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D 000	Initial Comments The Adult Care Licensure Section and the Macon County Department of Social Services completed a follow-up survey and a complaint investigation from 05/12/26 through 05/14/26. The complaint investigation was initiated by the county on 03/16/26 and 03/27/26.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: Type B Violation Based on interviews and record reviews, the facility failed to provide supervision for 1 of 2 sampled residents (Resident #3) who had a history of falls with no additional safety interventions ordered or implemented to minimize future falls. The findings are: Review of the facility's policy and procedures for falls dated 05/28/19 revealed the following interventions for falling would be used as needed included low bed, mat beside the bed, chair	D 270		

LSB Reviewed & acknowledged 06/26/26

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alarm, bed alarm, chair seatbelt, tilt-bars on wheelchairs, carpet in the resident's room, and restraints if no other alternative prevents falls.

Review of the facility's procedures for a fall reduction management program dated 11/13/02 revealed:
-A fall risk assessment form would be completed upon admission, quarterly, and with any significant change to the resident to determine the fall risk status so that interventions could be put into place to reduce and/or prevent future falls.
-Any resident with a history of falls within the past 90 days was automatically at risk for falling again, and should have interventions put in place immediately to decrease fall risk.
-The family/responsible party should have a conference with the facility staff to explain the inherent risk of falls, all interventions attempted in the past, and recommended future interventions for the resident while both parties sign an agreement which allowed the family to share in the responsibility by being involved in the interventions used for the resident's care.
-A physician notification form should be documented to notify in writing when a fall risk was noted or suspected, and a written response including recommendations should be sent back to the facility.
-The physician notification form should be filled out by the supervisor on duty upon admission if the resident had a fall at home or in the community, and any other time that the resident was found to be at risk for falls or had a fall and faxed to the physician.

Review of a blank physician notification of resident condition form provided by the facility revealed:

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-There was a space for the date, resident's name, and a list of interventions that were implemented for a resident with a fall with a signature line for the facility representative to sign and date.
-There was a section for the physician acknowledgement along with a section to check if the physician had new orders for the resident to reduce the risk of future falls or if there was no need for change in the resident's current plan of care.

Review of Resident #3's current FL2 dated 02/16/26 revealed:
-Diagnoses included recurring falls and dementia.
-The recommended level of care was special care unit (SCU).
-Resident #3 was semi-ambulatory with maximum assistance.
-Resident #3 was intermittently confused.

Review of Resident #3's Resident Register revealed:
-Resident #3's admission date was 02/17/26.
-Resident #3 had a Health Care Power of Attorney (HCPOA).
-There was documentation Resident #3 needed assistance with all activities of daily living (ADL'S) including dressing, bathing, ambulation, getting out of bed, toileting, positioning and turning and orientation to time and place.
-Resident #3's memory was documented as forgetful and needed reminders.
-Resident #3 needed a wheelchair for mobility.

Review of Resident #3's Care Plan dated 02/19/26 revealed:
-He was always disoriented.
-Resident #3 needed supervision while eating.
-Resident #3 needed extensive assistance with toileting, ambulation, bathing, dressing, and

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grooming.
-Resident #3 needed total assistance with transferring requiring 2-person assistance and propelled himself in a wheelchair.

Review of Resident #3's Incident and Accident Reports revealed:
-On 02/19/26 at 4:00am, Resident #3 stood up from the bed, lost his balance, and fell with no injuries noted.
-On 02/21/26 at 6:30pm, the alarm was going off, and Resident #3 was found kneeling by his chair with no injuries noted.
-On 02/22/26 at 5:00pm, Resident #3 was found lying in the living room floor by maintenance staff, no injuries were noted, the HCPOA was notified, and Resident #3 was assisted back into his wheelchair, and the chair alarm was put back onto the wheelchair.
-On 02/22/26 at 8:12pm, Resident #3 was found in the floor in another resident's room, his HCPOA was notified, no injuries were noted, and "will continue to monitor" was documented.
-On 03/03/26 at 2:00pm, Resident #3 tried to stand up from the wheelchair in the living room and fell with no injuries noted.
-On 03/06/26 at 6:54pm, Resident #3 was found lying on the floor and was sent to the local hospital emergency room (ER) for an evaluation.

Review of Resident #3's chart notes revealed:
-On 02/17/26 at 3:51pm, the Special Care Coordinator documented Resident #3 was admitted to the SCU, was a fall risk and had "a little" weight bearing, required 2-person assistance with transfers, needed assistance with getting to the toilet, needed extensive assistance in the shower, had a wheelchair, low bed, bed alarm, fall pad, and a urinal near his bed.
-On 02/19/26 at 5:14am, a medication aide (MA)

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documented Resident #3 stood up and lost his balance and fell, his HCPOA was notified, and no injuries were noted.
-On 02/21/26 at 6:30pm, a MA documented Resident #3 was found on the floor on his knees and no injuries were noted.
-On 02/22/26 at 10:43am, Resident #3 was found lying on the floor in the living room and no injuries were noted.
-On 02/22/26 at 8:11pm, Resident #3 was found lying on the floor in another resident's room with no injuries noted.
-On 03/06/26 at 6:58pm, Resident #3 was found lying on the floor with no injuries noted but he did choke at dinner twice and started changing color and staff sent Resident #3 to the ER.
-On 03/06/26 at 7:44pm, Resident #3 was found lying on the living room floor.

Review of Resident #3's record revealed there was no documentation from Resident #3's hospital admission on 03/06/26.

Interview with a MA on 05/13/26 at 10:03am revealed:
-Resident #3 would lose his balance and sometimes would fall.
-She was not instructed by management to do anything to try to prevent Resident #3 from falling.

Interview with a personal care aide (PCA) on 05/13/26 at 11:03am revealed:
-Resident #3 was unsteady and fell sometimes.
-Resident #3 had a low bed and a fall mat in front of the bed ordered when he was admitted.
-There were no new fall prevention interventions ordered for Resident #3.
-She was not told by management to do anything differently to try to prevent Resident #3 from falling.

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Telephone interview with a MA on 05/13/26 at 11:15am revealed:
-Resident #3 used a wheelchair for mobility.
-Resident #3 was confused and tried to get up by himself.
-On 02/21/26, she found Resident #3 on the floor on his knees, and he was assisted back into his wheelchair.
-Resident #3 had a low bed with a fall mat next to it, a chair alarm, and she tried to watch Resident #3 closely due to his falls.
-She did not notify Resident #3's primary care provider (PCP) of his falls because she was only supposed to notify a PCP if there was an injury.
-She was never instructed by management to do anything differently including increased supervision and there were no additional fall prevention interventions ordered or implemented after any of Resident #3's falls.
-She worked on 03/06/26 when Resident #3 fell to the floor in the living room and was sent to the ER.

