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D 000	Initial Comments The Adult Care Licensure section and Cabarrus County Department of Social Services conducted an annual survey and complaint investigation on February 19, 2026 through February 20, 2026. The complaint investigation was initiated by Cabarrus County Department of Social Services on January 9, 2026.	D 000		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews, the facility failed to ensure 1 of 3 sampled staff (Staff C) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) prior to hire. The findings are: Interview with the Administrator on 02/20/26 at 4:35pm revealed: -She was unable to locate Staff C's personnel record. -Staff C was hired as a PCA. -She was responsible for ensuring HCPR checks were completed for all staff upon hire. -She was sure that she completed a HCPR check for Staff C but misplaced Staff C's entire personnel record.	D 137		

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D 137	Continued From page 1 Interview with Staff C on 02/20/26 at 4:18pm revealed: -She was hired about a year ago as a PCA. -She worked full time and provided care to the residents.	D 137		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check completed in accordance with G.S. 131D-40 and results available in the staff person's personnel file; This Rule is not met as evidenced by: Based on interviews the facility failed to complete a criminal background check on 1 of 3 sampled staff (Staff C). The findings are: Interview with the Administrator on 02/20/26 at 4:35pm revealed: -She was unable to locate Staff C's personnel record. -Staff C was hired as a PCA. -She was responsible for ensuring criminal background checks were completed for all staff upon hire. -She was sure that she completed a criminal background check for Staff C but misplaced Staff C's entire personnel record. Interview with Staff C on 02/20/26 at 4:18pm revealed: -She was hired about a year ago as a PCA. -She worked full time and provided care to the	D 139		

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D 139	Continued From page 2 residents. -She did remember signing a consent for the facility to obtain a criminal background check.	D 139		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews and the facility failed to ensure 1 of 2	D 164		

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sampled medication aide (MA) staff (Staff A) had completed training on the care of diabetic residents prior to administering insulin.

The findings are:

Review of Staff A's personnel record revealed:
-Staff A was hired as a medication aide (MA) on 01/15/24.
-There was no documentation Staff A had completed training on the care of the diabetic resident prior to administering insulin.

Review of December 2025 electronic medication administration records (eMAR) revealed there was documentation Staff A administered insulin on 12/20/25, 12/21/25, 12/23/25,12/25/25, 12/27/25 and 12/28/25.

Review of January 2026 eMARs revealed there was documentation Staff A obtained FSBS and administered insulin on 01/03/25, 01/04/26, 01/10/26, 01/11/26, 01/14/26, 01/17/26, 01/18/26, 01/20/26, 01/21/26, 01/24/26, 01/25/26. 01/26/26, 01/27/26, 01/28/26 and 01/31/26.

Review of February 2026 eMAR revealed there was documentation Staff A obtained FSBS and administered insulin on 02/6/26, 02/07/26, 02/8/26, 02/11/26, 02/14/26, 02/15/26 and 02/18/26.

_____

Interview with Staff A on 02/20/26 at 3:15pm revealed she completed her diabetic training in 2013 or 2014 and gave a copy to the Administrator.

Telephone interview with the facilities contracted RN on 02/20/26 at 11:18am revealed:
-He completed all diabetic MA training for the

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D 164	Continued From page 4 facility. -He always gave the diabetic MA certificates to the facility and never kept copies of the certificates. Interview with the Administrator on 02/20/26 at 4:15pm revealed: -All diabetic training was completed online upon hire and yearly there after. -She could not access the online training to check to see if Staff A completed her diabetic training. -She could not find a copy of Staff A's diabetic training in Staff A's record. -She was responsible to make sure staff completed the diabetic training and keep the documents in Staff A's record. -She did not know what happened with Staff A's diabetic training.	D 164		
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 A2 VIOLATION Based on interviews and record reviews, the facility failed to ensure referral and follow-up with a physician for 3 of 5 sampled residents (#1, #2, & #3) related to Resident #3 who gave himself a tattoo and two other residents (#1 and #2). The findings are: Review of the Regional Environmental Health	D 273		

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Section (REHS) visit note dated 01/29/26 revealed:
-The tattoos took place after Christmas 2025 and before New Year's 2026.
-he informed the Administrator the dangers on improper tattooing to residents and that was prohibited at the facility.
-The resident was issued a 30-day discharge notice which was up today and the resident's family member took him out of the facility.
-He informed the Administrator to make the local health department aware when this happened.

