at 8:00am on 07/10/26 through 07/15/26, and on 07/20/26 and the space for initials and injection site were blank. -Insulin lispro was documented as not administered at 8:00am on 07/21/26 and on 07/23/26 with the exception documented as out of the facility on both occasions. -Insulin lispro was not documented as administered at 12:00pm, and on 07/10/26 through 07/14/26, on 07/18/26, 07/19/26, 07/26/26, and on 07/27/26 and the spaces for initials and injection site were blank. -Insulin lispro was documented as not administered at 12:00pm on 07/28/26 with the exception documented as out of the facility on each occasion. -Insulin lispro was not documented as administered at 6:00pm on 07/10/26 through 07/14/26, on 07/16/26, and on 07/25/26 and the space for initials and injection site were blank. -The resident missed 26 doses of insulin lispro in July 2026.	D 358		

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D 358	Continued From page 166 Review of Resident #2's August 2026 eMAR revealed: -There was an entry for insulin lispro 100unit/ml pen, inject 5 units subcutaneously three times daily with meals, hold for blood sugar less than 100, scheduled at 8:00am, 12:00pm, and 5:00pm with a stop date of 08/17/26. -There was a note that the resident was out of the facility from 08/14/26 to 08/17/26. -Insulin lispro was documented as not administered at 8:00am on 08/01/26, 08/04/26, 08/06/26, 08/08/26, and on 08/11/26 with the exception documented as out of facility. -Insulin lispro was documented as not administered at 12:00pm on 08/01/26, 08/04/26, and on 08/06/26 with the exception documented as out of facility. -Insulin lispro was not documented as administered at 12:00pm on 08/08/26 with no exception documented and the space for initials and the injection site were blank. -Insulin lispro was not documented as not administered at 6:00pm on 08/09/26 through 08/11/26 with the no exception documented an the spaces for initials and injection site were blank. -There was a second entry for insulin lispro 100unit/ml pen, inject 2 units subcutaneously three times daily with meals, scheduled at 7:30am, 10:30am and 5:30pm with a start date of 08/18/26. -Insulin lispro was documented as not administered at 7:30am and at 10:30am on 08/18/26 and on 08/20/26 with the exception documented as out of the facility. -The resident missed 16 doses of insulin lispro from 08/01/26 through 10:30am on 08/20/26. Observation of Resident #2's medications on hand on 08/20/26 at 3:26pm revealed there was	D 358		

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D 358	Continued From page 167 one 3ml pen of insulin lispro with a pharmacy label containing Resident #2's name with a handwritten dispose of date of 09/17/26. Telephone interview with a pharmacist with the facility's contracted pharmacy on 08/21/26 at 9:23am revealed: -The original order was received for Resident #2's insulin lispro on 06/05/25 to inject 5 units three times daily with meals. -A new order was received for Resident #2 for insulin lispro to inject 2 units three times daily with meals on 08/16/26. -Insulin lispro was last dispensed for Resident #2 for five 3ml pens on 06/10/26. Interview with Resident #2 on 08/20/26 at 2:24pm revealed: -She had dialysis on Tuesdays, Thursdays, and Saturdays. -She usually left for dialysis between 6:00am and 6:30am. -She did not receive her morning insulin lispro or have her morning blood sugar checks on dialysis days. -She thought there was a period in July 2026 that she did not have any of her medications for a few days but was not certain. Interview with a MA on 08/20/26 at 3:10pm revealed: -Resident #2 went to dialysis on Tuesday, Thursday, and Saturday. -Resident #2 had some medications scheduled at 6:00am on her dialysis days. -Resident #2 also had some medications scheduled at 8:00am which included her insulin lispro. -Resident #2 did not receive her morning dose of insulin lispro on her dialysis days because the	D 358		

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D 358	Continued From page 168 8:00am scheduled medications would pop up on the her eMAR after she had left for dialysis. -She was not sure if Resident #2's primary care PCP was aware that Resident #2 had medications scheduled at 8:00am on her dialysis days. Second interview with a MA on 08/26/26 at 11:00am revealed: -She noticed Resident #2 was without her oral medications when she returned to the facility from the SNF in July 2026 and she notified the Resident Care Coordinator (RCC). -She thought Resident #2 had insulin available but not her oral medications and eye drops. Interview with the former RCC on 08/20/26 at 10:42am revealed: -Resident #2 had dialysis on Tuesday, Thursday, and Saturdays. -She thought Resident #2 left for dialysis at 7:00am. -Resident #2 was supposed to have her FSBS checked and receive her insulin lispro before she left for dialysis. -She knew Resident #2's morning medications had been adjusted to be administered at 6:00am on her dialysis days. -She was not aware that Resident #2's insulin lispro morning administration was scheduled at 8:00am on her dialysis days. -She thought Resident #2's PCP was under the impression all her 8:00am medications had been adjusted to 6:00am on dialysis days. -Back in May 2026, Resident #2 had weakness and her PCP signed a new FL2 for Resident #2 to go to a SNF. -Resident #2 was sent to a SNF in July 2026 and returned either the same day or the next day. -She was leaving the facility as Resident #2 was	D 358		

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D 358	Continued From page 169	D 358		

being transferred out to the SNF and she received a call later in the day that Resident #2 had returned to the facility from the SNF.
-She was off for a few days and when she returned to work, Resident #2 had returned to the facility.
-She was not working on the day Resident #2 returned from the SNF, so she did not know if a paper MAR was implemented when Resident #2 returned to the facility.

Interview with Resident #2's PCP on 08/21/26 at 11:21am revealed:
-Resident #2 recently had multiple hospitalizations.
-She was not aware that Resident #2 was without medications for several days in July 2026.
-Resident #2's diabetes was pretty well controlled but being without the insulin lispro could result in the resident having elevated blood sugars that could result in diabetic ketoacidosis which could lead to altered mental status, and weakness.
-She was not aware until today 08/21/26 that Resident #2 was not receiving her morning insulin lispro on her dialysis days.
-She expected Resident #2's medications to be administered as ordered.

b. Review of Resident #2's signed physician's order dated 05/29/26 revealed an order for Lantus (a long-acting insulin used to treat elevated blood glucose levels) Solostar 100unit/ml, inject 22 units subcutaneously once daily at bedtime.

Review of Resident #2's hospital AVS dated 07/02/26 revealed:
-The resident was admitted from 06/23/26 to 07/02/26.
-The primary diagnosis was cellulitis.

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D 358	Continued From page 170 -There was an order to pause Lantus. Review of Resident #2's hospital discharge summary dated 07/24/26 revealed: -The chief complaint/reason for admission was dyspnea. -Her insulin was held on discharge as she did not require any insulin while inpatient. -She had not been receiving home medications for the past 2 weeks due to medication mix-up that occurred after her last discharge between a SNF and her ALF. -With resumption of her medications as well as diuresis her symptoms improved requiring no further interventions. -Her type 2 diabetes was managed with insulin, and she was discharged on insulin. -She was stable for discharge on 07/24/26. Review of Resident #2's July 2026 eMAR revealed; -There was an entry for Lantus Solostar 100units/ml, inject 22 units subcutaneously once daily at bedtime, scheduled for 8:00pm with a stop date of 07/09/26. -There was a note that the resident was out of the facility from 06/29/26 to 07/02/26. -There was note, Lantus was suspended 07/02/26 to 07/31/26 per hospital discharge summary. -There was a second entry for Lantus Solostar 100units/ml, inject 22 units subcutaneously once daily at bedtime, scheduled for 8:00pm. -Lantus was not documented as administered at 8:00pm on 07/09/26 through 07/14/26, with no exception documented and the spaces for initials was blank. -The resident missed 6 doses of Lantus in July 2026.	D 358		

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D 358	Continued From page 171 Observation of Resident #2's medications on hand revealed four 3ml pens of Lantus Solostar for Resident #2 with a dispense date of 06/29/26, to inject 22 units subcutaneously once a day at bedtime. Telephone interview with a pharmacist with the facility's contracted pharmacy on 08/21/26 at 9:23am revealed: -The original order was received for Resident #2's Lantus on 05/20/25 to inject 22 units once daily at bedtime. -Lantus was last dispensed for Resident #2 for five 3ml pens on 06/29/26. Interview with Resident #2 on 08/20/26 at 2:24pm revealed she thought there was a period in July 2026 that she did not have any of her medications for a few days but was not certain. Interview with a MA on 08/26/26 at 11:00am revealed she thought Resident #2 had insulin when she returned from the SNF in July 2026. Interview with Resident #2's PCP on 08/21/26 at 11:21am revealed: -She was not aware that Resident #2 was without medications for several days in July 2026. -Resident #2's diabetes was pretty well controlled but being without the Lantus could cause spikes in her blood sugar. c. Review of Resident #2's hospital discharge summary dated 08/16/26 revealed: -The chief complaint for the visit was constipation and colitis. -She was treated with intravenous ceftriaxone (an antibiotic used to treat bacterial infections). -There was an order for oral cephalexin (an antibiotic to treat bacterial infections) 500mg	D 358		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 172 twice a day for four more days (7 days total, final dose 08/20/26 am) was ordered. Review of Resident #2's August 2026 eMAR revealed: -There was an entry for cephalexin 500mg, take one tablet twice daily for 4 days, on dialysis days take after dialysis, scheduled at 8:00am and 8:00pm with a start date of 08/18/26 and a stop date of 08/22/26. -Cephalexin 500mg was documented as not administered at 8:00am on 08/18/26 and on 08/20/26 with the exception documented as out of facility. -The resident missed 2 doses of cephalexin in August 2026. Observation of Resident #2's medications on hand on 08/20/26 at 3:22pm revealed: -There was a bubble card with a pharmacy label for Resident #2 for cephalexin 500mg, take one capsule twice daily for four days, on dialysis days, take after dialysis. -Eight capsules of cephalexin 500mg were dispensed for Resident #2 on 08/17/26 and there were five cephalexin capsules remaining in the bubble card. Telephone interview with a pharmacist with the facility's contracted pharmacy on 08/21/26 at 9:34am revealed: -An order was received for Resident #2 for cephalexin 500mg take one tablet twice daily for 4 days on 08/15/26. -Eight capsules of cephalexin 500mg were sent to the facility for Resident #2 on 08/17/26, take one tablet twice daily and on dialysis days, take after dialysis for a 4-day supply. Interview with a MA on 08/20/26 at 3:10pm	D 358		

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D 358	Continued From page 173 revealed: -Resident #2 went to dialysis on Tuesday, Thursday, and Saturday. -Resident #2 had some medications scheduled at 6:00am on her dialysis days. -Resident #2 did not receive her morning dose of cephalexin 500mg on her dialysis days because the 8:00am scheduled medications would pop up on the her eMAR after she had left for dialysis. Interview with the former RCC on 08/20/26 at 10:42am revealed Resident #2 was supposed to receive her cephalexin 500mg before she left for dialysis. Interview with the Administrator on 08/20/26 at 2:53pm revealed: -She was not aware that Resident #2 did not receive her 8:00am cephalexin on her dialysis days, -Staff should have contacted Resident #2's PCP about her 8:00am scheduled cephalexin on her dialysis days. Interview with Resident #2's PCP on 08/21/26 at 11:21am revealed: -Cephalexin had been prescribed for Resident #2 after a recent hospitalization for colitis. -Not receiving the full course of cephalexin could cause Resident #2's infection to not be fully treated and could results in the infection returning with worsening symptoms. -Also not completing the course of cephalexin as ordered could result in antibiotic resistance and cause the infection to be harder to treat. -She was not aware until today 08/21/26 that Resident #2 was not receiving her morning dose of cephalexin on her dialysis days. -She expected Resident #2's medications to be administered as ordered.	D 358		

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D 358	Continued From page 174 d. Review of Resident #2's hospital discharge summary dated 08/16/26 revealed: -The chief complaint for the visit was constipation and colitis. -She was treated with oral metronidazole (an antibiotic used to treat bacterial infections) with plan to complete a seven-day course. -Metronidazole 500mg twice a day for four more days (7 days total, final dose 08/20/26 am) was ordered. Review of Resident #2's August 2026 eMAR revealed: -There was an entry for metronidazole 500mg, take one tablet twice daily with meals and a full glass of water for 4 days, on dialysis days take after dialysis, scheduled at 8:00am and 8:00pm with a start date of 08/18/26 and a stop date of 08/22/26. -Metronidazole 500mg was documented as not administered at 8:00am on 08/18/26 and on 08/20/26 with the exception documented as out of facility. -The resident missed 2 doses of metronidazole in August 2026. Observation of Resident #2's medications on hand on 08/20/26 at 3:22pm revealed: -There was a bubble card with a pharmacy label for Resident #2 for metronidazole 500mg, take one capsule twice daily with meals and a full glass of water for four days, on dialysis days, take after dialysis. -Eight capsules of metronidazole 500mg were dispensed for Resident #2 on 08/17/26 and there were five metronidazole capsules remaining in the bubble card. Telephone interview with a pharmacist with the	D 358		

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D 358	Continued From page 175 facility's contracted pharmacy on 08/21/26 at 9:34am revealed: -An order was received for Resident #2 for metronidazole 500mg take one tablet twice daily with meals and a full glass of water for 4 days was received on 08/15/26. -Eight capsules of metronidazole 500mg was sent to the facility for Resident #2 on 08/17/26, take one tablet twice daily, on dialysis days, take after dialysis for a 4-day supply. Interview with a MA on 08/20/26 at 3:10pm revealed Resident #2 did not receive her morning dose of metronidazole 500mg on her dialysis days because the 8:00am scheduled medications would pop up on the her eMAR after she had left for dialysis. Interview with the former RCC on 08/20/26 at 10:42am revealed: -Resident #2 was supposed to receive her metronidazole 500mg before she left for dialysis. -She was not aware that Resident #2's morning dose of metronidazole 500mg was scheduled at 8:00am on her dialysis days. Interview with the Administrator on 08/20/26 at 2:53pm revealed: -She was not aware that Resident #2 did not receive her 8:00am metronidazole on her dialysis days, -Staff should have contacted Resident #2's PCP about her 8:00am scheduled metronidazole on her dialysis days. Interview with Resident #2's PCP on 08/21/26 at 11:21am revealed: -Metronidazole had been prescribed for Resident #2 after a recent hospitalization for colitis. -Not receiving the full course of metronidazole	D 358		

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could cause Resident #2's infection to not be fully treated and could result in the infection returning with worsening symptoms.
-Also not completing the course of metronidazole as ordered could result in antibiotic resistance and cause the infection to be harder to treat.
-She was not aware until today 08/21/26 that Resident #2 was not receiving her morning dose of metronidazole on her dialysis days.
-She expected Resident #2's medications to be administered as ordered.

e. Review of Resident #2's signed physician's order sheet dated 05/19/26 revealed an order for dorzolamide-timolol (a prescription eye drop used to lower high fluid pressure inside the eye caused by conditions like glaucoma or ocular hypertension), instill one drop into right eye twice daily.