Interview with a PCA on 05/13/26 at 12:37pm revealed:
-Resident #3 was confused and had two falls during the day shifts she worked.
-Resident #3 required 2-person assistance with transfers and ambulated in a wheelchair.
-She was not instructed to monitor Resident #3 more closely or do anything for fall prevention management after he fell.
-She tried to round on all the residents every 30 minutes.
-She did not document rounds.

Interview with a PCA on 05/13/26 at 4:13pm revealed:
-He was in a resident's room across from the

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living room on 03/06/26 when another resident told him Resident #3 was lying on the living room floor.
-There was no sound alarming from Resident #3's chair alarm.
-He found Resident #3 lying on the floor.
-He reported the fall to the MA and got Resident #3 back into his wheelchair.
-He knew Resident #3 had fallen multiple times but that was the only time Resident #3 fell while he was working.
-He made rounds on the residents every 2 hours.
-He was not instructed by management to monitor Resident #3 more frequently or implement any other fall prevention interventions for Resident #3 after he fell.

Telephone interview with a PCA on 05/14/26 at 8:40am revealed:
-Resident #3 needed 2-person assistance and could not stand or walk by himself.
-Resident #3 had half rails on his bed and a fall mat.
-Shewas not aware of how many times Resident #3 had fallen.
-She was never instructed by the MAs or management to watch Resident #3 more closely or check on him more often.
-She was never instructed to do anything to try to prevent Resident #3 from falling.
-She completed rounds every 2 hours.
-Resident #3 had a wheelchair alarm to alert staff when Resident #3 was trying to get up on his own, but it was not working when he fell on 03/06/26.

Interview with the Special Care Coordinator (SCC) on 05/14/26 at 9:45am revealed:
-Resident #3 was admitted on 02/17/26 with a history of falls.

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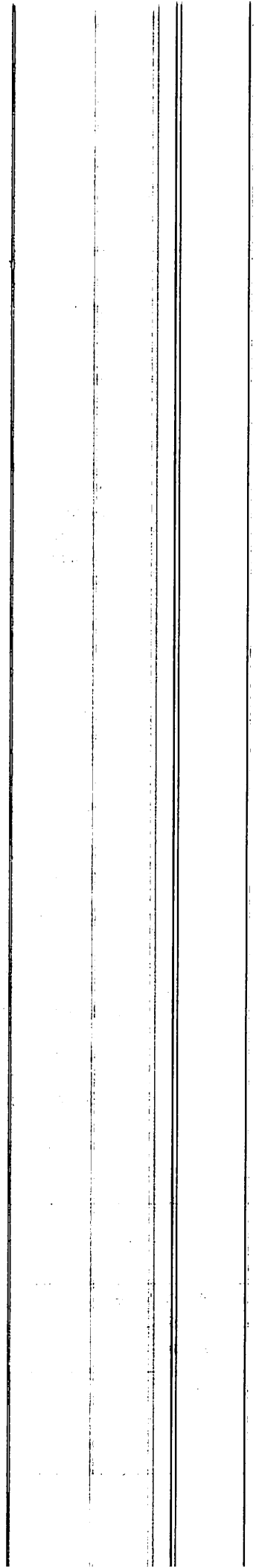
-She documented all the fall prevention interventions that were ordered on admission to the facility including Resident #3 required 2-person assistance with transfers, needed assistance with getting to the toilet, needed extensive assistance in the shower, had a wheelchair, low bed, bed alarm, fall pad, and a urinal near his bed.
-There was nothing else that could be ordered for fall prevention except the use of restraints.
-The MAs did not notify Resident #3's PCP after Resident #3 experienced a fall because she would notify the PCP when she visited the facility "more than monthly".
-She did not document all notifications to Resident #3's HCPOA or the PCP when she visited the facility because she was "just one person" and she did not have time to document everything because "that's all I would ever do".
-She did not ask Resident #3's PCP for other fall prevention intervention orders because there was nothing else that could be ordered.
-She did not complete a fall assessment after each of Resident #3's falls but she did notify Resident #3's HCPOA and PCP that there was a fall.
-She did not complete an assessment on Resident #3 after each fall because Resident #3 had no injuries.
-She did not instruct staff to implement any other fall prevention interventions for Resident #3.

Telephone interview with Resident #3's HCPOA on 05/14/26 at 1:39pm revealed:
-Resident #3 was admitted to the facility with a history of falls and diagnosis of dementia.
-Resident #3 used a wheelchair for mobility and had an alarm on the chair that was supposed to sound when he tried to get up on his own.
-She was notified by the facility of about 10 falls

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D 270	Continued From page 8 Resident #3 experienced while residing at the facility. -Resident #3 fell on 03/06/26 and the facility staff notified her about the fall and said they thought Resident #3 hurt himself, so they sent him to the ER to be evaluated. -The facility staff notified her when Resident #3 fell but did not tell her if they were trying to do anything differently to prevent falls. Interview with the Administrator on 05/14/26 at 9:56am revealed: -She knew Resident #3 used a wheelchair for mobility and was a fall risk when he was admitted to the facility. -She was not aware Resident #3 fell six times within a 3-week span. -She expected the MAs to complete an Incident and Accident Report when a resident fell and notify the resident's HCPOA or responsible person. -According to the facility's fall policy, fall assessments should be completed by the SCC each time a resident fell and documented on a fall assessment form. -She was not aware the SCC did not complete fall assessments for each of Resident #3's falls. -She expected the SCC to complete a fall assessment when a resident fell, document the assessment, notify the PCP and ask to see if any additional fall prevention interventions could be ordered for fall management. Attempted telephone interview with Resident #3's PCP on 05/13/26 at 3:13pm was unsuccessful. The facility failed to provide supervision to minimize additional falls for Resident #3, who experienced at least 6 documented falls from 02/19/26-03/06/26 with no additional fall	D 270	The process and procedure for recording and assessing fall status to be reviewed and updated. ED and Administrator with Health Services Supervisor will complete. Fall assessment form to be completed at admission and quarterly by care coordinators. Information from accident reports will be utilized by Health Services Supervisor to implement intervention(s).Notes will be made in Chart notes for review by RCC. Dots on room name-plate will identify residents at risk from falls; and staff will complete on-line Fels class on Fall Prevention. Administrator will regularly oversee process.	6/28/2026



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D 270	Continued From page 9 prevention interventions put into place. This failure was detrimental to the health, safety, and welfare of Resident #3 and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/14/26. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 28, 2026.	D 270		
D 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews, the facility failed to respond immediately when 1 of 2 sampled residents (Resident #4) needed immediate care and intervention for a medical emergency when the resident required additional assistance with getting out of his bed, found it	D 271		

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difficult to remain sitting upright and required additional staff in order to transfer to a wheelchair.