1. Review of Resident #3 current FL2 dated 01/10/25 revealed diagnosis included bipolar and stimulant dependence.

Review of Resident #3's Resident Register revealed he was admitted on 05/30/24 and was discharged on 01/29/26 due to Resident #3 gave himself a tattoo and two other residents at the facility.

Review of Resident #3's record revealed:
-He was issued a 30-day discharge notice by the facility Administrator on 12/26/25 with the documented reason: "the safety of the resident or other individuals is endangered".
-There was no documentation of any incident report related to the tattoo machine.
-There was no documentation of communication with Resident #3's physician regarding the tattoo machine.

Interview with the Administrator on 01/14/26 at 2:00pm revealed:
-Resident #3 received a tattoo machine in the mail and sometime before Christmas, gave himself and two other residents tattoos.
-She was made aware of the incident on

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12/26/25.
-Upon learning of the incident, she immediately called Resident #3's family member to come to the facility and pick up the tattoo machine.
-As a result of the incident, a 30-day discharge notice was issued to Resident #3's guardian on 12/26/25.
-She did not notify Resident #3's physician of the incident.

Refer to telephone interview with a representative from the Regional Environmental Health Section (REHS) on 02/20/26 at 12:12pm.

Refer to telephone interview with the local Health Department Communicable Disease Registered Nurse (CDRN) on 02/20/26 at 8:54am.

Refer to telephone interview with the facility's contracted Primary Care Physician (PCP) on 02/19/26 at 3:04pm.

Refer to interview with the Administrator on 02/19/26 at 3:48pm.

2. Review of Resident #1's current FL2 dated 12/19/25 revealed diagnoses included schizophrenia, polysubstance use, anxiety, back pain and depression.

Review or Resident #1's Resident Register revealed an admission date of 03/19/20.

Review of Resident #1's record revealed there was no documentation his primary care physician (PCP), local health department communicable disease nurse (CDRN) or guardian was notified related to Resident #1 who received a tattoo by another resident who did not have a permit to administer tattoos.

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D 273	Continued From page 7 Review of Resident #1's record revealed there was no documentation Resident #1 was tattooed by Resident #3. Observation of Resident #1 on 02/19/26 at 11:12am revealed an 1/2 inch cross tattooed on his left thumb. Interview with Resident #1 on 02/19/26 at 11:12am revealed: -Resident #3 purchased a tattoo gun online and gave himself a tattoo and he wanted one too. -Resident #3 gave him and Resident #2 the same tattoo of a cross on their left thumbs. -He did not see Resident #3 giving another resident a tattoo. -The other resident showed him the tattoo he received and he wanted one too. -Resident #3 used alcohol to clean his thumb and the tattoo gun. -He did not see Resident #3 change the needle before tattooing him. -He did not tell anyone after he got the tattoo. Telephone interview with Resident #1's guardian on 02/19/26 at 2:17pm revealed: -She did not know Resident #1 received a tattoo from another resident around Christmas 2025. -She expected to get permission from her for Resident #1 to get a tattoo because then she would have made sure it was from a person who had a permit to administer tattoos. -Resident #1 received a tattoo from a person who did not have a permit to administer tattoos and the risk of contracting an infection or communicable disease. -She was not made aware. Refer to telephone interview with a representative	D 273		

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from the REHS on 02/20/26 at 12:12pm.

Refer to telephone interview with the local Health Department CDRN on 02/20/26 at 8:54am.

Refer to telephone interview with the facility's contracted PCP on 02/19/26 at 3:04pm.

Refer to interview with the Administrator on 02/19/26 at 3:48pm.

3. Review of Resident #2's current FL2 dated 12/30/25 revealed diagnoses included cerebral palsy tremors, adjustment disorder with anxiety and depression.

Review or Resident #2's Resident Register revealed an admission date of 10/14/20.

Review of Resident #2's record revealed there was no documentation his PCP, local health department communicable disease nurse or guardian was notified about Resident #2 who received a tattoo by another resident who did not have a permit to administer tattoos.

Review of Resident #2's record revealed there was no documentation Resident #2 was tattooed by Resident #3.

Interview with Resident #2 on 02/19/26 at 10:00am revealed another resident gave him a tattoo.