Review of Resident #2's signed physician's order sheet dated 07/31/26 revealed an order for dorzolamide-timolol, instill one drop into right eye twice daily.

Review of Resident #2's hospital discharge summary dated 07/24/26 revealed:
-Chief complaint/Reason for admission was dyspnea (shortness of breath).
-Additional history gathered was that she had not been receiving home medications for the past 2 weeks due to medication mix-up that occurred after her last discharge between a SNF and her ALF.
-With resumption of her medications as well as diuresis her symptoms improved requiring no further interventions.
-History of vitrectomy (an eye surgery to remove the gel-like fluid from the center of the eye) was managed by continuing home medications.

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D 358	Continued From page 177 -She was stable for discharge on 07/24/26. Review of Resident #2's telephone triage note dated 08/20/26 revealed: -There was a note that since surveyors were in the facility, the facility staff requested to change the administration time for dorzolamide-timolol drops for Tuesday, Thursday, and Saturday at 6:00am and on Monday, Wednesday, Friday at 8:00am. -A response was received to the times as requested, please place in book for PCP to follow-up, notify triage of any acute changes. Review of Resident #2's June 2026 eMAR revealed: -There was an entry for dorzolamide-timolol drops, instill one drop into right eye twice daily, scheduled at 8:00am and 8:00pm. -There was a note that Resident #2 was out of the facility on 06/29/26 through 07/02/26. -Dorzolamide-timolol was documented as not administered at 8:00am on 06/02/26, 06/06/26, 06/09/26, 06/11/26, 06/12/26, 06/13/26, 06/16/26, 06/18/26, and on 06/23/26 with the exception documented as out of facility on each occasion. -Thre resident missed 9 doses of dorzolamide-timolol drops in June 2026. Review of Resident #2's July 2026 eMAR revealed: -There was an entry for dorzolamide-timolol drops, instill one drop into right eye twice daily, scheduled at 8:00am and 8:00pm. -There was a note that Resident #2 was out of the facility on 06/29/26 through 07/02/26. -Dorzolamide-timolol drops were not documented as administered at 8:00am on 07/03/26 and on 07/10/26 though 07/13/26, there was no exception documented and the spaces for initials	D 358		

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were blank.
-Dorzolamide-timolol drops were documented as not administered at 8:00am on 07/21/26, 07/25/26, and on 07/28/26 with the exception documented as out of facility on each occasion.
-Dorzolamide-timolol drops were not documented as administered at 8:00pm on 07/02/26 and on 07/09/26 through 07/13/26, with no exception documented and the spaces for initials were blank.
-The resident missed 15 doses of dorzolamide-timolol drops in July 2026.

Review of Resident #2's August 2026 eMAR revealed:
-There was an entry for dorzolamide-timolol drops, instill one drop into right eye twice daily, scheduled at 8:00am and 8:00pm.
-There was a note that the resident was out of the facility on 08/14/26 through 08/17/26.
-Dorzolamide-timolol was documented as not administered at 8:00am on 08/01/26, 08/04/26, 08/06/26, 08/08/26, 08/11/26, 08/13/26, 08/18/26, and on 08/20/26 with the exception documented as out of the facility on each occasion.
-The resident missed 8 doses of dorzolamide-timolol drops in August 2026.

Observation of Resident #2's medications on hand on 08/20/26 at 3:31pm revealed there were three 10 ml bottles of dorzolamide-timolol drops with a pharmacy label containing Resident #2's name with instructions to instill one drop in right eye twice daily with dispense dates of 04/08/26, 06/10/26, and 07/29/26.

Telephone interview with a pharmacist with the facility's contracted pharmacy provider on 08/21/26 at 9:34am revealed:
-An order was received for Resident #2's

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dorzolamide-timolol drops on 01/22/26 to instill one drop in right eye twice daily.
-One 10ml bottle of dorzolamide-timolol drops were dispensed for Resident #2 on 02/13/26, 04/08/26, 06/10/26, and on 07/29/26, to instill one drop in the right eye twice daily.

Interview with Resident #2 on 08/20/26 at 2:24pm revealed:
-She had dialysis on Tuesdays, Thursdays, and Saturdays.
-She usually left for dialysis between 6:00am and 6:30am.
-She did not receive her morning eye drops on dialysis days.
-She thought there was a period in July 2026 that she did not have any of her medications for a few days but was not certain.

Interview with a MA on 08/20/26 at 3:10pm revealed:
-Resident #2 went to dialysis on Tuesday, Thursday, and Saturday.
-Resident #2 had some medications scheduled at 6:00am on her dialysis days.
-Resident #2 also had some medications scheduled at 8:00am which included her dorzolamide-timolol drops.
-Resident #2 did not receive her morning dose of dorzolamide-timolol drops on her dialysis days because the 8:00am scheduled medications would pop up on the her eMAR after she had left for dialysis.
-She was not sure if Resident #2's PCP was aware that Resident #2 had medications scheduled at 8:00am on her dialysis days.

Second interview with a MA on 08/26/26 at 11:00am revealed:
-She noticed Resident #2 was without her oral

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medications when she returned to the facility from the SNF in July 2026 and she notified the RCC.
-She thought Resident #2 had some of her medications but not her oral medications and eye drops.

Interview with the former RCC on 08/20/26 at 10:42am revealed:
-Resident #2 had dialysis on Tuesday, Thursday, and Saturdays.
-She thought Resident #2 left for dialysis at 7:00am.
-Resident #2 was supposed to receive her dorzolamide-timolol drops before she left for dialysis.
-She knew Resident #2's morning medications had been adjusted to be administered at 6:00am on her dialysis days.
-She was not aware that Resident #2's dorzolamide-timolol morning dose was scheduled at 8:00am on her dialysis days.
-She thought Resident #2's PCP was under the impression all her 8:00am medications had been adjusted to 6:00am on dialysis days.
-Back in May 2026, Resident #2 had weakness and her PCP signed a new FL2 for Resident #2 to go to a SNF.

Interview with Resident #2's PCP on 08/21/26 at 11:21am revealed:
-She was not aware that Resident #2 was without medications for several days in July 2026.
-Resident #2's ophthalmologist originally prescribed her dorzolamide-timolol drops for increased intraocular pressure.
-Being without the dorzolamide-timolol drops placed Resident #2 at risk for increased pressure in the eyes which could lead to vision loss.
-She was not aware until today 08/21/26 that Resident #2 was not receiving her morning

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dorzolamide-timolol on her dialysis days.
-She expected Resident #2's medications to be administered as ordered.

Telephone interview with a technician with Resident #2's ophthalmology office on 08/24/26 at 10:40am revealed:
-Resident #2 had a history of tractional retinal detachment in the right eye from proliferative diabetic retinopathy.
-Dorzolamide-timolol was prescribed twice daily to the right eye to treat increased intra-ocular pressure.
-There was no documentation of contact from the facility regarding the scheduling of Resident #2's dorzolamide-timolol eye drops on her dialysis days.

Attempted telephone interview with Resident #2's ophthalmologist on 08/20/26 at 1:48pm and on 08/24/26 at 10:40am were unsuccessful.

f. Review of Resident #2's signed physician order dated 05/29/26 revealed an order for prednisolone (a steroid medication used to treat mild to moderate non-infectious eye allergies and inflammation of the eye caused by certain conditions) AC 1% eye drop, instill one drop into the right eye every 3 hours.

Review of Resident #2's signed physician order dated 07/31/26 revealed an order for prednisolone AC 1% eye drop, instill one drop into the right eye every 3 hours.

Review of Resident #2's telephone triage note dated 08/20/26 revealed:
-There was a note that since surveyors were in the facility, the facility staff requested to change the administration time for prednisolone drops for

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D 358	Continued From page 182 Tuesday, Thursday, and Saturday at 6:00am and on Monday, Wednesday, Friday at 8:00am. -A response was received to the times as requested, please place in book for PCP to follow-up, notify triage of any acute changes. Review of Resident #2's June 2026 eMAR revealed: -There was an entry for prednisolone AC 1% eye drop, instill one drop in right eye every 3 hours, scheduled at 12:00am, 3:00am, 6:00am, 9:00am, 12:00pm, 3:00pm, 6:00pm, and 9:00pm. -There was a note, the resident was out of the facility from 06/29/26 to 07/02/26. -Prednisolone 1% was documented as not administered at 9:00am on 06/02/26, 06/06/26, 06/09/26, 06/11/26, 06/13/26, 06/16/26, and on 06/18/26, with the exception documented as out of facility for each occasion. -Prednisolone 1% was documented as not administered at 12:00pm on 06/02/26, 06/09/26, 06/11/26, 06/13/26, 06/16/26, and on 0/23/26 with the exception documented as out of facility. -Prednisolone 1% was not documented as administered at 3:00pm, 6:00pm, and 9:00pm on 06/13/26, with no exception documented and the space for initials was blank. -Prednisolone 1% was documented as not administered at 3:00am and 3:00pm on 06/17/26 with the exception documented as resident refused on each occasion. -Prednisolone 1% was not documented as administered at 3:00am, 6:00am on 06/21/26, and at 9:00am on 06/22/26, with no exception documented and the space for initials was blank. -Prednisolone 1% was documented as not administered at 3:00pm, 6:00pm, and 9:00pm on 06/24/26 with the exception documented as out of the facility on each occasion. -The resident missed 24 dose of prednisolone	D 358		

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D 358	Continued From page 183 eye drops in June 2026. Review of Resident #2's July 2026 eMAR revealed: -There was an entry for prednisolone AC 1% eye drop, instill one drop in right eye every 3 hours, scheduled at 12:00am, 3:00am, 6:00am, 9:00am, 12:00pm, 3:00pm, 6:00pm, and 9:00pm. -There was a note, the resident was out of the facility from 06/29/26 to 07/02/26. -Prednisolone 1% was not documented as administered at 12:00am on 07/03/26, 07/10/26 through 07/15/26, and on 07/19/26, with no exception documented and the spaces for initials was blank. -Prednisolone 1% was not documented as administered at 3:00am on 07/03/26, 07/05/26, 07/10/26 through 07/15/26, and on 07/19/26, with no exception documented and the spaces for initials was blank. -Prednisolone 1% was not documented as administered at 6:00am on 07/03/26, 07/10/26 through 07/15/26, and on 07/19/26, with no exception documented and the spaces for initials was blank. -Prednisolone 1% was not documented as administered at 9:00am on 07/03/26, 07/10/26 through 07/15/26, 07/19/26 and on 07/20/26, with no exception documented and the spaces for initials was blank. -Prednisolone 1% was documented as not administered at 9:00am on 07/25/26 , and on 07/28/26 with the exception documented as out of facility. -Prednisolone 1% was documented as not administered at 12:00pm on 07/07/26, 07/25/26, and on 07/28/26 with the exception documented as out of the facility. -Prednisolone 1% was not documented as administered at 12:00pm on 07/10/26 through	D 358		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 184 07/14/26, 07/18/26, 07/26/26, and on 07/27/26 with no exception documented and the space for initials was blank. -Prednisolone 1% was not documented as administered at 3:00pm on 07/09/06 through 07/14/26, 07/16/26, and on 07/25/26 with no exception documented and the space for initials was blank. -Prednisolone 1% was not documented as administered at 6:00pm on 07/02/06, 07/09/26 through 07/14/26, 07/16/26, and on 07/25/26 with no exception documented and the space for initials was blank. -Prednisolone 1% was not documented as administered at 9:00pm on 07/02/06, and on 07/09/26 through 07/14/26, with no exception documented and the space for initials was blank. -The resident missed 67 doses of presdnisolone drops in July 2026. Review of Resident #2's August 2026 eMAR revealed: -There was an entry for prednisolone AC 1% eye drop, instill one drop in right eye every 3 hours, scheduled at 12:00am, 3:00am, 6:00am, 9:00am, 12:00pm, 3:00pm, 6:00pm, and 9:00pm. -There was a note, the resident was out of the facility from 08/14/26 to 08/17/26. 16 dose-Prednisolone 1% was documented as not administered at not administered at 9:00am on 08/01/26, 08/04/26, 08/08/26, 08/18/26 and 08/20/26 with the exception documented as out of facility. -Prednisolone 1% was documented as not administered at not administered at 12:00pm on 08/01/26, and on 08/04/26, with the exception documented as out of facility. -Prednisolone 1% was not documented as administered at 12:00pm on 08/08/26, with no exception documented and the space for initials	D 358		

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	HAL074046	A. BUILDING: _____ B. WING _____	08/27/2026

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

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D 358	Continued From page 185	D 358		

was blank.
-Prednisolone 1% was not documented as administered at 3:00pm on 08/07/26 and on 08/10/26, with no exception documented and the space for initials was blank.
-Prednisolone 1% was not documented as administered at 6:00pm on 08/09/26 through 08/11/26, with no exception documented and the space for initials was blank.
-Prednisolone 1% was not documented as administered at 9:00pm on 08/11/26, with no exception documented and the space for initials was blank.
-The resident missed 16 doses of prednisolone drops in August 2026.

Observation of Resident #2's medications on hand on 08/20/26 at 3:28pm revealed there were two 10 ml bottles of prednisolone 1% drops, one opened with a handwritten opened date of 05/11/26 and one sealed unopened, with instructions to instill one drop in right eye every 3 hours with dispense dates of 04/03/26 and 07/31/26.