The findings are:

Review of the facility's 2015 Medical Care Policy revealed:
-The shift supervisor and the shift medication aide (MA) are responsible for seeking immediate medical attention and recording actions taken in the nurses' notes and for notifying care coordinators, family and Administrator.
-A neurological condition (numbness or weakness, inability to walk, change in level of consciousness, difficult to arouse, change in speech) was a condition necessitating implementation of the Medical Care Policy.

Review of the facility's undated Code Blue: Medical Emergency policy revealed:
-Staff should respond immediately.
-Staff should assess the resident's condition.
-If the resident appears to be in crisis, call 911 immediately.
-Document in the resident's medical chart a brief note about the event.

Review of Resident #4's FL2 dated 05/08/25 revealed:
-Diagnoses include dementia, anxiety, coronary artery disease and hypertension.
-He was intermittently disoriented.
-He was semi-ambulatory with the use of a wheelchair.
-The recommended level of care was special care unit (SCU).

Review of Resident #4's care plan dated 01/13/26 revealed:

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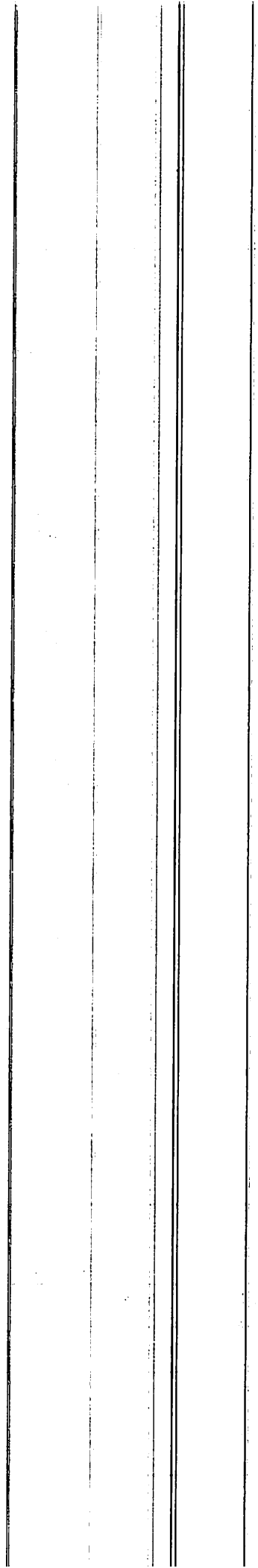
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-He was ambulatory with the use of a wheelchair.
-He was sometimes forgetful and needed reminders.
-He required extensive assistance with bathing and dressing.
-He required one person to assist with transfers.

Review of Resident #4's Licensed Health Professional Support Evaluation dated 12/22/25 revealed he needed the assistance from one staff member for transfers to a wheelchair.

Interview with a third shift personal care aide (PCA) on 03/17/26 at 2:16pm, 04/21/26 at 2:08pm and 05/14/26 at 8:30am revealed:
-She was working as a PCA on third shift on 03/14/26 when she attempted to get Resident #4 up and dressed at about 5:30am when she noticed he could not follow her commands.
-He usually was able to dress himself with assistance and that morning he was lethargic and unable to dress himself.
-She requested assistance from another PCA.
-Even with the help from the other PCA, he kept falling back onto the bed as they tried to move him to the wheelchair.
-She and the other PCA had to pick up Resident #4 and place him in his wheelchair where he continued to be lethargic and stare blankly.
-She called the third shift MA supervisor at 6:06am, who was working on the Assisted Living (AL) side of the building, to report her concern; that he was not waking up, not responding as usual and was demonstrating stroke-like behaviors with lip sagging.
-The MA supervisor told her she would get there when she could.
-The MA Supervisor did not come to the SCU until after 6:30am and rather than checking on Resident #4 at that time she started administering



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medications at the opposite end of the hall from Resident #4's room.
-She left the facility on 03/14/26 about 7:00am.

Review of a screenshot from a personal care aide's (PCA) cell phone dated 03/14/26 at 6:06am revealed a 39-second telephone call was made to a the MA Supervisor.

Telephone interview with a first shift PCA on 03/17/26 at 2:30pm and on 05/14/26 at 9:43am revealed:
-She arrived at work at 7:30am and went to get Resident #4 from his room and noticed he was sitting in his wheelchair with his head down.
-Resident #4 was not responding when she rolled him into the dining room for breakfast.
-She told the facility supervisor that "something was not right".
-The facility supervisor and the cook attempted to speak with him, but he was staring off, gazing and appeared to be "not there."
-She asked the third shift MA supervisor to check on him and she replied, "I don't know what you want me to do."
-The third shift MA supervisor told her she was busy and would be there when she could.
-When the third shift MA supervisor came, she checked Resident #4's vitals and oxygen saturation level but she did not check his temperature and told her Resident #4 was "fine" and slammed the door when she left the dining room.
-She moved Resident #4 from the dining room to the hallway and she and the facility supervisor continued to monitor him.
-Resident #4 continued to sit slumped over while he was in his wheelchair.
-The facility supervisor asked the third shift MA Supervisor to come check Resident #4 again and