Telephone interview with Resident #2's guardian on 02/19/26 at 2:19pm revealed:
-He did not know did not know Resident #2 received a tattoo from another resident around Christmas 2025.
-He was concerned that if Resident #2 received a

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D 273	Continued From page 9 tattoo from a person without a permit and the risk of contracting a an infection or a communicable disease. Refer to telephone interview with a representative from the REHS on 02/20/26 at 12:12pm. Refer to telephone interview with the local Health Department CDRN on 02/20/26 at 8:54am. Refer to telephone interview with the facility's contracted PCP on 02/19/26 at 3:04pm. Refer to interview with the Administrator on 02/19/26 at 3:48pm. _____ Telephone interview with a representative from the REHS on 02/20/26 at 12:12pm revealed: -On 01/29/26, he received a complaint related to a person who did not have a permit, giving tattoos to other residents at the faciliy. -The Administrator told him the tattoo incident happened around Christmas 2025 and before January 1, 2026. -A resident tattooed himself and two other residents had been discharged. -He informed the Administrator of the dangers of improper tattooing and that it was prohibited at the facility. -He instructed the Administer to contact the local CDRN for further recommendations. Telephone interview with the local Health Department CDRN on 02/20/26 at 8:54am revealed: -On 02/19/26, she received a call from the REHS Supervisor inquiring about a resident who gave himself a tattoo and two other residents from a machine bought online, and she explained to the supervisor she had not heard from the	D 273		

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Administrator yet.
-She did not receive a call from the Administrator to get recommendations related to a resident without a permit tattooing at the facility.
-Today, 02/20/26, she was made aware all three residents were not tested for any blood borne infectious diseases.
-Because the resident who did not have a permit, tattooed the other two residents and there was no conformation the resident who administered the tattoos used proper infection control procedures such as changing the needle between every resident and using antiseptic procedures to help prevent infections.
-All three residents were all considered "source" patients because all three residents were stuck by tattoo needles.
-Since all three residents were considered sources, all three residents should have been tested for a blood borne infectious diseases.
-All three residents medical history could be a risk factor for contracting a blood borne infectious disease, but the biggest risk factor was sharing the needle itself.
-It was the facility's responsibility to contact her for the recommendations of testing all three residents.
-The staff at the facility should have set up appointments for the three residents to be tested at the local health department.

Telephone interview with the facility's contracted PCP on 02/19/26 at 3:04pm revealed:
-He did not know a resident gave himself and two other residents tattoos around Christmas 2025 until on 01/29/26 when staff called and requested a new FL2 for Resident #3 because he was being discharged.
-It was unacceptable for a resident to tattoo themselves and others because of the risk of

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blood borne diseases.
-There was also the risk of infection because a person without a permit was not trained in infection prevention and could introduce bacteria into the area they tattoo.

Interview with the Administrator on 02/19/26 at 3:48pm revealed:
-On 12/26/25, she issued a 30-day discharge notice to Resident #3 because she was told by staff Resident #3 bought a tattoo gun online and gave himself a tattoo and Resident #1 and #2 around Christmas 2025.
-On 12/26/25, she notified Resident #3's guardian about the incident when she issued the 30-day discharge notice.
-On 12/26/25, she notified Resident #1 and #2's guardians about the tattoos.
-She did not notify the facility's contracted PCP because she did not "think it was a big deal".
-On 01/29/26, the Adult Home Specialist (AHS) notified the REHS and a representative came out to investigate a complaint related to Resident #3 tattooing at the facility without a permit.
-The REHS representative informed her Resident #3 could not tattoo at the facility without a license and he looked at the tattoos on Resident #1 and #2 and said they were not infected and closed the case.
-He gave her a report sheet, but she did not look at it.
-The report stated at the bottom to contact the local health department the next time it happened.
-She did not know she was to contact the PCP and the health department CDRN.

4. Review of Resident #5's current FL2 dated 01/20/26 revealed diagnoses included muscle weakness and diabetes mellitus type II.

