STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099018	A. BUILDING: _____ B. WING _____	07/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATRIOT LIVING OF YADKINVILLE	409 HARRISON AVENUE YADKINVILLE, NC 27055

(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 and Yadkin County Department of Social Services conducted an annual survey and a complaint investigation from 07/07/26 to 07/09/26. The complaint investigation was initiated by the Yadkin County Department of Social Services on 06/26/26.	D 000		
D 033	10A NCAC 13F .0302 (e) Design And Construction 10A NCAC 13F .0302 Design And Construction (e) The facility shall maintain in the facility and have available for review current sanitation and fire safety inspection reports. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure sanitation inspection reports were current, maintained in the facility and were available for review. The findings are: Review of the facility's current license effective 01/01/26 revealed: -The capacity was 50. -The license would expire on 12/31/26. Review of the facility's Food Establishment Inspection Report revealed the last report on file was dated 03/13/25.	D 033		

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D 033	Continued From page 1 Telephone interview with the Environmental Health Specialist on 07/09/26 at 11:33am revealed: -The facility's last sanitation inspections were conducted on 03/13/25. -There was a note entered into their records from 07/07/26 that stated someone from the facility contacted him about an inspection for the Food Establishment section of the facility. -Sanitation inspections were required to be conducted annually in the kitchen and residential area for facilities. -Inspections were done to ensure cleanliness and ensure people were not living in unsanitary conditions. Interview with the Dietary Manager (DM) 07/07/26 at 11:46am revealed: -He had been the facility DM previously but had returned recently to the DM position within the last 2 weeks. -He knew the Food Establishment Inspection Report was outdated and out of compliance. -He was not aware if the Administrator knew the Inspection Report was out of compliance and he had not told her. -The Administrator was responsible for contacting the Environmental Health Specialist to schedule the kitchen inspections. Interview with the Administrator on 07/07/26 at 11:50am revealed: -She was aware there was no current Food Establishment sanitation inspection for the facility. -She had not communicated with the Environmental Health Specialist about the Food Establishment Inspection Report since May 2026. -The Administrator was responsible for ensuring for sanitation inspections were completed when	D 033		

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D 033	Continued From page 2 they were needed.	D 033		
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 by providing a discharge notice to 1 of 3 sampled residents (#3) who was discharged to another facility. The findings are: Review of Resident #3's FL2 dated 05/20/26 revealed: -Diagnosis included idiopathic progressive neuropathy, hyperlipidemia, gastro-esophageal	D 226		

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D 226	Continued From page 3	D 226		

reflux disease (GERD), atherosclerotic heart disease, lumbago with sciatica, kidney disease, and major depressive disorder.
-Recommended level of care was documented as domiciliary (rest home).

Review of Resident #3's Resident Register revealed:
-He was admitted to the facility on 05/21/26.
-He did not have a Power of Attorney (POA) or Responsible Party (RP).
-The notice of discharge date was documented as 06/15/26 under the discharge section.
-The discharge was initiated by the Administrator and the reason for discharge was not documented.
-The discharge was dated 06/15/26 and the Administrator had not signed the discharge section.

Telephone interview with Resident #3 on 07/08/26 at 9:30am revealed:
-He was admitted to the facility on 05/21/26.
-He was responsible for himself and did not have a guardian or POA.
-The Administrator told him on 6/14/26 he would be moved to another facility on 06/15/26.
-He had not requested a transfer to another facility and had told the Administrator he did not want to move to another facility.
-He was discharged from the facility on 06/15/26 and was given a one-day notice.
-He did not receive discharge paperwork on the day of discharge.