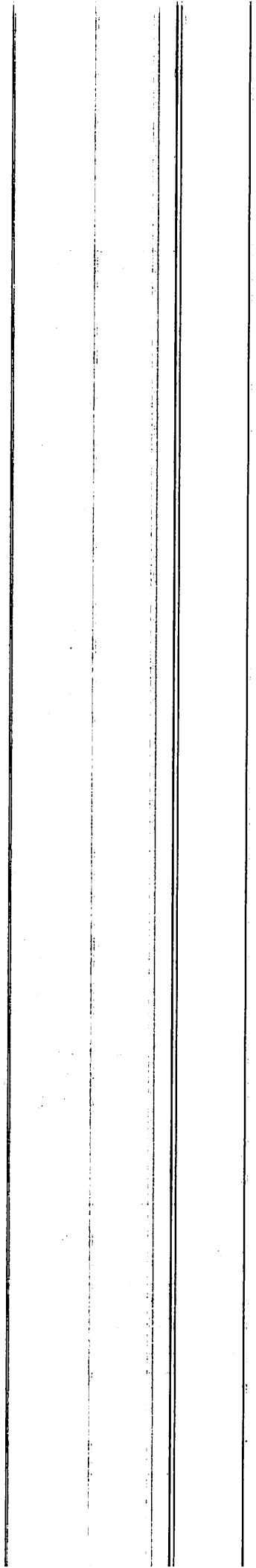
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she never came.
-The first shift MA supervisor came to work about 9:30am and was asked to check on Resident #4.
-The first shift MA supervisor told her she could check Resident #4's vital signs because she was both a PCA and a MA.
-She took Resident #4's vital signs, determined they were not good, so she pushed Resident #4 in his wheelchair to the first shift MA supervisor who took his vital signs again and together they decided to call 911 and send him out.
-She learned later that morning that a third shift PCA had also noticed Resident #4 was not acting like himself and had requested he be checked by the third shift MA supervisor.

Telephone interview with the Facility Supervisor on 3/27/26 at 11:53am revealed:
-She usually worked 7:00am to 4:00pm.
-When she came to work that day, it was not reported to her that Resident #4 was having any medical problems.
-When Resident #4 was brought to the dining room for breakfast she noticed he was not acting like himself, was looking off in the distance, would not respond to staff and would not eat his breakfast or drink his coffee.
-She asked the third shift MA Supervisor to come check on him and she arrived about 10 minutes later.
-When the third shift MA Supervisor checked his blood pressure and oxygen saturation level she said, "They are better than mine."
-She took Resident #4 to the hallway so she could contine to monitor him.
-She and the first shift PCA asked the third shift MA Supervisor to check on him again, but she never came.
-The first shift MA Supervisor arrived for her shift, so she asked her to check on him, which she did.



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-The vital signs were not reported to her but Resident #4 was given a glass of water, which he drank and she and the first shift PCA monitored him in the hallway.
-The first shift PCA noticed Resident #4 slump over in his wheelchair, so she asked the first shift MA Supervisor to check him again and at that time it was decided to call 911.
-MAs and MA Supervisors were the only staff who were allowed to decide if a resident should be sent to the hospital.

Interview with a cook on 03/27/26 at 12:15pm revealed:
-Resident #4 was not acting normal when he was brought to the dining room for breakfast on 03/14/26.
-He was not talking, had a blank stare, his mouth was drooping and he was drooling.
-A third shift MA Supervisor was called to check on Resident #4, and he saw her take his vital signs but not his temperature and then she returned to the AL side of the facility.
-He sat at the table along with other staff to monitor him.

Interview with a third shift MA Supervisor on 04/16/26 at 9:30am revealed:
-The first time she was made aware of Resident's #4's medical condition was at 8:00am when she was asked to go to the SCU dining room and check Resident #4's vital signs.
-She checked his blood pressure, oxygen saturation level and his heart rate and "they were all within normal limits".
-She did not think Resident #4 was having any medical emergency because his vital signs were normal.
-She did not think it was necessary to place Resident #4 on 30-minute checks to monitor his

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condition.
-MAs were the ones to decide if a resident should be sent to the emergency room for evaluation.

Interview with a first shift MA Supervisor on 03/17/26 at 11:00am and 05/13/26 at 3:36pm revealed:
-She was on her way to work on 03/14/26 at about 8:00am when a first shift PCA called her to report Resident #4 needed to be checked on as soon as she got to work.
-She was told Resident #4 was lethargic and not responding to staff as usual.
-When she first got to work the third shift MA Supervisor told her Resident #4 needed to be checked saying "you are now on shift and he is your problem".
-She requested the first shift PCA check his vital signs because she was also a MA.
-The PCA informed her Resident #4's oxygen saturation was 89 and his heart rate was 125.
-She gave Resident #4 a glass of water and he drank it, so she continued to pass the morning medications and had the PCA continue to watch him.
-She decided to call 911 thirty or forty minutes later when it was reported to her Resident #4's oxygen saturation had decreased to 86 and his heart rate increased to between 150-200.
-She noticed documentation had been added when she checked later on in her shift, but there was no documentation when she arrived for her shift that morning
-She informed the Executive Director/Owner there were no chart notes for her to review initially.
-The Executive Director/Owner told her the third shift MA Supervisor had been busy administering medications and did not have time to check on Resident #4 when the PCA asked her to.

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Review of the facility's video surveillance footage on 03/14/26 revealed:
-At 5:56am a third shift PCA came out of Resident #4's room.
-From 6:06am to 7:45am no one entered or exited Resident #4's room.
-At 6:58am the third shift MA Supervisor entered the room adjacent to Resident #4.
-At 7:33am the first shift PCA arrived for work.
-At 7:45am the first shift PCA took Resident #4 from his room to the dining room.
-At 7:48am Resident #4 was observed to be in the dining room with the cook, the first shift PCA and another PCA around him.
-At 7:53am the third shift MA Supervisor entered the dining room and sat down next to Resident #4 and obtained his pulse, blood pressure and oxygen saturation level but no temperature was observed to be taken.
-At 7:55am the third shift MA Supervisor exited the dining room.
-At 8:08am the Facility Supervisor sat down at the table with Resident #4.
-At 8:25am Resident #4 was taken from the dining room and moved to the SCU hallway.
-From 8:42am to 9:12am Resident #4 was observed to be slumped over in his wheelchair and no one was near him.
-At 9:46am the first shift PCA took his vital signs.
-At 10:34am the first shift MA Supervisor handed the first shift PCA medical equipment to check Resident #4's vital signs.
-At 10:57am Resident #4 was removed from the facility by emergency medical technicians (EMT).

Review of Resident #4's charting notes dated 03/14/26 at 8:30am revealed:
-The note was entered by the third shift MA Supervisor.

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-"This morning with third shift went to get resident up aide reported he was slow to respond to her. I did check his vitals and everything was within normal. I did ask him normal questions like are you ok what's your name and he responded appropriately. I was called again to the dining room and rechecked his vital signs and they were still good, vital signs will be documented. Will continue to monitor."