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D 273	Continued From page 12 Review or Resident #5's Resident Register revealed an admission date of 10/19/18. Review of Resident #3's signed physician's order dated 12/05/25 revealed: -Resident #5 was to have his finger stick blood sugar (FSBS) three times daily. -There was an order for Novolog (used to improve blood sugar control) sliding scale for FSBS 200-249 take 4 units; 250-299 take 8 units; 300-349 take 12 units; 350-399 call Primary Care Practitioner (PCP). Review of Resident #5's December 2025 electronic medication administration record (eMAR) revealed: -There was an entry Novolog sliding scale for FSBS 200-249 take 4 units; 250-299 take 8 units; 300-349 take 12 units; 350-399 call Primary Care Practitioner. -There was documentation of Resident #5's FSBS was 384 on 12/27/25 at 12:00pm. -There was documentation of Resident #5's FSBS was 387 on 12/29/25 at 12:00pm. -There were 2 of 8 opportunities when Resident #5's FSBS was greater than 350. -There was no documentation Resident #5's PCP was notified. Review of Resident #5's signed physician's order dated 01/02/26 revealed: -Resident #5 was to have FSBS three times daily. -There was an order for Novolog 4 units at every meal + sliding scale for FSBS 200-249 take 4 units; 250-299 take 8 units; 300-349 take 12 units; 350-399 call Primary Care Practitioner. Review of Resident #5's February 2026 eMAR revealed:	D 273		

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D 273	Continued From page 13 -There was an entry Novolog sliding scale for FSBS 200-249 take 4 units; 250-299 take 8 units; 300-349 take 12 units; 350-399 call Primary Care Practitioner. -There was documentation of Resident #5's FSBS was 369 on 02/18/26 at 12:00pm. -There were 1 of 6 opportunities when Resident #5's FSBS was greater than 350. -There was no documentation Resident #5's PCP was notified. Review of Resident #5's record revealed there was no documentation his PCP was notified when his FSBS were greater than 350 on 12/27/25, 12/29/25 and on 02/18/26. Interview with the Registered Nurse (RN) at Resident #5's PCP office on 02/19/26 at 4:08pm revealed the facility did not notify Resident #5's PCP office on 12/27/25, 12/29/25 and on 02/18/26 of Resident #5's FSBS's being greater than 350. Interview with a MA on 02/20/26 at 8:55am revealed: -The MAs were responsible for checking Resident #5's FSBS and notifying his PCP if his FSBS was greater than 350. -The MAs left the Resident Care Director (RCD) and/or Administrator's contact number with Resident #5's PCP office for the return call. -The MAs were responsible for documenting all PCP notifications in Resident 5's progress notes or in the eMAR system. -The PCP office did not always call the facility back. -She always notified the RCD and Administrator when Resident #5's FSBS were greater than 350 but did not document notification.	D 273		

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D 273	Continued From page 14 Interview with a second MA on 02/20/26 at 9:15am revealed: -The MAs were responsible for checking Resident #5's FSBS and notifying his PCP if his FSBS was greater than 350. -She would leave the Administrator's contact number when she called Resident #5's PCP office when Resident #5's FSBS was greater than 350. -She had never documented when she had called Resident #5's PCP office when his FSBS was greater than 350. Interview with the RCC on 02/20/26 at 10:02am revealed: -The MAs were responsible for contacting the PCP when Resident #5's FSBS were greater than 350. -The MAs were responsible for documenting PCP notification in the residents' progress notes and also in the eMAR system. Interview with the Administrator on 02/20/26 at 4:35pm revealed: -The MAs were responsible for contacting the PCP when Resident #5's FSBS were greater than 350. -The MAs were responsible for documenting all PCP notifications in the residents' progress notes. -She expected the MAs to notify the RCD if the PCP office had not called back. Attempted telephone interview with Resident #5's PCP on 02/19/26 at 2:47pm and on 02/20/26 at 4:08pm were not successful. [Refer to Tag 610 10A NCAC 13F .0801(a) Infection Prevention and Control Policies and Procedures (Type B Violation)].	D 273		

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D 273	Continued From page 15 The facility failed to contact the PCP and CDRN at the local health department related to a resident without a permit, tattooed himself (#3) and two other residents (#1 and #2) putting all three residents at risk for contracting a blood borne disease. This failure resulted in a substantial risk for serious physical harm to the residents and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/20/26 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED 03/22/26.	D 273		
D 454	10A NCAC 13F .1212(e) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting Of Accidents And Incidents (e) The facility shall assure the notification of a resident's responsible person or contact person, as indicated on the Resident Register, of the following, unless the resident or his responsible person or contact person objects to such notification: (1) any injury to or illness of the resident requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but no later than 24 hours from the time of the initial discovery or knowledge of the injury or illness by staff and documented in the resident's file; and (2) any incident of the resident falling or elopement which does not result in injury requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but not later than 48	D 454		