Telephone interview with a pharmacist with the facility's contracted pharmacy on 08/21/26 at 9:34am revealed:
-An order was received for Resident #2's prednisolone 1% drops on 02/18/26 to instill one drop in right eye every 3 hours.
-One 10ml bottle of prednisolone 1% drops were dispensed for Resident #2 on 06/10/26, 06/28/26, 07/31/26 and on 08/21/26, to instill one drop in the right eye every three hours.

Interview with Resident #2 on 08/20/26 at 2:24pm revealed:
-She had dialysis on Tuesdays, Thursdays, and Saturdays.

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D 358	Continued From page 186 -She usually left for dialysis between 6:00am and 6:30am. -She did not receive her morning eye drops on dialysis days. -She thought there was a period in July 2026 that she did not have any of her medications for a few days but was not certain. Interview with a MA on 08/20/26 at 3:10pm revealed: -Resident #2 went to dialysis on Tuesday, Thursday, and Saturday. -Resident #2 had some medications scheduled at 6:00am on her dialysis days. -Resident #2 also had some medications scheduled at 8:00am which included her prednisolone drops. -Resident #2 did not receive her morning dose of prednisolone 1% drops on her dialysis days because the 9:00am scheduled medications would pop up on the her eMAR after she had left for dialysis. -She was not sure if Resident #2's PCP was aware that Resident #2 had medications scheduled at 9:00am on her dialysis days. Interview with the former RCC on 08/20/26 at 10:42am revealed: -Resident #2 had dialysis on Tuesday, Thursday, and Saturdays. -She thought Resident #2 left for dialysis at 7:00am. -Resident #2 was supposed to receive her prednisolone 1% drops before she left for dialysis. -She knew Resident #2's morning medications had been adjusted to be administered at 6:00am on her dialysis days. -She was not aware that Resident #2's prednisolone 1% morning dose was scheduled at	D 358		

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D 358	Continued From page 187 9:00am on her dialysis days. -She thought Resident #2's PCP was under the impression all her 9:00am medications had been adjusted to 6:00am on dialysis days. Interview with Resident #2's PCP on 08/21/26 at 11:21am revealed: -She was not aware that Resident #2 was without medications for several days in July 2026. -Resident #2's ophthalmologist originally prescribed her prednisolone 1% drops after an eye procedure. -Being without the prednisolone 1% drops placed Resident #2 at risk for inflammation in the eyes which could lead to vision loss. -She was not aware until today 08/21/26 that Resident #2 was not receiving her morning prednisolone 1% on her dialysis days. -She expected Resident #2's medications to be administered as ordered. Telephone interview with a technician with Resident #2's ophthalmology office on 08/24/26 at 10:40am revealed: -Resident #2 had a surgical procedure on her right eye 01/24/26. -Prednisolone 1% was prescribed every 3 hours to the right eye to treat inflammation. -There was no documentation of contact from the facility regarding the scheduling of Resident #2's prednisolone 1% eye drops on her dialysis days. Attempted telephone interview with Resident #2's ophthalmologist on 08/20/26 at 1:48pm and on 08/24/26 at 10:40am were unsuccessful. g. Review of Resident #2's signed physicians order dated 05/29/26 revealed an order for vitamin D3 (a supplement to support bone health) 1000 unit, take one capsule once daily.	D 358		

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D 358	Continued From page 188 Review of Resident #2's signed physicians order dated 07/31/26 revealed an order for vitamin D3 1000 unit, take one capsule once daily. Review of Resident #2's telephone triage note dated 08/20/26 revealed: -There was a note that since surveyors were in the facility, the facility staff requested to change the administration time for Vitamin D3 for Tuesday, Thursday, and Saturday at 6:00am and on Monday, Wednesday, Friday at 8:00am. -A response was received to the times as requested, please place in book for PCP to follow-up, notify triage of any acute changes. Review of Resident #2's June 2026 eMAR revealed; -There was an entry for vitamin D3 1000 unit, take one capsule once daily, scheduled at 8:00am. -There was a note that the resident was out of the facility 06/29/26 to 07/02/26. -Vitamin D3 was documented as not administered at 8:00am on 06/02/26, 06/06/26, 06/09/26, 06/11/26, 06/12/26, 06/13/26, 06/16/26, and on 06/18/26 with the exception documented as out of the facility. -The resident missed 8 doses of Vitamin D3 in June 2026. Review of Resident #2's July 2026 eMAR revealed; -There was an entry for vitamin D3 1000 unit, take one capsule once daily, scheduled at 8:00am. -There was a note that the resident was out of the facility 06/29/26 to 07/02/26. -Vitamin D3 was not documented as administered at 8:00am on 07/03/26, and	D 358		

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D 358	Continued From page 189 07/10/26 through 07/15/26, 07/19/26, and on 07/20/26, with no exception documented and the space for initials was blank. -The resident missed 9 doses of Vitamin D3 in July 2026. Review of Resident #2's August 2026 eMAR revealed; -There was an entry for vitamin D3 1000 unit, take one capsule once daily, scheduled at 8:00am. -There was a note that the resident was out of the facility 08/14/26 to 08/17/26. -Vitamin D3 was documented as not administered at 8:00am on 08/01/26, 08/04/26, 08/06/26, 08/08/26, 08/11/26, 08/18/26, and on 08/20/26 with the exception documented as out of facility. -Vitamin D3 was documented as not administered at 8:00am on 08/15/26 through 08/17, and on 08/18/26 and on 08/20/26 with the exception documented as out of facility on each occasion. -The resident missed 8 doses of Vitamin D3 in August 2026. Observation of Resident #2's medications on hand on 08/20/26 at 3:13pm revealed: -There was a multi-dose card of medications for Resident #2 with a printed date of 08/12/26 for a seven-day supply of medications. -There were 3 remaining tablets of vitamin D3 for Resident #2 , one tablet packaged individually, labeled morning and dated 08/20/26, one tablet packaged with nine other oral medications labeled morning and dated 08/21/26, and one tablet packaged individually labeled morning and dated 08/22/26. Telephone interview with a pharmacist with the	D 358		

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D 358	Continued From page 190 facility's contracted pharmacy on 08/21/26 at 9:34am revealed: -Resident #2's medications were dispensed weekly. -Vitamin D3 was dispensed for Resident #2 on 07/03/26 for 8 tablets to take one daily, on 07/22/26 for 3 tablets to take one daily, on 07/28/26, 07/31/26, 08/07/26, 08/14/26, and on 08/21/26 for 8 tablets each time to take one daily. Interview with Resident #2 on 08/20/26 at 2:24pm revealed: -She had dialysis on Tuesdays, Thursdays, and Saturdays. -She usually left for dialysis between 6:00am and 6:30am. -She received her oral medications at 6:00am on her dialysis days. -She thought there was a period in July 2026 that she did not have any of her medications for a few days but was not certain. Interview with a MA on 08/20/26 at 3:10pm revealed: -Resident #2 went to dialysis on Tuesday, Thursday, and Saturday. -Resident #2 had some medications scheduled at 6:00am on her dialysis days. -Resident #2 did not receive her morning dose of vitamin D3 on her dialysis days because the 8:00am scheduled medications would pop up on the her eMAR after she had left for dialysis. -She was not sure if Resident #2's PCP was aware that Resident #2 had medications scheduled at 8:00am on her dialysis days. Interview with the former RCC on 08/20/26 at 10:42am revealed: -Resident #2 had dialysis on Tuesday, Thursday, and Saturdays.	D 358		

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D 358	Continued From page 191 -She thought Resident #2 left for dialysis at 7:00am. -Resident #2 was supposed to receive her vitamin D3 before she left for dialysis. -She knew Resident #2's morning medications had been adjusted to be administered at 6:00am on her dialysis days. -She was not aware that Resident #2's vitamin D3 was scheduled at 8:00am on her dialysis days. -She thought Resident #2's PCP was under the impression all her 8:00am medications had been adjusted to 6:00am on dialysis days. Interview with Resident #2's PCP on 08/21/26 at 11:21am revealed: -She was not aware that Resident #2 was without medications for several days in July 2026. -She prescribed vitamin D3 for Resident #2 due to vitamin D defiency and she was not concerned about Resident #2 missing vitamin D3. -She was not aware until today 08/21/26 that Resident #2 was not receiving her vitamin D3 on her dialysis days. -She expected Resident #2's medications to be administered as ordered. h. Review of Resident #2's signed physicians order dated 05/29/26 revealed: -There was an order for amlodipine besylate (used to treat high blood pressure) 10mg, take one tablet once daily at 6:00am on Tuesday, Thursday, and Saturday. -There was an order for amlodipine besylate 10mg, take one tablet daily at 8:00am on Sunday, Monday, Wednesday, and Friday. Review of Resident #2's signed physicians order sheet dated 07/31/26 revealed: -There was an order for amlodipine besylate 10mg, take one tablet once daily at 6:00am on	D 358		

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D 358	Continued From page 192 Tuesday, Thursday, and Saturday. -There was an order for amlodipine besylate 10mg, take one tablet daily at 8:00am on Sunday, Monday, Wednesday, and Friday. Review of Resident #2's hospital discharge summary dated 07/24/26 revealed: -She presented from the ALF for shortness of breath. -She had not been receiving home medications for the past 2 weeks due to medication mix-up that occurred after her last discharge between a SNF and her ALF. -Her symptoms and fluid overload were believed to be from not having medications for blood pressure and heart failure or her home medications were restarted. -With resumption of her medications as well as diuresis her symptoms improved requiring no further interventions. -She was stable for discharge on 07/24/26. Review of Resident #2's July 2026 eMAR revealed: -There was an entry for amlodipine besylate10mg, take one tablet once daily scheduled at 6:00am. -There was a second entry for amlodipine besylate 10mg, take one tablet once daily scheduled at 8:00am. -There was a note that the resident was out of the facility 06/29/26 through 07/02/26. -Amlodipine besylate was not documented as administered at either 6:00am or 8:00am on 07/03/26, on 07/10/26 through 07/16/26, 07/19/26, and on 07/20/26 there was no exception documented and the space for initials was blank. -Amlodipine besylate was documented as not administered at 6:00am on 07/16/26 and on	D 358		

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D 358	Continued From page 193 07/21/26 with the exception documented as on order, waiting on delivery. -The resident missed 11 doses of amlodipine in July 2026. Observation of Resident #2's medications on hand on 08/20/26 at 3:13pm revealed; -There was a multi-dose card of medications for Resident #2 with a date of 08/12/26 for a seven-day supply of medications. -There were 2 remaining multidose packs for Resident #2, that contained one amlodipine besylate 10mg tablet packaged with nine other oral medications labeled morning and dated 08/21/26 and 08/22/26. Telephone interview with a pharmacist with the facility's contracted pharmacy on 08/21/26 at 9:34am revealed: -Resident #2's medications were dispensed weekly. -Amlodipine besylate 10mg was dispensed for Resident #2 on 07/03/26 for 8 tablets to take one daily, on 07/22/26 for 3 tablets to take one daily, on 07/28/26, 07/31/26, 08/07/26, 08/14/26, and on 08/21/26 for 8 tablets each time to take one daily. Interview with Resident #2 on 08/20/26 at 2:24pm revealed: -She had dialysis on Tuesdays, Thursdays, and Saturdays. -She usually left for dialysis between 6:00am and 6:30am. -She received her oral medications at 6:00am on her dialysis days and at 8:00am on the days she did not have dialysis. -She thought there was a period in July 2026 that she did not have any of her medications for a few days but was not certain.	D 358		

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D 358	Continued From page 194 Interview with a MA on 08/26/26 at 11:00am revealed she noticed Resident #2 was without her oral medications when she returned to the facility from the SNF in July 2026 and she notified the RCC. Interview with Resident #2's PCP on 08/21/26 at 11:21am revealed: -She was not aware that Resident #2 was without medications for several days in July 2026. -She prescribed amlodipine for Resident #2 for high blood pressure. -Being without amlodipine for an extended period could cause Resident #2's blood pressure to increase and put her at greater risk for stroke. -It was possible being without the amlodipine could have contributed to Resident #2's hospitalization on 07/21/26 to 07/24/26. i. Review of Resident #2's signed physicians order dated 05/29/26 revealed: -There was an order for aripiprazole (used to treat bi-polar disorder and major depression) 10mg, take one tablet once daily at 6:00am on Tuesday, Thursday, and Saturday. -There was an order for aripiprazole 10mg, take one tablet daily at 8:00am on Sunday, Monday, Wednesday, and Friday. Review of Resident #2's signed physicians order dated 07/31/26 revealed: -There was an order for aripiprazole 10mg, take one tablet once daily at 6:00am on Tuesday, Thursday, and Saturday. -There was an order for aripiprazole10mg, take one tablet daily at 8:00am on Sunday, Monday, Wednesday, and Friday. Review of Resident #2's July 2026 medication	D 358		

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D 358	Continued From page 195	D 358		

administration record (eMAR) revealed:
-There was an entry for aripiprazole10mg, take one tablet once daily scheduled at 6:00am.
-There was a second entry for aripiprazole 10mg, take one tablet once daily scheduled at 8:00am.
-There was a note that the resident was out of the facility 06/29/26 through 07/02/26.
-Aripiprazole was not documented as administered at either 6:00am or 8:00am on 07/03/26, 07/10/26 through 07/15/26, 07/19/26, and on 07/20/26, with there was no exception documented and the space for initials was blank.
-Aripiprazole was documented as not administered at 6:00am on 07/16/26 and on 07/21/26 with the exception documented as on order, waiting on delivery.
-Aripiprazole was not documented as administered at 8:00am or 6:00am on 07/19/26 and on 07/20/26, with no exception documented and the spaces for initials was blank.
-The resident missed 11 doses of aripiprazole in July 2026.

Observation of Resident #2's medications on hand on 08/20/26 at 3:13pm revealed;
-There was a multi-dose card of medications for Resident #2 with a date of 08/12/26 for a seven-day supply of medications.
-There were 2 remaining multidose packs for Resident #2, that contained one aripiprazole 10mg tablet packaged with nine other oral medications labeled morning and dated 08/21/26 and 08/22/26.