Review of Resident #4's charting notes dated 03/14/26 at 9:21am revealed:
-The note was entered by the Facility Supervisor.
-"When [Resident #4] was brought into breakfast he didn't seem himself..when spoken to he would stare at you.. I asked the MA to come do a set of vitals and when she came she said they were normal ..he would not eat his breakfast. it was like he did not know what to do..he finally got to where he would say a word or two but then he just stopped talking..it was reported by a third shift PCA when she went to get [Resident #4] up that she had to use a lift and she reported that to the third shift MA Supervisor".

Review of Resident #4's charting notes dated 03/14/26 at 1:33pm revealed:
-The note was entered by the first shift MA Supervisor.
-"When I arrived for my shift it was reported to me that during the night [Resident #4] was lethargic and unresponsive and was unable to get up for breakfast with out using a lift assisted by the aides the staff also report that they reported this to the med aide and nothing was done and no vitals were checked til about 8:00am during breakfast which were reported normal but when I got to my hall around 9:15 I checked on him and he was still very lethargic and was only saying one or two words I checked his vitals (BP[blood

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pressure] 117/62) (HR[heart rate] 121) (O2 [oxygen saturation %] 89%). I pulled him up in his wheelchair because he was slightly slumped over and I got him to drink a full glass of ice water and waited a little while for a recheck around 10am. I rechecked his vitals (BP would not register) (HR 150-200) (O2 87%) and he had started shaking with what looked like convulsions. I dispatched EMS and sent him out. "
-"There were zero notes or vitals about this incident from the night or morning before I arrived".

Review of the 911 call log dated 03/14/26 revealed:
-The 911 call from the facility was received at 10:34am.
-The call was for a 76-year-old male with facial drooping a seizure-like activity.
-Emergency Medical Technicians (EMTs) arrived on the scene at 10:52am.

Telephone interview with an advanced EMT on 04/10/26 at 4:10pm revealed:
-Resident #4 was in his room in a wheelchair and was lethargic when she arrived.
-He was having extremity shaking; arms and hands shaking like a tremor.
-Resident #4 tried to but was unable to answer questions.
-His heart rate was very fast, but he was in normal rhythm.

Telephone interview with a paramedic on 04/10/26 at 3:58pm revealed:
-Resident #4 was slumped in his wheelchair and covered in urine when he arrived.
-Resident #4's vitals were: temperature was 100.4, (normal is 97.7- 99.5) blood pressure was 142/84 (normal is 120/80), heart rate was 145

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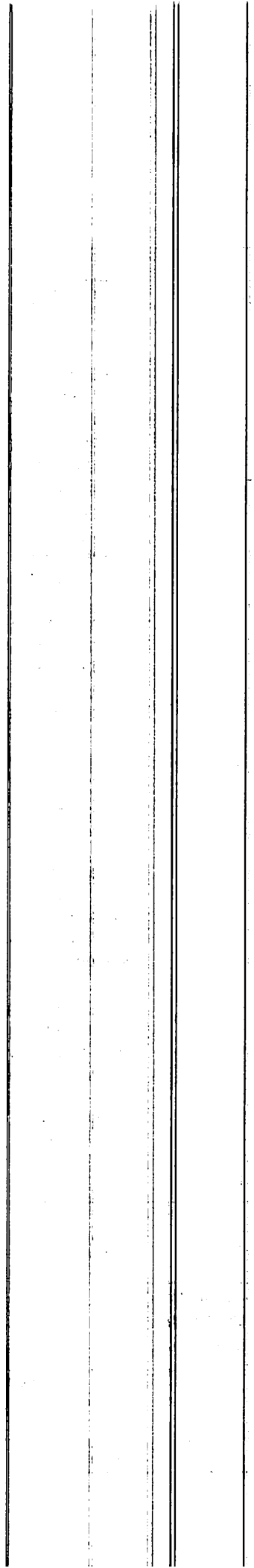
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D 271	Continued From page 19 (normal is 60-100)and respiratory rate was 16 (normal is 12-20). -The vitals fit criteria for adult sepsis (a life-threatening blood infection) protocol. Review of Resident #4's hospital discharge summary dated 03/19/26 revealed: -He was transported to the local hospital via ambulance on 03/14/26. -He was admitted to the hospital for acute metabolic encephalopathy (a change to the brain functions due to an underlying condition that may lead to confusion, memory loss or loss of consciousness), severe sepsis, acute cystitis (bladder infection) and acute kidney injury (sudden decline in kidney function). -He was discharged back to the facility on 03/19/26 at 8:19am. Interview with the Executive Director/Owner on 03/17/26 at 11:46am revealed: -Resident #4 was in the dining room for breakfast on 03/14/26 when he was lethargic and not eating. -The third shift MA Supervisor took Resident #4's vital signs at 8:15am and they were good, but at 9:15am they were taken again and had become irregular, so he was sent to the emergency room. -The decision to send a resident to the emergency room was a decision made between the Facility Supervisor and the MA. -The Facility Supervisor informed her Resident #4 was sent to the hospital. Interview with the Administrator on 03/17/26 at 10:30am, 05/13/26 at 3:06pm and 05/14/26 at 3:12pm revealed: -On 03/14/26 the third shift PCAs reported changes to the third shift MA Supervisor and asked her to check on Resident #4 but she did	D 271		

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D 271	Continued From page 20 not come when she was first contacted. -A MA should check on a Resident immediately when there was a request. -The first shift MA Supervisor was the staff who on 03/14/26 determined it was necessary to call 911 and send Resident #4 to the hospital for evaluation, not the third shift MA Supervisor who was initially told about the concern. -The facility policy stated the Shift Supervisor and MA were responsible for seeking immediate medical attention for a resident when necessary. -The Facility Supervisor, who was the shift supervisor did not know she had the authority to send a Resident out for medical evaluation without the consent of a MA. -The Facility Supervisor was responsible for completing an Accident and Incident Report and she did not know why one was not completed. The facility failed to respond immediately and provide care and intervention to Resident #4 when third shift staff observed he was lethargic and unable to assist with morning activities of daily living and called the third shift MA Supervisor at 6:06am to check on him. Staff assisted Resident #4 with dressing and was taken to the dining room for breakfast and was observed to be slumped over in his wheelchair. The facility dispatched 911 at 10:34am, four hours and 28 minutes after initially observing a change in Resident #4, and he was admitted to the hospital for 5 days and treated for a urinary tract infection, a life-threatening blood infection and metabolic encephalopathy. This failure resulted in neglect and serious physical harm and constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S.131D-34 on May 13, 2026, for this violation.	D 271	D 271 Responsibility for scheduling med-techs and supervisors removed from MA and given to Human Resources. Administrator to review schedules with human resources. Medical Care Policy reviewed and updated. ED and administrator are jointly responsible for ensuring the functionality of the policy. Emergency Procedure Checklist, previous date of 8/25, which was a template first provided by the NC Department of Emergency Mgt, was reviewed. The section on Medical Emergency was updated by Admin and ED. Meetings were held with shift supervisors and med techs to review the Procedure Checklist.	6/13/2026