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D 454	Continued From page 16	D 454		

hours from the time of initial discovery or knowledge of the incident by staff and documented in the resident's file, except for elopement requiring immediate notification according to Rule .0906(f)(4) of this Subchapter.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to notify the guardians of 3 of 5 sampled residents related to an unlicensed resident tattooed himself (#3) and two other residents (#1 and #2).

The findings are:

1. Review of Resident #3 current FL2 dated 01/10/25 revealed diagnoses included bipolar disorder and stimulant dependence.

Review of Resident #3's Resident Register revealed he was admitted on 05/30/24 and was discharged on 01/29/26.

Review of Resident #3's record revealed there was no documentation of an incident report related to him tattooing himself or others.

Interview with Resident #3's Guardian on 02/19/26 at 4:23pm revealed:
-He was given a verbal and written 30-day discharge notice from the administrator on 12/26/25 for Resident #3.
-He was not notified of the incident with the tattoo machine when it had happened.
-Resident #3 having the tattoo machine, and giving tattoos to other residents, was the reason

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given for the discharge by the Administrator
-He did not see the tattoo machine, as the Administrator had already given it to Resident #3's mother.
-Resident #3 stayed in the facility past the 30-day notice while he worked with another agency to find appropriate placement.
-He moved Resident #3 out of the facility on 01/29/25.

Refer to interview with the Administrator on 02/20/26 at 2:15pm.

2. Review of Resident #1's current FL2 dated 12/19//25 revealed diagnoses included schizophrenia, anxiety, back pain and depression.

Review or Resident #1's Resident Register revealed an admission date of 03/19/20.

Review of Resident #1's record revealed there was no documentation of an incident report related to Resident #3 tattooing him.

Refer to interview with the Administrator on 02/20/26 at 2:15pm.

3. Review of Resident #2's current FL2 dated 12/30/25 revealed diagnoses included cerebral palsy tremor, adjustment disorder with anxiety, and depression.

Review or Resident #2's Resident Register revealed an admission date of 10/14/20.

Review of Resident #2's record revealed there was no documentation of an incident report related to Resident #3 tattooing him.

Refer to interview with the Administrator on

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D 454	Continued From page 18 02/20/26 at 2:15pm. _____ Interview with the Administrator on 02/20/26 at 2:15pm revealed: -She was responsible for notifying the guardians of Resident #1, #2 and #3 when she found out about Resident #3 tattooing himself, and Resident #1 and #2. -She thought she notified Resident #1 and #2's guardians but she did not.	D 454		
D 610	10A NCAC 13F .1801(a) Infection Prevention & Control Policies & Pro 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL POLICIES AND PROCEDURES (a) In accordance with Rule .1211(a)(4) of this Subchapter and G.S. 131D-4.4A(b)(1), the facility shall establish and implement infection prevention and control policies and procedures consistent with the federal Centers for Disease Control and Prevention (CDC) published guidelines on infection prevention and control. The Department shall approve a set of policies and procedures for infection prevention and control consistent with the federal CDC published guidelines on infection prevention and control that shall be made available on the Division of Health Service Regulation, Adult Care Licensure Section website at https://info.ncdhhs.gov/dhsr/acls/acforms.html at no cost. The facility shall either: (1) utilize the set of policies and procedures for infection prevention and control approved by the Department; (2) develop policies and procedures for infection prevention and control that are consistent with the set of Department approved	D 610		

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D 610	Continued From page 19 policies and procedures; or (3) develop policies and procedures for infection prevention and control that are based on nationally recognized standards in infection prevention and control that are consistent with the federal CDC published guidelines on infection prevention and control. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews, and record reviews, the facility failed to establish and implement a written infection control policy and procedure consistent with the Federal Centers for Disease Control and Prevention (CDC) Risks and Safety Information Identified by the CDC/Public Health Agencies to ensure proper infection control procedures for the use of a tattoo gun for 3 of 5 sampled residents (#1, #2, and #3) who were tattooed by an unlicensed resident (#3). The findings are: Review of the Federal Centers for Disease Control and Prevention (CDC) Risks and Safety Information Identified by the CDC/Public Health Agencies revealed:	D 610		