Telephone interview with a pharmacist with the facility's contracted pharmacy on 08/21/26 at 9:34am revealed:
-Resident #2's medications were dispensed weekly.
-Aripiprazole 10mg was dispensed for Resident

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D 358	Continued From page 196 #2 on 07/03/26 for 8 tablets to take one daily, on 07/22/26 for 3 tablets to take one daily, on 07/28/26, 07/31/26, 08/07/26, 08/14/26, and on 08/21/26 for 8 tablets each time to take one daily. Interview with Resident #2 on 08/20/26 at 2:24pm revealed: -She had dialysis on Tuesdays, Thursdays, and Saturdays. -She usually left for dialysis between 6:00am and 6:30am. -She received her oral medications at 6:00am on her dialysis days and at 8:00am on the days she did not have dialysis. -She thought there was a period in July 2026 that she did not have any of her medications for a few days but was not certain. Interview with Resident #2's PCP on 08/21/26 at 11:21am revealed: -She was not aware that Resident #2 was without medications for several days in July 2026. -Aripiprazole was prescribed for Resident #2 by behavioral health. -Being without aripiprazole for an extended period could cause Resident #2's to have behaviors and put her at greater risk withdrawal symptoms. j. Review of Resident #2's signed physicians order dated 05/29/26 revealed: -There was an order for aspirin (used for heart and to prevent blood clots) 81mg, take one tablet once daily at 6:00am on Tuesday, Thursday, and Saturday. -There was an order for aspirin 81mg, take one tablet daily at 8:00am on Sunday, Monday, Wednesday, and Friday. Review of Resident #2's signed physicians order dated 07/31/26 revealed:	D 358		

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D 358	Continued From page 197 -There was an order for aspirin 81mg, take one tablet once daily at 6:00am on Tuesday, Thursday, and Saturday. -There was an order for aspirin 81mg, take one tablet daily at 8:00am on Sunday, Monday, Wednesday, and Friday. Review of Resident #2's July 2026 eMAR revealed: -There was an entry for aspirin 81mg, take one tablet once daily scheduled at 6:00am. -There was a second entry for aspirin 81mg, take one tablet once daily scheduled at 8:00am. -There was a note that the resident was out of the facility 06/29/26 through 07/02/26. -Aspirin 81mg was not documented as administered at either 6:00am or 8:00am on 07/03/26, 07/10/26 through 07/15/26, 07/19/26, and on 07/20/26 , with no exception documented and the space for initials was blank. -Aspirin 81mg was documented as not administered at 6:00am on 07/16/26 and on 07/21/26, with the exception documented as on order, waiting on delivery. -The resident missed 11 doses of aspirin 81mg in July 2026. Observation of Resident #2's medications on hand on 08/20/26 at 3:13pm revealed; -There was a multi-dose card of medications for Resident #2 with a date of 08/12/26 for a seven-day supply of medications. -There were 2 remaining multidose packs for Resident #2, that contained one aspirin 81mg tablet packaged with nine other oral medications labeled morning and dated 08/21/26 and 08/22/26. Telephone interview with a pharmacist with the facility's contracted pharmacy on 08/21/26 at	D 358		

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D 358	Continued From page 198 9:34am revealed: -Resident #2's medications were dispensed weekly. -Aspirin 81mg was dispensed for Resident #2 on 07/03/26 for 8 tablets to take one daily, on 07/22/26 for 3 tablets to take one daily, on 07/28/26, 07/31/26, 08/07/26, 08/14/26, and on 08/21/26 for 8 tablets each time to take one daily. Interview with Resident #2 on 08/20/26 at 2:24pm revealed: -She had dialysis on Tuesdays, Thursdays, and Saturdays. -She usually left for dialysis between 6:00am and 6:30am. -She received her oral medications at 6:00am on her dialysis days and at 8:00am on the days she did not have dialysis. -She thought there was a period in July 2026 that she did not have any of her medications for a few days but was not certain. Interview with a MA on 08/26/26 at 11:00am revealed she noticed Resident #2 was without her oral medications when she returned to the facility from the SNF in July 2026 and she notified the RCC. Interview with Resident #2's PCP on 08/21/26 at 11:21am revealed: -She was not aware that Resident #2 was without medications for several days in July 2026. -Aspirin 81mg was prescribed for Resident #2 for coronary artery disease and heart failure. -She had no concerns for Resident #2 going without the aspirin 81mg for several days. k. Review of Resident #2's signed physicians order dated 05/29/26 revealed there was an order for atorvastatin (used to treat elevated	D 358		

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cholesterol) 40mg, take one tablet once daily at bedtime.

Review of Resident #2's July 2026 eMAR revealed:
-There was an entry for atorvastatin 40mg, take one tablet once daily at bedtime, scheduled at 8:00pm.
-There was a note that the resident was out of the facility 06/29/26 through 07/02/26.
-Atorvastatin was not documented as administered at 8:00pm on 07/02/26, and on 07/09/26 through 07/13/26, with no exception documented and the space for initials was blank.
-There was a second entry for atorvastatin 40mg, take once daily at bedtime, scheduled at 9:00pm.
-The resident missed 5 doses of atorvastatin.

Observation of Resident #2's medications on hand on 08/20/26 at 3:13pm revealed;
-There was a multi-dose card of medications for Resident #2 with a date of 08/12/26 for a seven-day supply of medications.
-There were 3 remaining individual packs for Resident #2, that contained one atorvastatin 40mg tablet each labeled bedtime and dated 08/20/26, 08/21/26 and 08/22/26.

Telephone interview with a pharmacist with the facility's contracted pharmacy on 08/21/26 at 9:34am revealed:
-Resident #2's medications were dispensed weekly.
-Atorvastatin 40mg was dispensed for Resident #2 on 07/03/26 for 8 tablets to take one daily, on 07/22/26 for 3 tablets to take one daily, on 07/28/26, 07/31/26, 08/07/26, 08/14/26, and on 08/21/26 for 8 tablets each time to take one daily.

Interview with Resident #2 on 08/20/26 at 2:24pm

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revealed she thought there was a period in July 2026 that she did not have any of her medications for a few days but was not certain.

Interview with a MA on 08/26/26 at 11:00am revealed she noticed Resident #2 was without her oral medications when she returned to the facility from the SNF in July 2026 and she notified the RCC.

Interview with Resident #2's PCP on 08/21/26 at 11:21am revealed:
-She was not aware that Resident #2 was without medications for several days in July 2026.
-Atorvastatin was prescribed for Resident #2 for elevated cholesterol.
-She had no concerns for Resident #2 going without the atorvastatin for several days.

I. Review of Resident #2's signed physicians order dated 05/29/26 revealed there was an order for bumetanide (a diuretic used to treat fluid buildup and swelling caused by heart failure or kidney disease) 2mg, take one tablet on Monday, Wednesday, and Friday only.

Review of Resident #2's signed physicians order dated 07/31/26 revealed there was an order for bumetanide 2mg, take one tablet on Monday, Wednesday, and Friday only.

Review of Resident #2's hospital discharge summary dated 07/24/26 revealed:
-The chief complaint/reason for admission was dyspnea.
-She presented from the ALF for shortness of breath.
-She had not been receiving home medications for the past 2 weeks due to medication mix-up that occurred after her last discharge between a

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SNF and her ALF.
-Her symptoms and fluid overload were believed to be from not having medications for blood pressure and heart failure or her home medications were restarted.
-With resumption of her medications as well as diuresis her symptoms improved requiring no further interventions.
-She was stable for discharge on 07/24/26.

Review of Resident #2's July 2026 eMAR revealed:
-There was an entry for bumetanide 2mg, take one tablet once daily on Monday, Wednesday, and Friday scheduled at 8:00am.
-There was a note that the resident was out of the facility 06/29/26 through 07/02/26.
-Bumetanide was not documented as administered at 8:00am on 07/03/26, 07/10/26. and on 07/13/26, with no exception documented and the spaces for initials were blank.
-The resident missed 3 doses of bumetanide in July 2026.

Observation of Resident #2's medications on hand on 08/20/26 at 3:13pm revealed;
-There was a multi-dose card of medications for Resident #2 with a date of 08/12/26 for a seven-day supply of medications.
-There were 3 remaining multi dose packs for Resident #2, one that contained one bumetanide 2mg tablet along with nine other oral medications, labeled morning and dated Friday 08/21/26.

Telephone interview with a pharmacist with the facility's contracted pharmacy on 08/21/26 at 9:34am revealed:
-Resident #2's medications were dispensed weekly.
-Bumetanide 2mg was dispensed for Resident #2

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D 358	Continued From page 202 on 07/03/26 for 3 tablets to take one daily on Monday, Wednesday, and Friday, on 07/22/26 for 1 tablet to take one daily on Monday, Wednesday, and Friday, on 07/28/26, 07/31/26, 08/07/26, 08/14/26, and on 08/21/26 for 3 tablets each time to take one daily on Monday, Wednesday, and Friday. Interview with Resident #2 on 08/20/26 at 2:24pm revealed she thought there was a period in July 2026 that she did not have any of her medications for a few days but was not certain. Interview with a MA on 08/26/26 at 11:00am revealed she noticed Resident #2 was without her oral medications when she returned to the facility from the SNF in July 2026 and she notified the RCC. Interview with Resident #2's PCP on 08/21/26 at 11:21am revealed: -She was not aware that Resident #2 was without medications for several days in July 2026. -Bumetanide was prescribed for Resident #2 for congestive heart failure. -Going without bumetanide could cause Resident #2 to have fluid buildup which could cause shortness of breath. m. Review of Resident #2's signed physicians order dated 05/29/26 revealed: -There was an order for bupropion (used to treat major depressive disorder) hcl xl 150mg, take one tablet once daily at 6:00am on Tuesday, Thursday, and Saturday. -There was an order for bupropion hcl xl 150mg, take one tablet daily at 8:00am on Sunday, Monday, Wednesday, and Friday. Review of Resident #2's signed physicians order	D 358		

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D 358	Continued From page 203 sheet dated 07/31/26 revealed: -There was an order for bupropion hcl xl 150mg, take one tablet once daily at 6:00am on Tuesday, Thursday, and Saturday. -There was an order for bupropion hcl xl 150mg, take one tablet daily at 8:00am on Sunday, Monday, Wednesday, and Friday. Review of Resident #2's July 2026 eMAR revealed: -There was an entry for bupropion hcl xl 150mg, take one tablet once daily scheduled at 6:00am. -There was a second entry for bupropion hcl xl 150mg, take one tablet once daily scheduled at 8:00am. -There was a note that the resident was out of the facility 06/29/26 through 07/02/26. -Bupropion was not documented as administered at either 6:00am or 8:00am on 07/03/26, on 07/10/06 through 07/14/26, and on 07/19/26, with no exception documented and the space for initials was blank. -Bupropion was documented as not administered at 6:00am on 07/16/26 and on 07/21/26, with the exception documented as on order, awaiting delivery. -The resident missed 9 doses of bupropion in July 2026. Observation of Resident #2's medications on hand on 08/20/26 at 3:13pm revealed; -There was a multi-dose card of medications for Resident #2 with a date of 08/12/26 for a seven-day supply of medications. -There were 2 remaining multidose packs for Resident #2, that contained one bupropion hcl xl 150mg tablet packaged with nine other oral medications labeled morning and dated 08/21/26 and 08/22/26.	D 358		

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D 358	Continued From page 204 Telephone interview with a pharmacist with the facility's contracted pharmacy on 08/21/26 at 9:34am revealed: -Resident #2's medications were dispensed weekly. -Bupropion hcl xl 150mg was dispensed for Resident #2 on 07/03/26 for 8 tablets to take one daily, on 07/22/26 for 3 tablets to take one daily, on 07/28/26, 07/31/26, 08/07/26, 08/14/26, and on 08/21/26 for 8 tablets each time to take one daily. Interview with Resident #2 on 08/20/26 at 2:24pm revealed she thought there was a period in July 2026 that she did not have any of her medications for a few days but was not certain. Interview with a MA on 08/26/26 at 11:00am revealed she noticed Resident #2 was without her oral medications when she returned to the facility from the SNF in July 2026 and she notified theRCC. Interview with Resident #2's PCP on 08/21/26 at 11:21am revealed: -She was not aware that Resident #2 was without medications for several days in July 2026. -Bupropion was prescribed for Resident #2 by behavioral health. -Being without bupropion for an extended period could cause Resident #2's to have behaviors and put her at greater risk withdrawal symptoms. Refer to Tag D9999 for continuation of Tag D0358.	D 358		
D 367	10A NCAC 13F .1004 (j) Medication Administration	D 367		

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D 367	Continued From page 205 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the accuracy of the electronic medication administration records (eMARs) for 1 of 6 residents (#37) related to a medication used to treat breathing disorders. The findings are: Review of the facility's undated Medication Administration policy revealed: -Medications, both prescription and non-prescription, would be administered in accordance with the prescribing practitioner's orders. -The medication administration record (MAR)	D 367		

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would include the following information, the resident's name, the name of the medication or treatment order, strength and dosage or quantity of medication administered, instructions for administering the medication or treatment, date and time of administration, documentation of any omission of medications or treatments and the reason for omission including refusals, name and initials of the person administering the medication, and omissions of medications and the reason for the omission would be documented on the MAR.

Review of Resident #37's current FL-2 dated 07/10/26 revealed diagnoses included hypertension, type 2 diabetes, coronary artery disease, acute kidney injury superimposed on chronic kidney disease, and hyperlipidemia.

Review of Resident #37's signed physician order dated 07/10/26 revealed an order for ipratropium-albuterol (a combination inhaled medication used to treat chronic obstructive pulmonary disease) 0.5-3 (2.5) mg/3ml, inhale one vial via handheld nebulizer every six hours.

Observation of the morning medication pass on 08/19/26 revealed:
-The medication aide (MA) prepared 7 oral medications for Resident #37 at 7:46am.
-The MA took the 7 oral medications to Resident#37's room and administered the medications with water at 7:46am.
-Ipratropium-albuterol was not administered to Resident #37 during the 8:00am medication pass.