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D 271	Continued From page 21 THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 13, 2026.	D 271	D 271 CONT. Shift supervisors and med techs provided with Emergency Procedures Booklet, and booklets are placed in all offices.	
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 A1 VIOLATION Based on interviews and record reviews, the facility failed to ensure health care referral and follow-up related to 1 of 5 sampled residents (#8) who slapped a resident multiple times, waking her from sleep, and who placed a pillow over the face of another resident who was sleeping. The findings are: Review of Resident #8's current FL2 dated 02/25/26 revealed: -Diagnoses included bipolar disorder, morbid obesity, diabetes, and cirrhosis. -She was ambulatory with intermittent disorientation. -She had "self-inflicted wounds" and "excessive picking at self-inflicted wounds." Review of Resident #8's Resident Register revealed an admission date of 07/18/22. Review of Resident #8's current plan of care dated 02/17/26 revealed:	D 273		6/13/2026

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-She was independent with transfers and ambulation.
-She received daily "wound care to arm" that "resident picks open."

Interview with a resident on 05/13/26 at 11:19am revealed:
-A resident had confided in him that her roommate (Resident #8) placed a pillow over her face two nights earlier and tried to smother her.
-He was very upset and worried that Resident #8 may try to hurt the other resident again.
-He was also concerned Resident #8 may try to hurt other residents.

Interview with a resident on 05/13/26 at 11:45am and 3:35pm revealed:
-She was asleep on her back two nights ago when she became unable to breathe.
-She felt something over her face and began pushing it away.
-When she pushed the item away, she saw that it was a pillow that her roommate had been holding down over her face.
-It was around midnight and she did not want to tell anyone about it until the next morning because she did not want her roommate to know that she was reporting her to staff.
-She asked the Administrator if she could be moved to another room because she was scared to stay in the same room with Resident #8.
-She was scared to sleep in the same room with Resident #8 the night of 05/12/26 and she did not sleep well.

Interview with the personal care aide (PCA) Supervisor on 05/13/26 at 12:36pm revealed:
-Around 6:00am on 05/12/26, Resident #8's roommate reported to her that Resident #8 had taken a pillow and placed it over her face during

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the night.
-She did not contact the responsible party (RP), primary care provider (PCP) or mental health provider (MHP).
-She did not direct the medication aide (MA) to contact the RP, PCP or MHP.

Interview with a resident on 05/13/26 at 4:15p revealed:
-She and Resident #8 used to be roommates back in December 2025.
-She was asleep one night in December 2025 when she was awakened by Resident #8 slapping her in the face multiple times.
-She asked Resident #8 what she was doing and Resident #8 replied "none of your business."
-She reported Resident #8 to the Special Care Coordinator (SCC) the next morning, but nothing was done.
-She reported it to the Executive Director (ED)/Owner who told her that she would "take care of it."
-She went back to the ED/Owner and requested that Resident #8 be moved to another room.
-The ED/Owner made the arrangements and Resident #8 was moved out of her room.

Telephone interview with a MA on 05/14/26 at 8:04am revealed:
-A PCA came to the Special Care Unit (SCU) where she was administering morning medications a few nights before to tell her that Resident #8 had placed a pillow over her roommate's face during the night.
-She went to the Assisted Living (AL) to make sure that the resident was okay.
-She did not know what the protocol was because she was fairly new.
-She did not contact the RP, PCP, or MHP.
-She had planned to make a chart note about it,

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but she got busy and forgot to make the chart note.
-When she came back to work that evening, the ED/Owner called and asked what had happened.
-When she told the ED/Owner what had been reported to her, the ED/Owner told her to put the two residents involved on thirty-minute checks.
-She placed a thirty-minute check list on the exterior door of the room for Resident #8 and her roommate.
-She and the two PCAs that were working checked on them every thirty minutes during the night.
-They slept with their door open, so it was easy to see if anything was going on that should not have been.

Telephone interview with a PCA on 05/14/26 at 8:25am revealed:
-Two or three days ago, the PCA Supervisor asked if she knew what happened between Resident #8 and her roommate.
-She did not know Resident #8 had placed a pillow over her roommate's face during the night.

Telephone interview with the Mental Health (MH) Clinical Assessor on 05/14/26 at 9:00am revealed:
-He was contacted on 05/13/26 by the SCC at the facility to perform a crisis assessment for Resident #8 after she had placed a pillow over her roommate's face.
-Resident #8 had not been seen for the incident that occurred in December 2025 when she slapped her roommate multiple times while her roommate was trying to sleep.

Interview with the SCC on 05/14/26 at 9:55am revealed she never had a resident tell her that Resident #8 had been physically abusive to them.

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D 273	Continued From page 25 Interview with the Administrator on 05/14/26 at 2:25pm revealed: -She was unaware until 05/13/26 that Resident #8 had slapped her previous roommate multiple times and had placed a pillow over her roommate's face on 05/12/26. -She contacted the SCC to ask if she was notified about the incidents that had occurred and the SCC denied being notified by staff for either incident. -She and the SCC contacted the local police department, RP, PCP, and MHP on 05/13/26 after they found out about the incidents with Resident #8 and the other residents. Interview with the ED/Owner on 05/14/26 at 3:58pm revealed: -She was aware that Resident #8 had been stealing a previous roommate's snacks and that Resident #8 had slapped the previous roommate. -She separated the two residents into different rooms with new roommates. -There was not an incident/accident report completed on the incident between Resident #8 and her previous roommate. Attempted telephone interviews with Resident #8's PCP on 05/13/26 at 3:13pm and 05/14/26 at 7:40am were unsuccessful. The facility failed to ensure referral and follow-up with the PCP or MHP for a resident that slapped another resident multiple times and placed a pillow over the face of another resident while she was sleeping which resulted in both residents being fearful of the resident that assaulted them and the resident not being transported to the hospital for a psychiatric evaluation. This failure resulted in neglect of the residents and	D 273	IDR requested. Emergency Policy reviewed and updated by ED and administrator. Emergency Procedure Checklist, previous revision 8/25, reviewed and updated. Section 19 on Workplace Violence updated with instructions for handling resident-on-resident violence. Meetings held with shift supervisors and med techs with review of regulations Administrator, HR and Health Services Supervisor will ensure ongoing training of supervisors and med techs.	6/13/2026