Interview with the Administrator on 07/09/26 at 8:45am revealed:
-She informed Resident #3 on 6/14/26 he would be moved to another facility on 6/15/26.
-She had not completed a notice of discharge for

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D 226	Continued From page 4 Resident #3 because it was a resident-initiated discharge. -She would not have provided a 30-day written notice of discharge when a resident requested a move-out or discharge. -She was responsible for resident discharges and discharge paperwork.	D 226		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 2 of 5 sampled residents (#2, #6) had completed tuberculosis (TB) testing upon admission. The findings are: 1. Review of Resident #2's FL2 dated 06/04/26 revealed diagnoses included mechanical heart valve and vascular dementia. Review of Resident #2's Resident Register	D 234		

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D 234	Continued From page 5 revealed the resident was admitted to the facility 02/20/24. Review of Resident #2s immunization records revealed: -There was documentation a chest X-ray was completed on 02/14/24 with negative for TB documented. -There was no documentation of a positive TB skin test. -There was additional documentation for TB testing available for Resident #2. Interview with Resident #6 on 07/09/26 at 3:30pm revealed he did not remember if he had a two-step TB skin test completed after being admitted to the facility. Interview with the Administrator on 07/09/26 at 4:30pm revealed she did not know why Resident #2's TB skin test was not completed and available for review. Attempted interview with the Resident Care Coordinator (RCC) on 07/09/26 at 4:00pm was unsuccessful. Refer to the interview with the Administrator on 07/09/26 at 4:30pm. 2. Review of Resident #6's current FL2 dated 01/20/26 revealed diagnoses included schizophrenia. Review of Resident #6's resident register revealed an admission date of 02/18/26. Review of Resident #6's immunization records revealed: -There was no documentation of a negative TB skin test.	D 234		

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D 234	Continued From page 6 -There was no documentation of a positive TB skin test. Interview with Resident #6 on 07/09/26 at 11:30am revealed he did not remember if he had a two-step TB skin test completed after being admitted to the facility. Interview with the Administrator on 07/09/26 at 4:30pm revealed she did not know why Resident #6's TB skin test was not completed and available for review. Refer to the interview with the Administrator on 07/09/26 at 4:30pm. Attempted interview with the Resident Care Coordinator (RCC) on 07/09/26 at 4:00pm was unsuccessful. _____ Interview with the Administrator on 07/09/26 at 4:30pm revealed: -All residents must have a completed skin test prior to admission. -She was responsible for ensuring TB skin tests were completed upon residents' admissions to the facility and the RCC completed the new resident documentation.	D 234		
D 306	10A NCAC 13F .0904(d)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (4) Water shall be served to each resident at each meal, in addition to other beverages.	D 306		

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This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure water was served at each meal for 24 of 36 assisted living (AL) residents in addition to other beverages.

The findings are:

Observation of the lunch meal service on 07/07/26 for the AL dining room between 12:20pm and 1:00pm revealed:
-There were 36 residents present for the lunch meal service.
-The beverages were served by the personal care aides (PCA) from a beverage cart.
-Beverages included lemonade, milk, tea, and water.
-The PCAs poured lemonade and tea for all the residents and offered water or milk to each resident.
-Twelve residents were served water and all the other residents were served other beverages.
-No other residents were served water.

Observation of the breakfast meal service on 07/08/26 for the AL dining room between 7:20am and 8:00am revealed:
-There were 32 residents present for the breakfast meal service.
-The beverages were served by the PCAs from a beverage cart.
-Beverages included juice, milk, tea, coffee, and water.
-The PCAs poured juice and tea for all the residents and offered water or milk to each

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resident.
-Thirteen residents were served water and all the other residents were served other beverages.
-No other residents were served water.

Interview with a resident on 07/08/26 at 7:45am:
-Beverages served with meals usually included coffee, juice, and tea.
-If he wanted water with his meals, he had to ask for it.
-He would drink water with every meal if it was served to him with each meal.

Interview with a second resident on 07/08/26 at 7:50am revealed:
-Residents were offered water with each meal.
-He would drink water with his meals if it was served to him.
-He drank what was served to him and did not ask for water.

Interview with a PCA on 07/08/26 at 7:55am revealed:
-She assisted in the AL dining room during meals.
-Water was offered to all residents.
-A few residents were served water, but the other residents were served a mixture of other beverages.
-She was aware water should have been served to all residents with each meal, but she offered water because some of the AL residents refused to drink the water.