Review of Resident #37's August 2026 eMAR revealed:
-There was an entry for ipratropium-albuterol 0.5(2.5)mg/3ml, inhale on vial via handheld

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nebulizer every 6 hours, scheduled at 1:30am, 7:30am, 1:30pm, and at 7:30pm.
-Ipratropium-albuterol 0.5 (2.5)mg/3ml was documented as administered at 7:30am on 08/19/26 by the first shift MA.

Observation of Resident #37's medications on hand on 08/19/26 at 10:28am revealed there was a ziptop type clear plastic bag with a pharmacy label for Resident #37 for ipratropium-albuterol 0.5(2.5mg/3ml), inhale one vial via handheld nebulizer every 6 hours, for 360ml with a dispense date of 06/03/26, that contained one unopened foil pouch of 30 3ml vials of ipratropium-albuterol, one opened foil pouch of ipratropium-albuterol with 25 3ml vials, and 3 loose 3ml vials of ipratropium-albuterol.

Interview with the MA on 08/19/26 at 9:20am revealed:
-Resident #37's ipratropium-albuterol scheduled at 7:30am was administered by the third shift MA.
-She saw that Resident #37's 7:30am ipratropium-albuterol was not clicked off on the eMAR as administered so she checked with the third shift MA before she left, and the third shift MA said she administered the ipratropium-albuterol scheduled at 7:30am to Resident #37 that morning but forgot to document on the eMAR.
-She documented the 7:30am dose of ipratropium-albuterol as administered to Resident #37 since she confirmed that the third shift MA administered the 7:30am nebulizer dose.
-She normally did not document a medication as administered if she did not actually administer the medication.

Interview with Resident #37 on 08/19/26 at 9:12am revealed:

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D 367	Continued From page 208 -She did not receive an ipratropium-albuterol nebulizer treatment that morning. -She usually received her ipratropium-albuterol nebulizer treatment once or twice a day. -She denied shortness of breath. Interview with the former Resident Care Coordinator (RCC) on 08/24/26 at 4:28pm revealed the MAs should never document a medication as administered if it was not administered or if the medication was administered by another MA. Interview with the Administrator on 08/19/26 at 12:30pm revealed: -The MAs should never document a medication was administered if they did not actually administer the medication. -The first shift MA should not have documented that she administered Resident #37's 7:30am ipratropium-albuterol.	D 367		
D 387	10A NCAC 13F .1007 (b) Medication Disposition 10A NCAC 13F .1007 Medication Disposition (b) Medications, excluding controlled medications that are expired, discontinued, prescribed for a deceased resident or deteriorated shall be stored separately from actively used medications until disposed of. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure discontinued medications were stored separately from actively used medications for 1 of 5 sampled residents	D 387		

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D 387	Continued From page 209 (#3). The findings are: Review of the facility's Medication Disposition Policy (policy undated) revealed: -Medications that were expired, discontinued, belonging to a deceased resident, or deteriorated, would be stored in a separate area from currently used medications until properly disposed. -Controlled substances would be stored in a locked area until returned to the pharmacy for disposal. Review of Resident #3's current FL-2 dated 03/13/26 revealed diagnoses included dysphagia, anemia, muscle atrophy, and type 2 diabetes. Review of Resident #3's Resident Register revealed the resident's admission date was 01/23/25. Review of Resident #3's physician orders dated 03/13/26 revealed: -There was an order for Lorazepam 0.5mg, ½ tablet twice daily as needed (used to treat anxiety). -There was an order for and Glutose-15 GEL 40%gm, 1 tube to be administered slowly and evenly as needed (used to treat low blood sugar). Review of Resident #3's Psychiatry progress note dated 07/13/26 revealed Lorazepam 0.5mg, ½ tablet twice daily as needed was discontinued. Review of Resident #3's hospital after-visit summary (AVS) dated 08/17/26 revealed: -The resident was admitted to the hospital on 08/15/26. -There were orders to discontinue taking Glutose-15 40% gel.	D 387		

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D 387	Continued From page 210 -She returned to the assisted living (AL) facility on 08/17/26. Observation of Resident #3's medications on hand on 08/20/26 at 11:00am revealed: -There was a supply of Lorazepam 0.5mg ½ tablet dispensed on 03/06/26 with instructions to take ½ tablet twice daily as needed. -There were 30 of 30 tablets remaining. -There was a second supply of Lorazepam 0.5mg ½ tablet dispensed on 03/06/26 with instructions to take ½ tablet twice daily as needed. -There were 25 of 30 tablets remaining. -There was a supply of Lorazepam 0.5mg ½ tablet dispensed on 08/07/26 with instructions to take ½ tablet twice daily as needed. -There were 30 of 30 tablets remaining. -There was one tube of Glutose-15 40% gel dispensed on 01/29/26 with instructions for one tube to be administered as needed for low blood sugar. Interview with Resident #3's mental health provider on 08/21/26 at 11:00am revealed: -She was not aware that Resident #3's Lorazepam ½ tablet was on the medication cart as of 08/20/26. -She discontinued the medication on 07/13/26 for non-use of medication. Interview with a medication aide (MA) on 08/20/26 at 11:30am revealed: -She was aware that Resident #3 Lorazepam was discontinued. -She was aware that Resident #3's Glutose-15 was discontinued. -She did not realize the medications were still on the medication cart. -During administration of medications, she would place the discontinued medication to the side.	D 387		

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D 387	Continued From page 211 -It was an oversight that the medication was not removed from the medication cart. Interview with the Resident Care Coordinator (RCC) on 08/20/26 at 2:00pm revealed: -She was not aware that Resident #3's Lorazepam and Glutose-15 remained on the medication cart. -She removed medications that had been discontinued from the medication cart after the PCP had discontinued the medication. -The MAs also knew to remove a medication from the medication cart if the medication had been discontinued. -Discontinued medications were removed from the cart and placed in a folder with discontinued forms to be returned to the pharmacy. -She was responsible for ensuring all discontinued medications were off the medication cart. Interview with the Administrator on 08/24/26 at 11:00am revealed: -Medication that had been discontinued should have been removed from the medication cart by the MA or the RCC and returned to the pharmacy. -The MA or RCC were responsible for completing the discontinued form to be returned to the pharmacy for pick-up. -The RCC was responsible for ensuring all discontinued medications were off the medication cart. Based on observations, interviews and record reviews, it was determined Resident #3 was not interviewable.	D 387		
D 392	10A NCAC 13F .1008 (a) Controlled Substances	D 392		

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D 392	Continued From page 212 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure readily retrievable records that accurately reconciled the receipt and administration of controlled substances for 1 of 6 sampled residents (#26) with an order for a controlled substance used to treat moderate to severe pain. The findings are: Review of Resident #26's current FL2 dated 04/24/26 revealed: -Diagnoses included malignant neoplasm of the lung, chronic obstructive pulmonary disease (COPD), protein calorie malnutrition, dysphagia, iron defiency anemia, major depressive disorder, and emphysema. -The recommended level of care was assisted living. -Resident #26 was constantly disoriented. Review of Resident #26's signed physicians order dated 07/28/26 revealed an order for morphine sulfate (a long-acting opioid medication used to treat severe pain) extended release (ER) 30mg, take on tablet three times a day for pain. Review of Resident #26's July 2026 electronic medication administration record (eMAR) revealed:	D 392		

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D 392	Continued From page 213 -There was an entry for morphine sulfate ER 30mg, take one tablet three times daily, scheduled at 8:00am, 2:00pm, and 8:00pm. -Morphine sulfate ER 30mg was documented as administered at 8:00am, 2:00pm, and 8:00pm on 07/01/26 through 07/27/26. -Morphine sulfate ER 30mg was documented as administered at 8:00am, 2:00pm, and 8:00pm on 07/28/26 through 07/31/26 for a total of 12 doses. Review of Resident #26's August 2026 eMAR from 08/01/26 through 08/14/26 revealed: -There was an entry for morphine sulfate ER 30mg, take one tablet three times daily, scheduled at 8:00am, 2:00pm, and 8:00pm. -Morphine sulfate ER 30mg was documented as administered at 8:00am, 2:00pm, and 8:00pm on 08/01/26 through 08/14/26. -42 doses of morphine sulfate ER 30mg were documented as administered from 08/01/26 through 08/14/26. Telephone interview with a pharmacist with the facility's contracted pharmacy on 08/26/26 at 2:05pm revealed: -An order was received for Resident #26 for morphine sulfate ER 30mg, take one tablet three times a day on 05/17/26. -Morphine sulfate ER 30mg was dispensed for Resident #26 on 06/17/26, 07/02/26, 07/16/26, and 07/28/26 for 45 tablets on each occasion to take three times a day for a 15-day supply. Review of Resident #26's Controlled Substance Log (CSL) for morphine sulfate ER 30mg revealed: -There was no CSL provided for 07/28/26 through 08/03/26. -The CSL was dated 07/28/26 and the medication check-in was 30 tablets in the Quantity column.	D 392		

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D 392	Continued From page 214 -The first entry for morphine sulfate ER 30mg was documented as signed out on 08/04/26 at 7:31am leaving a balance of 29 tablets. -The next entry for morphine sulfate ER 30mg was documented as signed out on 08/07/26 at 1:47pm leaving a balance of 28 tablets. -There were no doses of morphine sulfate documented as signed out between 08/04/26 at 7:31am and 08/07/26 at 1:47pm. -Morphine sulfate ER 30mg was documented as signed out on 08/07/26 at 8:57pm leaving a balance of 27 tablets. -Morphine sulfate ER 30mg was documented as signed three times daily from 08/08/26 through 08/14/26 with a final remaining balance of 6 tablets. Interview with a medication aide (MA) on 08/24/26 at 10:25am revealed Resident #26 had been discharged from the facility on 08/14/26 and his medications including the morphine sulfate ER 30mg had been removed from the medication cart and taken to the resident on 08/21/26. Review of a Medications Released Form for Resident #26 revealed 6 tablets of morphine sulfate 30mg, take one three times a day, were released to the resident on 08/21/26. Second interview with a MA on 08/26/26 at 3:11pm revealed: -Controlled substances were always to be signed out on the CSL. -She had not noticed the date discrepancy on Resident #26's morphine sulfate ER 30mg CSL from 08/04/26 to 08/07/26. -Resident #26 always made sure he received his medications on time. -It was possible the first entry of 08/04/26 was incorrect and should have been documented as	D 392		

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D 392	Continued From page 215 08/07/26 at 7:31am instead of 08/04/26 at 7:31am. -Controlled substances were always counted at the beginning of each shift between the oncoming and off going MA. -There had been no discrepancy with Resident #26's morphine sulfate ER 30mg and he always received his medication as ordered. -There should be a CSL prior to the 08/04/26 CSL but it could not be located. Interview with a second MA on 08/26/26 at 11:08am revealed: -Controlled substances were always to be signed out on the CSL when administered. -Controlled substances were always counted at the beginning of each shift between the MAs. -If the controlled substance count was off, the Resident Care Coordinator (RCC) was notified and the oncoming MA should not accept the medication cart keys until the discrepancy was resolved. -There had never been an issue with any resident's controlled substances that she was aware of. Interview with a third MA on 08/27/26 at 4:27pm revealed: -She was very familiar with Resident #26. -Resident #26 always made sure he received his pain medication. -When she administered medications to Resident #26, she always placed his controlled medications in a separate medication cup so he could be certain he received his pain medications. -Controlled substances were always counted at each shift change between the MAs. -There had never been a discrepancy with the controlled substance count that she was aware	D 392		

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D 392	Continued From page 216 of. Interview with the RCC in training on 08/27/26 at 8:59am revealed: -She was new to the role of RCC at the facility. -MAs were to always document controlled substances on the eMAR when administered and sign them out on the CSL. -The CSL and controlled medication available should always match. -The MAs counted the controlled substances at every shift change and if the count was off, they were to report it to the RCC. Interview with the Administrator on 08/27/26 at 3:52pm revealed: -Controlled medications were counted each shift. -If the controlled substance count was off, the MAs were to report it to RCC and to her. -There had never been discrepancy with controlled substances reported to her. -The CSLs were kept in the facility. -She thought the date of 08/04/26 was entered incorrectly and 08/07/26 should have been entered instead on Resident #26's morphine sulfate ER 30mg CSL. -She and the Executive Director were unable to locate the prior CSL for Resident #26's morphine sulfate ER 30mg but knew it was in the facility somewhere.	D 392		
D 418	10A NCAC 13F .1103 (c) Authorized Representative 10A NCAC 13F .1103 Authorized Representative (c) The administrator shall give the resident's authorized representative or payee receipts for any monies received on behalf of the resident.	D 418		

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D 418	Continued From page 217	D 418		

This Rule is not met as evidenced by:
Based on interviews and record reviews the facility failed to ensure 2 of 5 sampled residents (#2, #38) were provided with receipts for monies received from the residents.

The findings are:

1. Review of Resident #2's current FL-2 dated 07/31/26 revealed diagnoses included end stage renal disease, reduced mobility, and chronic obstructive pulmonary disease.

Review of Resident #2's resident contract dated 07/10/26 revealed that beginning 07/10/26 the resident would be charged $1,432.00 per month for room and board.

Review of an invoice from the facility dated 06/22/26 revealed:
-Resident #2's past room and board was $12,243.06.
-The late fees for the resident were $35.00.
-Room and board for July 2026 was $1,004.00.
-The resident's total outstanding balance was $13,282.06.

Review of a typed statement signed by Resident #2 and the Administrator revealed:
-The resident paid $800.00 a month to reside at the assisted living facility, and social services paid

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the remainder of her balance.
-On the 1st and on the 3rd of the month she received a check.
-On the 1st she paid $200.00 cash to the previous Administrator.
-When she paid the previous Administrator, she observed the previous Administrator place the $200.00 cash into a lock box until she paid the rest of the $600.00 cash when she was paid on the 3rd.
-The document was signed by the resident, a witness and the current Administrator on 07/13/26.

Interview with Resident #2 on 08/27/26 at 1:46pm revealed:
-The previous Administrator had possession of her debit card.
-A staff member would take her to the bank each month.
-She used her debit card to withdraw $600.00 to $800.00 a month in cash.
-She gave the cash to the previous Administrator for her room and board.
-She had paid the previous Administrator $600.00 to $800.00 per month since she had resided at the facility.