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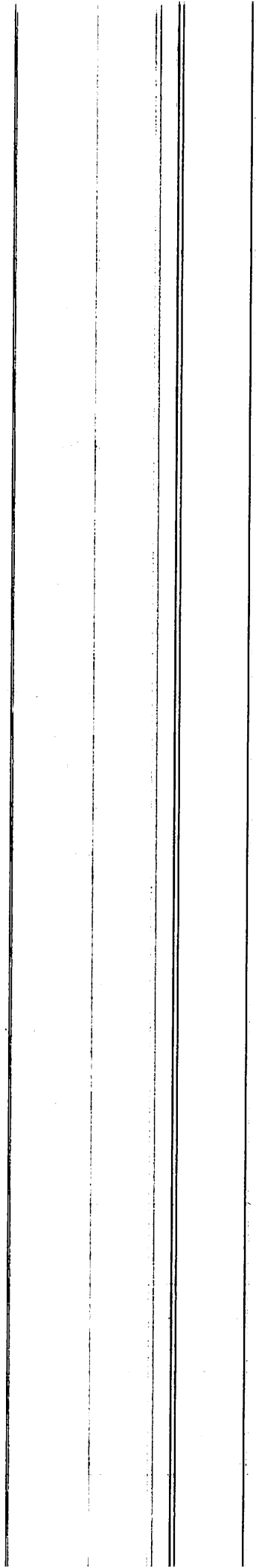
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D 273	Continued From page 26 constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S.131D-34 on May 13, 2026, for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 13, 2026.	D 273		
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: Based on interviews the facility failed to maintain confidentiality related to protected health information (PHI) in accordance with the Health Insurance Portability and Accountability Act (HIPAA). The findings are: Interview with a resident's family member on 05/14/26 at 1:45pm revealed: -She thought the facility staff were sharing the resident's PHI with other family members instead of the resident's Health Care Power of Attorney (HCPOA). -Another family member called her and told her information about the resident that she knew the HCPOA did not know. -She asked how she found out the information and the other family member told her the Special	D 338	D 338 Aide responsible for failures to maintain confidentiality given a six-month Performance Improvement Plan with additional reports of such errors to result in termination. Administrator and ED to meet with employee monthly on this issue if no other errors are reported. All med-techs and shift supervisors will be required to re-take online class on HIPAA and privacy. IDR requested	6/28/2026

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D 338	Continued From page 27 Care Coordinator (SCC) told her. Interview with a resident on 04/22/26 at 10:54am and 05/13/26 at 11:19am revealed: -He learned PHI about residents by overhearing information as it was discussed by staff in the facility. -There was a medication aide (MA) that shared information with him about the other residents. -About 3 weeks ago, a resident was being taken out of the facility by Emergency Medical Services (EMS) and he asked the MA what happened. -The MA told him the resident had fallen in the bathroom and she was being sent out to the hospital to be checked out. -He was not the resident's Responsible Party (RP) or Power of Attorney (POA). -The MA would also tell him if residents that were sick were improving and when residents passed away. -It would bother him if a staff member shared his PHI with other residents. Interview with the SCC on 05/14/26 at 2:03pm revealed: -She only communicated a resident's health information with whomever was listed to be informed whether it was a HCPOA, responsible person, or family member. -She only shared a resident's health information with other family members if the HCPOA said it was okay otherwise she told them they would have to check with the HCPOA. -She did not remember ever sharing the resident's personal health information with anyone except the HCPOA. Interview with a MA on 05/13/26 at 9:53am revealed: -She was aware of one third shift MA who gave	D 338		



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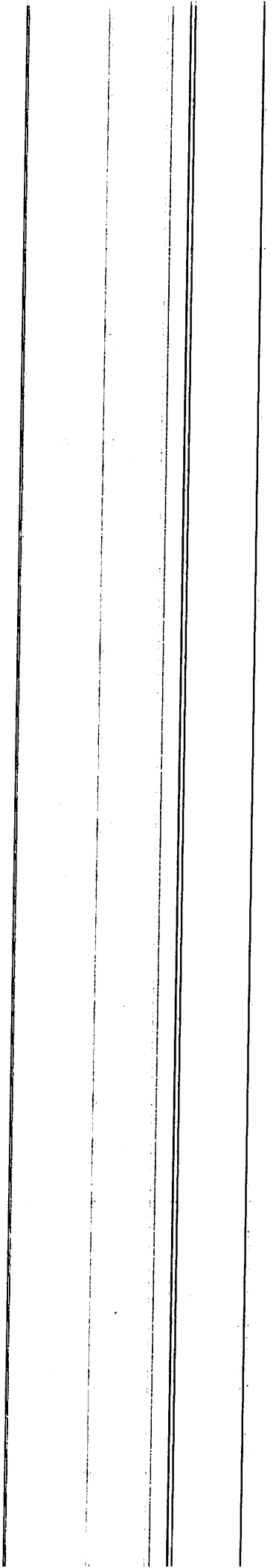
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resident PHI to her family member in January or February 2026.
-She saw a text message from the MA's family member when the MA's phone was opened and active on the desk.
-In a different incident a few months ago, she had a resident during second shift tell her information that he said he learned from the same third shift MA.
-The resident told her the MA gave him the PHI when she was administering his medications.
-She informed the Administrator about the events and was told the Administrator would speak with the Executive Director (ED)/Owner.
-She was present when the Administrator spoke with the MA and the MA did not deny the incidents.
-She also spoke with the ED/Owner about the incidents but the ED/Owner replied "Um, okay" and seemed to"just brushed it off".
-The MA told PCAs information that was not pertinent to their job duties.
-About six weeks ago a different MA called her when she was not at work and told her about a resident who had passed away.
-Staff recently had a refreshed course on HIPAA.

Telephone interview with a personal care aide (PCA) on 05/14/26 at 8:39am revealed:
-Staff were recently instructed by the Resident Care Coordinator (RCC) and the Administrator to not pass on resident's PHI to other employees unless it was pertinent that they know that information to complete their job duties.
-One particular third shift MA was known to "blurt stuff out" and it did not matter what residents or staff were around to hear confidential information.

Telephone interview with another PCA on 04/21/26 at 2:57pm and 05/14/26 at 9:43am



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revealed:
-She overheard a telephone conversation that was on speakerphone when a family member who did not work at the facility called another family member and reported PHI.
-Some staff told residents information that should be private.
-One particular resident "somehow knows everything" and said a third shift MA would give him information.
-The ED/Owner had been trying to "fix" the problem and staff recently had a training on HIPAA.