Interview with a second PCA on 07/08/26 at 7:58am revealed:
-She assisted in the AL dining room during meals.
-The PCA served the residents beverages from the beverage cart.
-A few residents were served water, but the other residents were served tea and juice.

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D 306	Continued From page 9 -She did not know water should have been served to all residents with each meal. Interview with a cook on 07/08/26 at 8:02am revealed: -Beverages were prepared and placed on a beverage cart by the PCAs before mealtimes. -Water was always available as a beverage for the AL residents. -The PCAs were responsible for serving beverages to the AL residents from the beverage cart. -He was not aware water was not served with the lunch meal service on 07/07/26 for 24 residents or with the breakfast meal service on 07/08/26 for 19 residents. -He was not aware water should have been served to all residents with each meal and thought it was optional for the residents. Interview with the Dietary Manager (DM) on 07/09/26 at 8:09am revealed: -He was aware water should have been served daily to all AL residents with each meal. -Beverages were prepared by the dietary staff on beverage trays and served by the PCAs at every meal. -Water was always available as a beverage for the AL residents. -He was not aware water was not served with the lunch meal service on 07/07/26 for 24 residents or with the breakfast meal service on 07/08/26 for 19 residents. -he expected water to be served to the AL residents during every meal according to nutritional requirements. Interview with the Administrator on 07/09/26 at 4:30pm revealed: -She did not know the AL residents were not	D 306		

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D 306	Continued From page 10 served water with each meal. -She knew residents were to be served water daily with each meal. -There should be no issues for AL residents to be served water during each meal. -She expected water to be served to all residents during every meal.	D 306		
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 record reviews and interviews, the facility failed to ensure resident rights were met of 2 of 6 sampled residents (#3, #8) who were restricted from leaving the facility. The findings are: 1. Review of Resident #3's Resident Contract revealed: -Resident #3 signed the Resident Contract on 05/21/2026. -The administrator signed the Resident Contract on 05/21/2026. -There was no documentation that indicated the facility was a secured assisted living unit (SAL). Review of Resident #3's FL-2 dated 05/20/2026 revealed: -Diagnosis included idiopathic progressive neuropathy, hyperlipidemia, gastro-esophageal reflux disease (GERD), atherosclerotic heart	D 338		

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disease, lumbago with sciatica, kidney disease, and major depressive disorder.
-Recommended level of care was documented as domiciliary (rest home).

Review of Resident #3's Resident Register revealed:
-Resident #3 was admitted to the facility on 05/21/2026.
-Resident #3 was responsible for his own decisions and there was no Power of Attorney (POA) or Responsible Party (RP) indicated for Resident #3.
-The notice of discharge date was documented as 06/15/26 under the discharge section and the discharge was dated 06/15/2026.
-The discharge was initiated by the Administrator and the reason for discharge was not documented.

Telephone interview with Resident #3 on 07/08/2026 at 9:30am revealed:
-He was admitted to the facility on 05/21/2026.
-He was responsible for himself and did not have a guardian or POA.
-He was not informed the facility was a SAL and he was restricted from signing out of the facility.
-He asked staff to take him to the store on four occasions. Facility staff took him to the store on one occasion.
-The Administrator told him he would be moved to another facility on 06/15/2026 and he was discharged from the facility on 06/15/2026.

Interview with the Administrator on 07/09/2026 at 8:45am revealed:
-Resident #3 was informed that facility was a SAL time of his admission,
-Resident #3 had told her he had not liked the facility and wanted to move to another facility

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because he had requested to out of the facility on numerous occasions.
-Resident #3 had told her he was being held hostage.
-She informed Resident #3 on 6/14/2026 he would be moved to another facility on 6/15/2026.
2. Review of Resident #8's current FL2 dated 11/13/25 revealed:
-Diagnoses included chronic pain syndrome, heart failure, schizophrenia, and bipolar disorder.
-The resident intermittently disoriented, semi-ambulatory with a wheelchair.
-The recommended level of care was domiciliary.