Interview with the Business Office Manager (BOM) on 08/25/26 at 2:29pm revealed:
-The previous Administrator would not provide her with information related to Resident #2's accounts payable and accounts receivable.
-She and the current Administrator went to the local Social Security office on 07/09/26 to ask about Resident #2's social security account.
-The representative from social security informed she and the Administrator that Resident #2's Social Security funding went directly to Resident #2.

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D 418	Continued From page 219 -Resident #2 told the current Administrator that she would withdraw money to take cash payments to the previous Administrator on the 1st and 3rd of each month, and she assumed the money she paid her was for her room and board. Interview with the current Administrator on 08/27/26 at 11:05am revealed: -She spoke with Resident #2 on 07/09/26 who told her that she still wanted to continue to work with her case manager and eventually move to independent living and that she had paid the previous Administrator on the 1st and 3rd of each month cash for room and board. -The previous Administrator had destroyed any receipts that the resident had in her room. -The previous Administrator denied that Resident #2 paid her any cash. Refer to interview with the BOM on 08/25/26 at 2:29pm. Refer to interview with the current Administrator on 08/27/26 at 11:05am. Refer to second interview with the current Administrator on 08/27/26 at 6:44pm. 2. Review of Resident #38's current FL-2 dated 07/24/26 revealed diagnoses included type 2 diabetes, chronic obstructive pulmonary disease, hypertension, congestive heart failure, and cerebral infarction. Request for Resident #38's resident contract on 08/27/26 at 11:00am was not provided by the end of survey exit. Review of an invoice for Resident #38 from the facility dated 06/22/26 revealed:	D 418		

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D 418	Continued From page 220 -The resident's past due room and board was $4,171.43 -There were no late fees listed. -Room and board for July 2026 was $1,194.00. -The resident's total amount outstanding was $5,365.43. Interview with Resident #38 on 08/27/26 at 3:00pm revealed: -He paid for his room and board with a money order that staff would obtain from his debit card. -To his knowledge the previous Administrator had possession of his debit card. -The previous Administrator had not provided him with a receipt of his payments for room and board. Telephone interview with Resident #38's family member on 08/27/26 at 1:16pm revealed: -Her family member paid for his room and board with his debit card that the previous Administrator would use to get a money order for his room and board. -She had spoken to the previous Administrator on numerous occasions and requested receipts for the resident's payment of room and board. -The previous Administrator never provided her with copies of receipts and told her that the resident had the receipts. -When she reviewed the bank statements from her family member's checking account, she noticed that $1,100 was deducted each month but was not credited to the resident's room and board. Refer to interview with the BOM on 08/25/26 at 2:29pm. Refer to interview with the current Administrator on 08/27/26 at 11:05am.	D 418		

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D 418	Continued From page 221 Refer to second interview with the current Administrator on 08/27/26 at 6:44pm. Interview with the Business Office Manager (BOM) on 08/25/26 at 2:29pm revealed: -She began working as the BOM at the facility on 09/01/25. -The previous Administrator left the facility on 07/13/26. -She was not aware how much each resident paid for their room and board; the previous Administrator would not share that information with her. Interview with the current Administrator on 08/27/26 at 11:05am revealed: -She was hired with the company on 06/01/26 and started working as a Regional Director at the facility on 06/01/26. -She was responsible for oversight of the previous Administrator and the facility. -The facility had a bank account, and she was unsure if the previous Administrator was listed on that account. -She noticed that many residents were behind on their room and board bills. -The facility had not been paid for room and board for several residents for approximately one year. -She was not sure if the previous Administrator had given all resident's a receipt when they paid room and board with their debit card or cash. Second interview with the current Administrator on 08/27/26 at 6:44pm revealed: -She was the Regional Director at the facility beginning 06/01/26. -Her corporate boss wanted to know why the facility had not received many payments on room	D 418		

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

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D 418	Continued From page 222 and board for over a year. -She realized something was not right with resident's past due balances when the previous Administrator discharged a resident to a skilled nursing facility (SNF), because she had allegedly been taking money from the resident for room and board and there was no documentation that the resident had paid her bill with the facility. -She notified the local police department to request assistance with investigating the possible misappropriation of funds from residents at the facility.	D 418		
D 433	10A NCAC 13F .1201(a) Resident Records 10A NCAC 13F .1201Resident Records (a) The following shall be maintained on each resident in an orderly manner in the resident's record in the adult care home and made available for review by representatives of the Division of Health Service Regulation and county departments of social services: (1) FL-2 or MR-2 forms and the patient transfer form or hospital discharge summary, when applicable; (2) Resident Register; (3) receipt for the following as required in Rule .0704 of this Subchapter: (A) contract for services, accommodations and rates; (B) house rules as specified in Rule .0704(a)(2) of this Subchapter; (C) Declaration of Residents' Rights (G.S. 131D-21); (D) the home's grievance procedures; and (E) civil rights statement; (4) resident assessment and care plan; (5) contacts with the resident's physician, physician service or other licensed health	D 433		

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D 433	Continued From page 223 professional as required in Rule .0902 of this Subchapter; (6) orders or written treatments or procedures from a physician or other licensed health professional and their implementation; (7) documentation of immunizations against influenza virus and pneumococcal disease according to G.S. 131D-9 or the reason the resident did not receive the immunizations based on this law; and (8) the Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form if the resident is being or has been discharged. When a resident leaves the facility for a medical evaluation, records necessary for that medical evaluation such as Subparagraphs (1), (4), (5), (6) and (7) above may be sent with the resident. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to maintain records that were readily available for review for 1 of 7 sampled residents (#7). The findings are: Review of Resident #7's FL-2 that was provided by the facility's contracted pharmacy on 08/26/26 at 1:05pm revealed: -The resident's FL-2 was signed by a physician on 06/03/26. -Diagnoses included chronic obstructive pulmonary disease, chronic kidney disease, and schizophrenia. -The resident was ambulatory. -There was no information provided about the	D 433		

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D 433	Continued From page 224 orientation of the resident. Review of a handwritten list provided by the Administrator of resident admissions and discharges in June 2026 revealed Resident #7 was listed as a new admission in June 2026, there was no date listed. Review of a handwritten list provided by the Administrator of resident admissions and discharges in July 2026 revealed Resident #7 was listed as discharged from the facility in July 2026, there was no date listed. Review of the facility's June 2026 census revealed: -Resident #7 was listed as a new admission to the facility in June 2026. -The resident was listed as "IN" the facility from 06/04/26 to 06/30/26. Review of the facility's July 2026 census revealed Resident #7 was not listed as a resident at the facility. Review of a facility census provided on 08/18/26 revealed Resident #7 was not listed as a resident that resided at the facility. Request for Resident #7's facility record on 08/18/26 at 12:40pm, 08/21/26 at 9:35am, and 08/24/26 at 8:55am was not provided by survey exit. Request for any contact information for Resident #7 or his family was requested on 08/26/26 at 10:35am and was not provided by survey exit. The Administrator was unable to provide records for Resident #7 by survey exit.	D 433		

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D 433	Continued From page 225 Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/26/26 at 1:05pm revealed: -The pharmacy was able to provide surveyors with a copy of Resident #7's FL-2 since the Administrator was unable to locate any records for Resident #7. -The pharmacy received an FL-2 for Resident #7 from the facility on 06/04/26 at 5:14pm. Interview with the Administrator on 08/24/26 at 10:11am revealed: -She asked the survey team if they could choose another resident's record rather than Resident #7 because she and her staff were unable to locate any information on the resident. -She did not think that Resident #7 had ever been a resident at the facility. -She and staff had not been able to locate any information that the resident had resided at the facility. -She thought the previous Administrator may have packed the resident's chart away somewhere that they were unable to locate. Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/26/26 at 1:05pm revealed: -The pharmacy had a record of Resident #7's FL-2 and offered to send by facsimile or email to surveyors. -The pharmacy received Resident #7's FL-2 from the facility on 06/04/26 by facsimile or electronic transfer at 5:14pm. -The pharmacy first dispensed a medication for Resident #7 at the facility on 06/09/26. -The last dispense date the pharmacy had for Resident #7 was 07/10/26.	D 433		

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D 433	Continued From page 226 Interview with a medication aide (MA) on 08/26/26 at 10:30am revealed she did not remember Resident #7 ever being a resident at the facility. Interview with the Business Office Manager on 08/25/26 at 2:29pm revealed: -The previous Administrator sent her a text on 07/13/26 that she left her keys and files in her box and was removing her Administrator license from the wall. -The previous Administrator told her she was placing the Regional Directors Administrator License on the wall and sent a photo. -The current Administrator was the previous Regional Director. -The current Administrator helped with admissions. Interview with the Administrator on 08/26/26 at 2:56pm revealed: -She did not know where Resident #7 was located. -She found an obituary for Resident #7 on her cellular telephone. -To the best of her knowledge the resident's family picked him up and took him to a different facility when the previous Administrator was in charge of admissions and discharges. -She assumed that the previous Administrator had shredded all his documentation after he was discharged from the facility since she was not able to find any information on the resident.	D 433		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents	D 451		

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D 451	Continued From page 227 (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to notify the county Department of Social Services (DSS) for 1 of 6 sampled residents who had a fall and was sent to the hospital (#3). The findings are: Review of Resident #3's current FL-2 dated 03/13/26 revealed: -Diagnoses included dysphagia, anemia, muscle atrophy, and type 2 diabetes. -The resident was semi-ambulatory. Review of Resident #3's Resident Register revealed the resident's admission date was 01/23/25. Review of the Resident #3's care plan dated 03/13/26 revealed the resident required assistance from staff with ambulation and with transfers. Review of the Resident #3's incident and accident (I/A) report dated 08/15/26 revealed: -On 08/15/26 at 4:15pm, Resident #3 was found lying on her bedroom floor. -There was documentation Resident #3 sustained	D 451		

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D 451	Continued From page 228	D 451		

an injury, but no note of where the injury was located.
-Emergency dispatch was called.
-Resident #3's family was notified.
-There was no indication the local Department of Social Services (DSS) was notified.
-The medication aide (MA) completed the form.
-The Administrator signed the form.

Review of Resident #3's hospital after-visit summary (AVS) report dated 08/17/26 revealed:
-The resident was admitted to the hospital on 08/15/26.
-The resident's diagnosis was acute kidney injury superimposed on chronic kidney disease.
-She returned to the assisted living (AL) facility on 08/17/26.

Interview with county DSS Adult Home Specialist (AHS) on 08/19/26 at 2:20pm revealed:
-She did not receive an I/A report in August 2026 regarding Resident #3's fall dated 08/15/26 requiring emergency evaluation.
-The facility was responsible for faxing or sending an electronic mail (email) to her I/A reports within 48 hours of the initial discovery or knowledge by staff of any falls witnessed or unwitnessed that required a hospital visit.

Interview with the former Resident Care Coordinator (RCC) on 08/20/26 at 2:30pm revealed:
-She was responsible for ensuring all I/A reports were completed and faxed to DSS.
-The MA completed an I/A report for Resident #3 for the incident on 08/15/26.
-She was responsible for sending the I/A report for Resident #3 dated 08/15/26 to DSS and she could not explain why the I/A form was not faxed.

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D 451	Continued From page 229 Interview with the Administrator on 08/27/26 at 6:44pm revealed: -The former RCC completed I/A reports. -The former RCC provided her with a copy of I/A reports. -If the former RCC had not sent a copy of the I/A report to DSS she would fax it to the AHS. Based on observations, interviews, and record reviews, it was determined Resident #3 was not interviewable.	D 451		
D9999	Final Observation Continued from Tag D0358. n. Review of Resident #2's signed physicians order dated 05/29/26 revealed: -There was an order for carvedilol (used to treat high blood and heart failure) 6.25mg, take one tablet twice daily with food at 6:00am on Tuesday, Thursday, and Saturday. -There was an order for carvedilol 6.25mg, take one tablet twice daily with food at 8:00am on Sunday, Monday, Wednesday, and Friday. Review of Resident #2's hospital discharge summary dated 07/24/26 revealed: -The chief complaint/reason for admission on 07/21/26 was dyspnea. -She had not been receiving home medications for the past 2 weeks due to medication mix-up that occurred after her last discharge between a SNF and her ALF. -Her symptoms and fluid overload were believed to be from not having medications for blood pressure and heart failure or her home medications were restarted. -With resumption of her medications as well as	D9999		

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D9999	Continued From page 230	D9999		

diuresis her symptoms improved requiring no further interventions.
-She was stable for discharge on 07/24/26.

Review of Resident #2's July eMAR revealed:
-There was an entry for carvedilol 6.25mg, take one tablet twice daily with food scheduled at 6:00am and 5:00pm.
-There was a second entry for carvedilol 6.25mg, take one tablet twice daily with food scheduled at 8:00am and 5:00pm.
-There was a note that the resident was out of the facility 06/29/26 through 07/02/26.
-Carvedilol was not documented as administered at either 6:00am or 8:00am on 07/03/26, and on 07/10/26 through 07/14/26, with no exception documented and the space for initials was blank.
-Carvedilol was documented as not administered at 6:00am on 07/16/26, and on 07/21/26, with the exception documented as on order, waiting on delivery.
-Carvedilol was not documented as administered at 5:00pm on 07/02/26, on 07/09/26 through 07/14/26, 07/16/26, and on 07/25/26, with no exception documented and the spaces for initials was blank.
-Carvedilol was documented as not administered at 5:00pm on 07/21/26 with the exception documented as on order, awaiting delivery.
-The resident missed 19 doses of carvedilol in July 2026.

Observation of Resident #2's medications on hand on 08/20/26 at 3:13pm revealed;
-There was a multi-dose card of medications for Resident #2 with a date of 08/12/26 for a seven-day supply of medications.
-There were 2 remaining multidose packs for Resident #2, that contained one carvedilol 6.25mg tablet packaged with nine other oral

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medications labeled morning and dated 08/21/26 and 08/22/26.
-There were 3 remaining individual packs for Resident #2, that contained one carvedilol 6.25mg tablet each, labeled evening, dated 08/20/26, 08/21/26, and 08/22/26.