Interview with a third shift MA on 04/16/26 at 10:00am revealed:
-The importance of HIPAA was stressed at the facility.
- Information was discussed by MAs at the medication cart.
-She "typically would not tell" anyone outside of the facility any PHI.
-She did not know how her family member knew information about a resident when she did not work at the facility.
-Her family member was also in the medical field and knew the imprtance of keeping PHI confidential.

Interview with another MA on 05/13/26 at 9:50am revealed:
-One of the residents in the facility had knowledge about other residents' health conditions.
-He would tell her information about other residents that he should not be aware of.
-He recently told the MA that they needed to pray for another resident because the resident was in kidney failure.
-When she asked how he knew this information,

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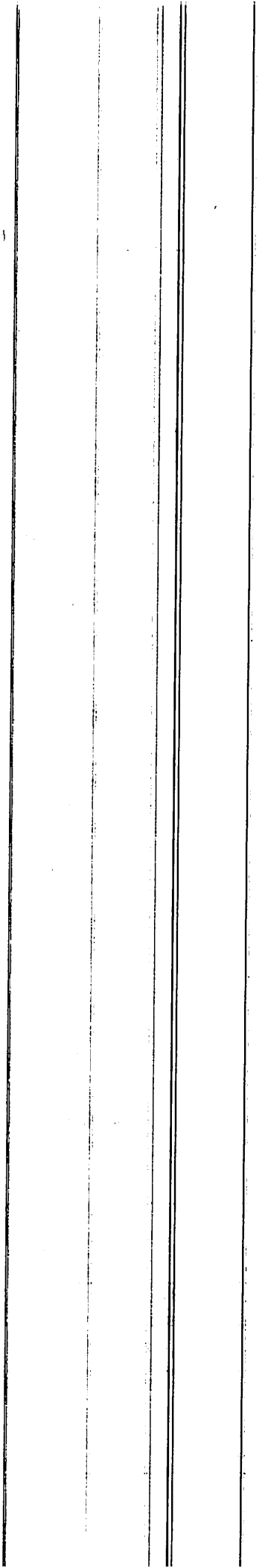
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he told her another MA told him what was going on with this resident and others when she brought his medications to him every morning.

Interview with the Maintenance Director on 05/13/26 at 10:40am revealed:
-Recently, when he was on vacation, a family member called him to ask if a resident had passed away at the facility from choking.
-He told the family member he was not at work and did not know what had happened but would not be able to discuss it with her if he did.
-He asked the family member where the information she shared with him came from.
-The family member indicated a MA from the facility had called her to tell her what happened.
-He called the MA and told her she should not be sharing resident's PHI with people outside the facility.
-The MA told him "it just slipped" regarding the resident's PHI she had shared.
-He had taken the HIPAA training and knew not to share residents' PHI.

Interview with the facility's Human Resources Director on 04/22/26 at 11:34am revealed:
-New employees received an employee handbook and included with that was a copy of the Declaration of Resident's Rights.
-Staff signed a confidentiality statement upon hire.
-She had documentation the third shift MA who was reported to disclose PHI inappropriately signed the confidentiality statement on 08/20/2014.
-It was not reported to her that staff were talking to people that did not work at the facility about resident information.

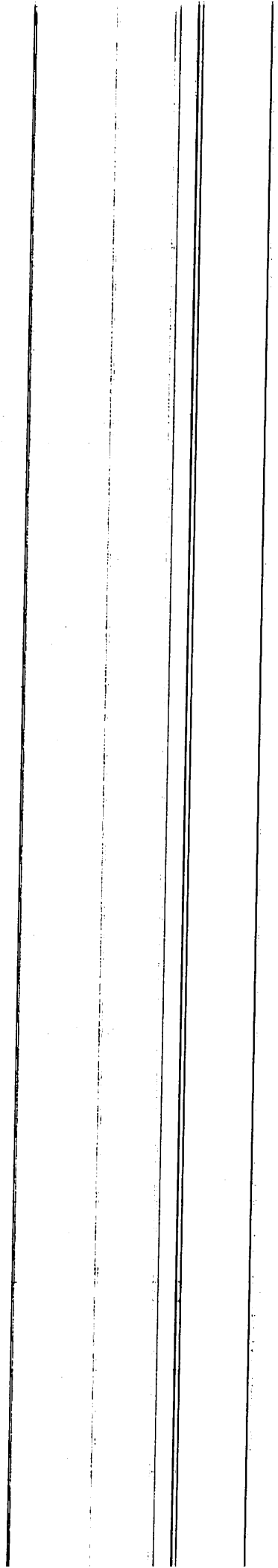
Interview with the ED/Owner on 05/14/26 at



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D 338	Continued From page 31 3:57pm revealed: -The facility staff received HIPAA training upon hire and annually. -Staff should not share any PHI with anyone except who was listed as the resident's responsible person, HCPOA, or guardian and other co-workers if the information was needed to provide care to a resident. -She heard some PHI was shared 2-3 months ago so a staff meeting was held for the MAs and supervisors to reiterate that resident's PHI was not to be shared with others that were not approved to get the information. -If staff did not comply with HIPAA, they would be given a verbal warning, secondly a written warning, and termination for a third offense. -It was hard to find qualified people to work at the facility so she could not "fire them" and that was why the staff meeting was held to remind supervisors to "keep their mouth shut". -She heard the MA supervisor told her family member, who was not employed at the facility, about a resident who died and the MA supervisor's family member called another staff member while they were on vacation and informed them about the resident. -She expected staff to follow the HIPAA law and not share residents' PHI. Interview with the Administrator on 03/27/26 at 10:30am, 04/22/26 at 9:30am, 05/13/26 at 3:06pm and 05/14/26 at 2:26pm revealed: -She was recently told about a residents passing by a staff member that was on vacation. -She learned that an employee's family member, who was not a facility employee, was told resident's PHI by another employee. -Staff were trained to not give any PHI out to family members unless that family member was on the approved list completed at admission.	D 338		



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D 338	Continued From page 32 -The facility used an on-line training module for staff HIPAA training. -The facility did not have a HIPAA policy but all staff received an employee handbook upon hire and they signed a confidentiality statement. -She expected staff to keep residents PHI confidential. -Staff should not be sharing with their family members, other residents, friends, or even other staff members if it was not pertinent information they needed to know.	D 338		