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-The CDC classified tattooing by unlicensed, unregulated individuals as a high-risk activity for transmitting blood-borne diseases like hepatitis C and infections like Methicillin-resistant Staphylococcus aureus (MRSA).
-Unregulated tattooing can transmit serious diseases through contaminated needles, inks, and non-sterile equipment.
-Unlicensed tattooing has been linked to severe CA-MRSA (Community-Associated Methicillin-Resistant Staphylococcus aureus) skin infections.
-Unlicensed individuals often lack necessary sterilization equipment, such as autoclaves, and may not follow proper aseptic techniques.
-Inks used by unlicensed, non-reputable artists may be contaminated with bacteria or mold, causing, red rashes, bumps, or permanent scars.

1. Review of Resident #3 current FL2 dated 01/10/25 revealed diagnosis included bipolar, polysubstance's use, and stimulant dependence.

Review of Resident #3's Resident Register revealed he was admitted on 05/30/24 and was discharged on 01/29/26.

Review of Resident #3's record revealed he was issued a 30-day discharge notice by the facility Administrator on 12/26/25 with the documented reason: "the safety of the resident or other individuals is endangered".

Refer to telephone interview with a representative from the REHS on 02/20/26 at 12:12pm.

Refer to telephone interview with the local Health Department CDRN on 02/20/26 at 8:54am.

Refer to interview with the Administrator on

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D 610	Continued From page 21 02/19/26 at 3:48pm. 2. Review of Resident #1's current FL2 dated 12/19//25 revealed diagnoses included Schizophrenia, polysubstance use, anxiety, back pain and depression. Review or Resident #1's Resident Register revealed an admission date of 03/19/20. Refer to telephone interview with a representative from the REHS on 02/20/26 at 12:12pm. Refer to telephone interview with the local Health Department CDRN on 02/20/26 at 8:54am. Refer to interview with the Administrator on 02/19/26 at 3:48pm. 3. Review of Resident #2's current FL2 dated 12/30/25 revealed diagnoses included cerebral palsy tremor, adjustment disorder with anxiety and depression. Review or Resident #2's Resident Register revealed an admission date of 10/14/20. Refer to telephone interview with a representative from the REHS on 02/20/26 at 12:12pm. Refer to telephone interview with the local Health Department CDRN on 02/20/26 at 8:54am. Refer to interview with the Administrator on 02/19/26 at 3:48pm. [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)]. _____	D 610		

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D 610	Continued From page 22 Telephone interview with a representative from the REHS on 02/20/26 at 12:12pm revealed: -On 01/29/26, he received a complaint related to a person who did not have a permit, giving tattoos to other residents at the faciliy. -The Administrator told him the tattoo incident happened around Christmas 2025 and before January 1, 2026. -A resident tattooed himself and two other residents had been discharged. -He informed the Administrator of the dangers of improper tattooing and that it was prohibited at the facility. Telephone interview with the local Health Department CDRN on 02/20/26 at 8:54am revealed: -Because the resident who did not have a permit, tattooed the other two residents and there was no conformation the resident who administered the tattoos used proper infection control procedures such as changing the needle between every resident and using antiseptic procedures to help prevent infections. -All three residents were all considered "source" patients because all three residents were stuck by tattoo needles and unknown if proper infection control procedures were followed. -Since all three residents were considered sources, all three residents should have been tested for a blood borne infectious diseases. -All three residents medical history could be a risk factor for contracting a blood borne infectious disease, but the biggest risk factor was sharing the needle itself. -It was the facility's responsibility to contact her for the recommendations of testing all three residents. Interview with the Administrator on 02/19/26 at	D 610		

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D 610	Continued From page 23 3:48pm revealed she did not have an infection control policy on what to do when a resident had an exposure to a blood borne communicable disease. _____ The facility failed to establish and implement an infection control procedures consistent with the Center for Disease Control risk and safety information resulting in an unlicensed resident (#3) who tattooed himself and two other residents (#1 and #2) placing the residents at risk for bloodborne pathogen diseases. The facility's failure was detrimental to the safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/20/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 6, 2026.	D 610		