Telephone interview with a pharmacist with the facility's contracted pharmacy on 08/21/26 at 9:34am revealed:
-Resident #2's medications were dispensed weekly.
-Carvedilol 6.25mg was dispensed for Resident #2 on 07/03/26 for 14 tablets, take one twice daily, on 07/22/26 for 6 tablets to take one twice daily, on 07/28/26, 07/31/26, 08/07/26, 08/14/26, and on 08/21/26 for 14 tablets each time, take one twice daily.

Interview with Resident #2 on 08/20/26 at 2:24pm revealed she thought there was a period in July 2026 that she did not have any of her medications for a few days but was not certain.

Interview with a MA on 08/26/26 at 11:00am revealed she noticed Resident #2 was without her oral medications when she returned to the facility from the SNF in July 2026 and she notified the RCC.

Interview with Resident #2's PCP on 08/21/26 at 11:21am revealed:
-She was not aware that Resident #2 was without medications for several days in July 2026.
-Carvedilol was prescribed for Resident #2 for heart failure.
-Being without carvedilol for an extended period could cause Resident #2's to have rebound high blood pressure, increased heart rate and could exacerbate her congestive heart failure.

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D9999	Continued From page 232 o. Review of Resident #2's signed physicians order dated 05/29/26 revealed: -There was an order for losartan (used to treat high blood pressure and protect kidney function in people with type 2 diabetes) potassium 25mg, take one tablet once daily at 6:00am on Tuesday, Thursday, and Saturday. -There was an order for losartan potassium 25mg, take one tablet daily at 8:00am on Sunday, Monday, Wednesday, and Friday. Review of Resident #2's hospital discharge summary dated 07/24/26 revealed: -The chief complaint/reason for admission was dyspnea. -She presented from the ALF for shortness of breath. -She had not been receiving home medications for the past 2 weeks due to medication mix-up that occurred after her last discharge between a SNF and her ALF. -Her symptoms and fluid overload were believed to be from not having medications for blood pressure and heart failure or her home medications were restarted. -She was worked up for possible pulmonary embolus, deep vein thrombosis, and COPD exacerbation with negative imaging. -With resumption of her medications as well as diuresis her symptoms improved requiring no further interventions. -She was stable for discharge on 07/24/26. Review of Resident #2's July 2026 eMAR revealed: -There was an entry for losartan potassium 25mg, take one tablet once daily scheduled at 6:00am. -There was a second entry for losartan 25mg,	D9999		

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take one tablet once daily scheduled at 8:00am.
-There was a note that the resident was out of the facility 06/29/26 through 07/02/26.
-Losartan was not documented as administered at either 6:00am or 8:00am on 07/03/26, on 07/10/26 through 07/14/26, with no exception documented and the space for initials was blank.
-Losartan was documented as not administered at 6:00am on 07/16/26 and on 07/21/26, with the exception documented as on order, awaiting delivery.
-The resident missed 8 doses of losartan in July 2026.

Observation of Resident #2's medications on hand on 08/20/26 at 3:13pm revealed:
-There was a multi-dose card of medications for Resident #2 with a date of 08/12/26 for a seven-day supply of medications.
-There were 2 remaining multidose packs for Resident #2, that contained one losartan 25mg tablet packaged with nine other oral medications labeled morning and dated 08/21/26 and 08/22/26.

Telephone interview with a pharmacist with the facility's contracted pharmacy on 08/21/26 at 9:34am revealed:
-Resident #2's medications were dispensed weekly.
-Losartan 25mg was dispensed for Resident #2 on 07/03/26 for 8 tablets to take one daily, on 07/22/26 for 3 tablets to take one daily, on 07/28/26, 07/31/26, 08/07/26, 08/14/26, and on 08/21/26 for 8 tablets each time to take one daily.

Interview with Resident #2 on 08/20/26 at 2:24pm revealed she thought there was a period in July 2026 that she did not have any of her medications for a few days but was not certain.

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D9999	Continued From page 234 Interview with a MA on 08/26/26 at 11:00am revealed she noticed Resident #2 was without her oral medications when she returned to the facility from the SNF in July 2026 and she notified the RCC. Interview with Resident #2's PCP on 08/21/26 at 11:21am revealed: -She was not aware that Resident #2 was without medications for several days in July 2026. -Losartan was prescribed for Resident #2 for high blood pressure. -Being without losartan for an extended period could cause Resident #2's to have rebound high blood pressure, putting her at increased stroke and heart attack. p. Review of Resident #2's signed physicians order dated 05/29/26 revealed: -There was an order for paroxetine (used to treat major depressive disorder and anxiety disorders) hcl 20mg, take one tablet once daily at 6:00am on Tuesday, Thursday, and Saturday. -There was an order for paroxetine 20mg, take one tablet daily at 8:00am on Sunday, Monday, Wednesday, and Friday. Review of Resident #2's July 2026 eMAR revealed: -There was an entry for paroxetine 20mg, take one tablet once daily scheduled at 6:00am. -There was a second entry for paroxetine 20mg, take one tablet once daily scheduled at 8:00am. -There was a note that the resident was out of the facility 06/29/26 through 07/02/26. -Paroxetine was not documented as administered at either 6:00am or 8:00am on 07/03/26, on 07/10/26 through 07/15/26, 07/19/26, and on 07/20/26, with no exception documented and the	D9999		

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space for initials was blank.
-Paroxetine was documented as not administered at 6:00am on 07/16/26 and on 07/21/26 with the exception documented as on order, awaiting delivery.
-The resident missed 11 doses of paroxetine in July 2026.

Observation of Resident #2's medications on hand on 08/20/26 at 3:13pm revealed;
-There was a multi-dose card of medications for Resident #2 with a date of 08/12/26 for a seven-day supply of medications.
-There were 2 remaining multidose packs for Resident #2, that contained one paroxetine 20mg tablet packaged with nine other oral medications labeled morning and dated 08/21/26 and 08/22/26.

Telephone interview with a pharmacist with the facility's contracted pharmacy on 08/21/26 at 9:34am revealed:
-Resident #2's medications were dispensed weekly.
-Paroxetine 20mg was dispensed for Resident #2 on 07/03/26 for 8 tablets to take one daily, on 07/22/26 for 3 tablets to take one daily, on 07/28/26, 07/31/26, 08/07/26, 08/14/26, and on 08/21/26 for 8 tablets each time to take one daily.

Interview with Resident #2 on 08/20/26 at 2:24pm revealed she thought there was a period in July 2026 that she did not have any of her medications for a few days but was not certain.

Interview with a MA on 08/26/26 at 11:00am revealed she noticed Resident #2 was without her oral medications when she returned to the facility from the SNF in July 2026 and she notified the RCC.

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D9999	Continued From page 236 Interview with Resident #2's PCP on 08/21/26 at 11:21am revealed: -She was not aware that Resident #2 was without medications for several days in July 2026. -Paroxetine was prescribed for Resident #2 by behavioral health. -Being without paroxetine for an extended period could cause Resident #2's to possibly experience increased depression and anxiety and or withdrawal type symptoms similar to flu-like symptoms. q. Review of Resident #2's signed physicians order dated 05/29/26 revealed: -There was an order for sevelamer (used to elevated phosphate levels in the blood in patients with chronic kidney disease who are on dialysis) carbonate 800mg, take one tablet once daily at 6:00am on Tuesday, Thursday, and Saturday. -There was an order for sevelamer carbonate 800mg, take one tablet daily at 8:00am on Sunday, Monday, Wednesday, and Friday. Review of Resident #2's hospital discharge summary dated 07/24/26 revealed: -The chief complaint/reason for admission was dyspnea. -Resident #2 with past medical history of ESRD on hemodialysis on Tuesday, Thursday, and Saturday. -She had not been receiving home medications for the past 2 weeks due to medication mix-up that occurred after her last discharge between a SNF and her ALF. -Her symptoms and fluid overload were believed to be from not having medications for blood pressure and heart failure or her home medications were restarted. -With resumption of her medications as well as	D9999		

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diuresis her symptoms improved requiring no further interventions.
-Her potassium was low upon presenting to the hospital and was replaced while waiting for dialysis to fully correct.
-She also received dialysis per nephrology.
-She was stable for discharge on 07/24/26.

Review of Resident #2's July 2026 eMAR revealed:
-There was an entry for sevelamer carbonate 800mg, take one tablet once daily scheduled at 6:00am.
-There was a second entry for sevelamer carbonate 800mg, take one tablet once daily scheduled at 8:00am.
-There was a note that the resident was out of the facility 06/29/26 through 07/02/26.
-Sevelamer was not documented as administered at either 6:00am or 8:00am on 07/03/26, on 07/10/26 through 07/15/26, 07/19/26, and on 07/20/26, with no exception documented and the space for initials was blank.
-Sevelamer was documented as not administered at 6:00am on 07/16/26, and on 07/21/26, with the exception documented as on order, awaiting delivery.
-The resident missed 11 doses of sevelamer in July 2026.

Observation of Resident #2's medications on hand on 08/20/26 at 3:13pm revealed;
-There was a multi-dose card of medications for Resident #2 with a date of 08/12/26 for a seven-day supply of medications.
-There were 2 remaining multidose packs for Resident #2, that contained one sevelamer carbonate 800mg tablet packaged with nine other oral medications labeled morning and dated 08/21/26 and 08/22/26.

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D9999	Continued From page 238 Telephone interview with a pharmacist with the facility's contracted pharmacy on 08/21/26 at 9:34am revealed: -Resident #2's medications were dispensed weekly. -Sevelamer carbonate 800mg was dispensed for Resident #2 on 07/03/26 for 8 tablets to take one daily, on 07/22/26 for 3 tablets to take one daily, on 07/28/26, 07/31/26, 08/07/26, 08/14/26, and on 08/21/26 for 8 tablets each time to take one daily. Interview with Resident #2 on 08/20/26 at 2:24pm revealed she thought there was a period in July 2026 that she did not have any of her medications for a few days but was not certain. Interview with a MA on 08/26/26 at 11:00am revealed she noticed Resident #2 was without her oral medications when she returned to the facility from the SNF in July 2026 and she notified the RCC. Interview with Resident #2's PCP on 08/21/26 at 11:21am revealed: -She was not aware that Resident #2 was without medications for several days in July 2026. -Sevelamer was prescribed for Resident #2 to treat high phosphate levels and worked well with dialysis patients. -Increased phosphate levels could cause Resident #2 to experience muscle spasms, bone and joint discomfort, and nausea and vomiting. r. Review of Resident #2's signed physicians order dated 05/29/26 revealed: -There was an order for Symbicort (an inhaled medication used to treat asthma and COPD) 80-4.5mcg inhaler, inhale 2 puffs twice daily, rinse	D9999		

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mouth after each use at 6:00am on Tuesday, Thursday, and Saturday.
-There was an order for Symbicort 80-4.5mcg inhaler, inhale 2 puffs twice daily, rinse mouth after each use at 8:00am on Sunday, Monday, Wednesday, and Friday.

Review of Resident #2's July 2026 eMAR revealed:
-There was an entry for Symbicort 80-4.5mcg, inhale 2 puffs twice daily, rinse mouth after each use, scheduled at 6:00am and 8:00pm.
-There was a second entry for Symbicort 80-4.5, inhale 2 puffs twice daily, rinse mouth after each use, scheduled at 8:00am and 8:00pm.
-There was a note that the resident was out of the facility 06/29/26 through 07/02/26.
-Symbicort was not documented as administered at 6:00am or 8:00am on 07/03/26, on 07/10/26 through 07/15/26, 07/19/26, and on 07/20/26, with no exception documented and the space for intial was blank.
-Symbicort was not documented as administered at 8:00pm on 07/02/26, and on 07/09/26 through 07/14/26, 07/16/26, 07/18/26, 07/25/26, and on 07/28/26, with no exception documented and the space for initials was blank.
-The resident missed 20 doses of Symbicort in July 2026.

Observation of Resident #2's medications on hand on 08/20/26 at 3:28pm revealed;
-There was a manufacturer box with pharmacy label for Symbicort that contained Resident #2's name and instruction to inhale 2 puffs twice daily, rinse mouth after each use and a dispense date of 05/27/26, that contained one Symbicort inhaler of 120 actuations.
-The manufacturer box of Symbicort for Resident #2 had a handwritten opened date of 05/28/26

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and a handwritten expiration date of 08/28/26.
-Resident #2's Symbicort inhaler had 100 actuations remaining on the count dial.

Telephone interview with a pharmacist with the facility's contracted pharmacy on 08/21/26 at 9:34am revealed:
-Symbicort was dispensed for Resident #2 on 04/29/26, 05/27/26, 06/23/26, 07/20/26, and on 08/17/26 for one inhaler on each occasion.
-Each Symbicort inhaler contained 120 actuations for a 30-day supply.

Interview with Resident #2 on 08/20/26 at 2:24pm revealed:
-She thought there was a period in July 2026 that she did not have any of her medications for a few days but was not certain.
-She currently denied having shortness of breath.

Interview with a MA on 08/26/26 at 11:00am revealed she noticed Resident #2 was without her oral medications when she returned to the facility from the SNF in July 2026 and she notified the RCC.

Interview with Resident #2's PCP on 08/21/26 at 11:21am revealed:
-She was not aware that Resident #2 was without medications for several days in July 2026.
-Symbicort was prescribed for Resident #2 to treat asthma and COPD.
-If Resident #2 did not receive her Symbicort inhaler, her COPD symptoms could be exacerbated resulting in increased coughing, wheezing, and shortness of breath.

s. Review of Resident #2's primary care provider (PCP) visit notes dated 07/31/26 revealed:
-The patient was returning to an assisted living

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facility and was being evaluated for ongoing management of type 2 diabetes, end stage renal disease on dialysis, COPD, and diabetic neuropathy,
-She was recently hospitalized for a contusion of the left great toe with damaged nail after attempting to board a van and striking her toe, the toenail came off on her left foot.
-The left toe was wrapped in gauze and she denied pain.
-There was an order to start Bacitracin (a topical antibiotic to treat bacterial infections) 500unit/gram topical ointment (start date 08/02/26, stop date 08/12/26), apply a small amount to affected area once a day, apply to left great toe, and apply bandage.

Review of Resident #2's August 2026 eMAR revealed:
-There was an entry for Bacitracin 500unit/gram ointment, apply a small amount to affected area on left great toe daily and apply bandage, scheduled at 7:00am with written date of 08/04/26 and a stop date of 08/13/26.
-Bacitracin was documented as not administered at 7:00am on 08/05/26, 08/06/26, 08/07/26, 08/08/26, 08/12/26, and on 08/13/26, with the exception documented as resident refused on each occasion.
-Bacitracin was not documented as administered at 7:00am on 08/09/26 with no exception documented and the space for initials was blank.
-Bacitracin was documented as not administered at 7:00am on 08/11/26 with the exception documented as out of facility.
-The resident missed 8 doses of bacitracin in August 2026.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/21/26 at

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D9999	Continued From page 242 9:23am revealed: -An order was received for Resident #2 for Bacitracin 500unit/gram ointment, apply small amount to left great toe and bandage daily on 08/02/26. -Bacitracin 500unit/gram ointment was dispensed for Resident #2 on 08/03/26 for a 28-gram tube. Interview with Resident #2 on 08/20/26 at 2:24pm revealed: -She injured her left toe a week or so ago getting onto the van. -She thought her toe was getting better. Interview with a MA on 08/26/26 at 11:00am revealed: -She was not aware Resident #2 refusing medications. -Resident #2 went to dialysis three days a week and left early in the day on dialysis days. -If a medication was scheduled at 7:00am, it was the third shift's responsibility to administer. -If a resident refused medications, there was a form that was completed and given to the PCP to review at her weekly visit. Interview with the RCC on 08/21/26 at 4:25pm revealed: -She was not aware that Resident #2 did not receive Bacitracin as ordered. -The MAs should have notified her if there was a problem administering medications. -Periodic eMAR audits were done but the facility had been short staffed lately and she had not been able to complete eMAR audits. Interview with the Administrator on 08/27/26 at 3:52pm revealed she expected the residents' medications to be available and administered as ordered by their PCP.	D9999		

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D9999	Continued From page 243 Interview with Resident #2's PCP on 08/21/26 at 11:21am revealed: -Resident #2 recently issues including diabetes which placed her at greater risk of infection and slow wound healing. -She saw Resident #2 today 08/21/26 and thought her left toe was healing. -She was not aware that Resident #2 only received the Bacitracin ointment twice as ordered earlier this month. 2. Review of Resident #1's current FL-2 dated 07/09/26 revealed diagnoses included hypertensive heart, chronic kidney disease, muscle weakness, and syncope. a. Review of Resident #1's signed physician order dated 07/09/26 revealed there was an order for Jardiance 25mg tablet, take one tablet once a day (Jardiance is a medication used to treat Type 2 Diabetes). Review of Resident #1's July 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Jardiance 25mg tablet, take one tablet once a day at 8:00am. -There were medication aide (MA) initials on the eMAR that were circled at 8:00am on 07/20/26, 07/26/26, 07/29/26, and 07/30/26. -There was an exception list at the back of the July 2026 eMAR that the Jardiance 25mg was not administered on 07/20/26, 07/26/26, 07/29/26, and 07/30/26 due to "withheld per DR orders." Review of Resident #1's August 2026 eMAR revealed: -There was an entry for Jardiance 25mg tablet, take one tablet once a day at 8:00am.	D9999		

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D9999	Continued From page 244 -There were MA initials on the eMAR that were circled at 8:00am on 08/04/26, 08/14/26, and 08/18/26. -There was an exception list at the back of the August 2026 eMAR that Jardiance 25mg was not administered on 08/04/26, 08/14/26, and 08/18/26 due to "withheld per DR orders." Telephone interview with a pharmacist from the facility's contracted pharmacy for Resident #1 on 08/24/26 at 10:00am revealed: -A quantity of 7 Jardiance 25mg tablets were dispensed on 07/10/26 for a 7 day supply. -A quantity of 7 Jardiance 25mg tablets were dispensed on 07/17/26 for a 7 day supply. -A quantity of 7 Jardiance 25mg tablets were dispensed on 07/24/26 for a 7 day supply. -A quantity of 7 Jardiance 25mg tablets were dispensed on 07/31/26 for a 7 day supply. -A quantity of 7 Jardiance 25mg tablets were dispensed on 08/07/26 for a 7 day supply. -A quantity of 7 Jardiance 25mg tablets were dispensed on 08/14/26 for a 7 day supply. -A quantity of 7 Jardiance 25mg tablets were dispensed on 08/21/26 for a 7 day supply. Observation of Resident #1's medications on hand on 08/24/26 at 1:12pm revealed there were 2 Jardiance 25mg tablets in a multidose pack. Interview with a MA on 08/20/26 at 11:24am revealed: -She could not remember documenting exceptions for the resident's Jardiance to hold per DR orders. -She was supposed to complete a facility progress note when she did not administer a medication but was not sure why there was not a facility progress note that she did not administer Jardiance.	D9999		

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D9999	Continued From page 245 Interview with the former Resident Care Coordinator (RCC) on 08/20/26 at 1:55pm revealed: -To her knowledge there was no doctor order in the resident's medical record to hold Jardiance. -She was not aware that Resident #1 ever refused his medications or that his Jardiance was not available due to waiting on the pharmacy. -MAs should only document an exception on the eMAR hold per doctor order if there was an actual order from the doctor to hold that medication. -The MAs were expected to correctly document why a medication was held, if they refused a medication or if the medication was not available because it had not been delivered by the facility's contracted pharmacy yet. Interview with the facility's primary care provider (PCP) on 08/21/26 at 10:12am revealed: -She had been Resident #1's PCP in the past but he had recently started seeing the physician at the local Veteran's Clinic. -Resident #1 should have received his prescribed medication if it was available on the cart because the physician at the Veteran's Clinic had prescribed it and the MAs were expected to administer the medication as ordered. Attempted telephone interview with Resident #1's physician at the Veteran's Clinic on 08/24/26 at 9:29am was unsuccessful. b. Review of Resident #1's signed physician order dated 07/09/26 revealed there was an order for Telmisartan 40mg tablet, take one tablet once a day (Telmisartan is a medication used to treat high blood pressure). Review of Resident #1's July 2026 eMAR	D9999		

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revealed:
-There was an entry for Telmisartan 40mg tablet, take one tablet once a day at 8:00am.
-There were MA initials on the eMAR that were circled at 8:00am on 07/28/26.
-There was an exception list at the back of the July 2026 eMAR that the Telmisartan 40mg was not administered on 07/28/26 due to "withheld per DR orders."

Review of Resident #1's August 2026 eMAR revealed:
-There was an entry for Telmisartan 40mg tablet, take one tablet once a day at 8:00am.
-There were MA initials on the eMAR that were circled at 8:00am on 08/04/26.
-There was an exception list at the back of the August 2026 eMAR that Telmisartan 40mg was not administered on 08/04/26 due to "withheld per DR orders."

Telephone interview with a pharmacist from the facility's contracted pharmacy for Resident #1 on 08/24/26 at 10:00am revealed:
-A quantity of 7 Telmisartan 40mg tablets were dispensed on 07/10/26 for a 7 day supply.
-A quantity of 7 Telmisartan 40mg tablets were dispensed on 07/17/26 for a 7 day supply.
-A quantity of 7 Telmisartan 40mg tablets were dispensed on 07/24/26 for a 7 day supply.
-A quantity of 7 Telmisartan 40mg tablets were dispensed on 07/31/26 for a 7 day supply.
-A quantity of 7 Telmisartan 40mg tablets were dispensed on 08/07/26 for a 7 day supply.
-A quantity of 7 Telmisartan 40mg tablets were dispensed on 08/14/26 for a 7 day supply.
-A quantity of 7 Telmisartan 40mg tablets were dispensed on 08/21/26 for a 7 day supply.

Observation of Resident #1's medications on

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	HAL074046	A. BUILDING: _____ B. WING _____	08/27/2026

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
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hand on 08/24/26 at 1:12pm revealed there were 2 Telmisartan 40mg tablets in a multidose pack.

Interview with a MA on 08/20/26 at 11:24am revealed:
-She could not remember documenting exceptions for the resident's Telmisartan to hold per DR orders.
-She was supposed to complete a facility progress note when she did not administer a medication but was not sure why there was not a facility progress note that she did not administer Telmisartan.

Interview with the former Resident Care Coordinator (RCC) on 08/20/26 at 1:55pm revealed:
-To her knowledge there was no doctor order in the resident's medical record to hold Telmisartan.
-She was not aware that Resident #1 ever refused his medications or that his Telmisartan was not available due to waiting on the pharmacy.
-MAs should only document an exception on the eMAR hold per doctor order if there was an actual order from the doctor to hold that medication.
-The MAs were expected to correctly document why a medication was held, if they refused a medication or if the medication was not available because it had not been delivered by the facility's contracted pharmacy yet.

Interview with the facility's primary care provider (PCP) on 08/21/26 at 10:12am revealed:
-She had been Resident #1's PCP in the past but he had recently started seeing the physician at the local Veteran's Clinic.
-Resident #1 should have received his prescribed medication if it was available on the cart because the physician at the Veteran's Clinic had prescribed it and the MAs were expected to

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administer the medication as ordered.

Attempted telephone interview with Resident #1's physician at the Veteran's Clinic on 08/24/26 at 9:29am was unsuccessful.

c. Review of Resident #1's signed physician order dated 07/09/26 revealed there was an order for Triamterene-HCTZ 37.5-25mg tablet, take two tablets (75mg/50mg) once a day (Triamterene-HCTZ is a medication used to treat high blood pressure and fluid retention).

Review of Resident #1's July 2026 eMAR revealed:
-There was an entry for Triamterene-HCTZ 37.5-25mg tablet, take two tablets (75mg/50mg) once a day at 8:00am.
-There were MA initials on the eMAR that were circled at 8:00am on 07/28/26.
-There was an exception list at the back of the July 2026 eMAR that Triamterene-HCTZ 37.5-25mg was not administered on 07/28/26 due to "withheld per DR orders."

Review of Resident #1's August 2026 eMAR revealed:
-There was an entry for Triamterene-HCTZ 37.5-25mg tablet, take two tablets (75mg/50mg) once a day at 8:00am.
-There were MA initials on the eMAR that were circled at 8:00am on 08/04/26.
-There was an exception list at the back of the July 2026 eMAR that Triamterene-HCTZ 37.5-25mg was not administered on 08/04/26 due to "withheld per DR orders."

Telephone interview with a pharmacist from the facility's contracted pharmacy for Resident #1 on 08/24/26 at 10:00am revealed:

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D9999	Continued From page 249 -A quantity of 14 Triamterene-HCTZ 37.5-25mg tablets were dispensed on 07/10/26 for a 7 day supply. -A quantity of 14 Triamterene-HCTZ 37.5-25mg tablets were dispensed on 07/17/26 for a 7 day supply. -A quantity of 14 Triamterene-HCTZ 37.5-25mg tablets were dispensed on 07/24/26 for a 7 day supply. -A quantity of 14 Triamterene-HCTZ 37.5-25mg tablets were dispensed on 07/31/26 for a 7 day supply. -A quantity of 14 Triamterene-HCTZ 37.5-25mg tablets were dispensed on 08/07/26 for a 7 day supply. -A quantity of 14 Triamterene-HCTZ 37.5-25mg tablets were dispensed on 08/14/26 for a 7 day supply. -A quantity of 14 Triamterene-HCTZ 37.5-25mg tablets were dispensed on 08/21/26 for a 7 day supply. Observation of Resident #1's medications on hand on 08/24/26 at 1:12pm revealed there were 4 Triamterene-HCTZ 37.5-25mg in a multidose pack. Interview with a MA on 08/20/26 at 11:24am revealed: -She could not remember documenting exceptions for the resident's Triamterene-HCTZ 37.5-25mg to hold per DR orders. -She was supposed to complete a facility progress note when she did not administer a medication but was not sure why there was not a facility progress note that she did not administer Triamterene-HCTZ. Interview with the former Resident Care Coordinator (RCC) on 08/20/26 at 1:55pm	D9999		

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D9999	Continued From page 250 revealed: -To her knowledge there was no doctor order in the resident's medical record to hold Triamterene-HCTZ. -She was not aware that Resident #1 ever refused his medications or that his Triamterene-HCTZ was not available due to waiting on the pharmacy. -MAs should only document an exception on the eMAR hold per doctor order if there was an actual order from the doctor to hold that medication. -The MAs were expected to correctly document why a medication was held, if they refused a medication or if the medication was not available because it had not been delivered by the facility's contracted pharmacy yet. Interview with the facility's primary care provider (PCP) on 08/21/26 at 10:12am revealed: -She had been Resident #1's PCP in the past but he had recently started seeing the physician at the local Veteran's Clinic. -Resident #1 should have received his prescribed medication if it was available on the cart because the physician at the Veteran's Clinic had prescribed it and the MAs were expected to administer the medication as ordered. Attempted telephone interview with Resident #1's physician at the Veteran's Clinic on 08/24/26 at 9:29am was unsuccessful. _____ The facility failed to administer medications as ordered to Resident #2 resulting in the resident missing 54 doses of a rapid acting insulin and 5 consecutive doses of a long acting insulin putting her at risk for elevated blood sugars which could lead to diabetic ketoacidosis. The resident missed 32 doses of a medication used to lower eye pressure and 107 doses of a medication	D9999		

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D9999	Continued From page 251 used to treat inflammation of the eye putting the resident at risk for vision loss. The resident was readmitted to the facility from a skilled nursing facility and missed multiple days of 11 medications in July 2026 due to these medications not being started when the resident returned. The medications included two medications used to treat high blood pressure, a medication used to treat fluid buildup, a medication used to treat heart failure, a medication used to decrease phosphate levels, and an inhaled medication used to treat shortness of breath. The resident subsequently was admitted to the hospital on 07/21/26 with symptoms of shortness of breath and fluid overload and with resumption of her medications and diuresis her symptoms resolved and she was discharged back to the facility on 07/24/26. This resident was hospitalized in August 2026 for colitis and discharged with two antibiotics, missing two doses of each, which could cause a worsening infection and antibiotic resistance. This failure resulted in serious neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/20/26 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 26, 2026.	D9999		