Review of Resident #6's Resident Register revealed:
-He was admitted to the facility on 11/11/2025.
-He was his own responsible person.
-He was forgetful and needed reminders.
-He required assistance with average daily living task of dressing, bathing, nail care, shaving, toileting, grooming, skin care, scheduling appointments, getting in and out of bed and ambulation.
-He had a wheelchair listed as special aide.
-He signed his Resident Register on 11/11/25.

Interview with Resident #8 during the initial facility tour on 07/07/26 at 9:40am revealed:
-Resident #8 questioned why he could not sign out of the facility if he was his own responsible person.
-He had arranged transportation with an outside transportation company that could accommodate his wheelchair, but was not allowed to go on the van when it arrived.
-He did not know the facility was a locked facility when he was admitted.
-Nobody had informed him before admission that he would not be able to sign out of the building to

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D 338	Continued From page 13 go on pre-arranged outings. Review of the facility's current license effective 01/01/26 revealed: -The license would expire on 12/31/26. -The facility was licensed for 50 assisted living beds. -The facility had no Alzheimer's/Dementia Special Care Unit beds. Review of Resident #8's admission packet with facility's policies on house rules and requirements revealed there was no documentation the facility was secured 24 hours hours a day and limited to resident sign-out for going outside the building. Interview the facility's Vice President of Clinical Services (VPCS) on 07/07/26 at 12:10pm revealed: -The facility was a secured assisted living meaning access to and from the building was restricted via a magnetic locking mechanism and key-pad system. -The entry/exit doors were locked by the key-pad system 24 hours a day to restrict residents going outside the building unsupervised. -No resident had the code for unlocking the exit doors. -The family members of one resident had the key code to enter the front door for visits. -The Home Health agencies with residents as patients had the keypad code for facility access. -There was no documentation for the residents or responsible parties(RP) to acknowledge the facility was a secured assisted living facility with keypad entry/exit included in the current admissions packet. -She had created an admission document disclosing the facility's locked assisted living status but none of the residents or RPs had been	D 338		

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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 338	Continued From page 14 asked to sign the form. Second interview with Resident #8 on 07/08/26 at 2:10pm revealed: -He could not sign out to go outside to sit under the canopy. -He felt like he was in lock-down. -There was a van transportation with wheelchair capacity available for a small fee. -He had arranged his transportation recently but was not allowed to go outside to the van when it came. Telephone interview with a representative for the local van transportation company on 07/08/26 at 2:50pm revealed: -The van company was available for transporting to doctor appointments, or other arranged appointments. -The van company was a door-to-door service meaning they would deliver and pick up residents, but were not able to stay with a resident or provide assistance with shopping or other appointment needs. -Resident #8 had come outside the building for pick-up the last time the resident arranged pick-up. -The facility expected the rider to be available for pickup when arranged but did not wait more than a few minutes at the site. Interview with the Administrator on 07/08/26 at 4:50pm revealed: -The Director of Admission was responsible for ensuring residents or RP were informed the facility was a secure assisted living with restricted access and egression. -She was told all residents were informed prior to admission that they were not able to sign out to go outside.	D 338		

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D 338	Continued From page 15 -There were no residents, except Resident #8, that requested to sign out of the building.	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 B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 5 sampled residents (#2, and #4) including one resident with orders for a blood thinner (#2) and a resident with orders for an antibiotic and pain/fever reliever ordered with an emergency department (ED) visit and not administered (#4). The findings are: 1. Review of Resident #2's current FL-2 dated 06/04/26 revealed diagnoses included mechanical heart valve and vascular dementia. Review of Resident #2's Resident Register revealed the resident was admitted to the facility 02/20/24. Interview with Resident #2 on 07/08/26 at 3:50pm	D 358		

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revealed:
-He received his medications from the VA.
-He was seen at the VA clinics for his medical care.
-He had an appointment with his heart physician today (07/08/26) but did not go to the warfarin clinic.
-He had no issues related to bleeding or his warfarin therapy.

Review of Resident #2's signed physician's orders dated 09/25/25 revealed:
-There was an order for warfarin (a blood thinning medication used to treat or prevent blood clots) 3mg on Monday, Wednesday and Friday.
-There was an order for warfarin 6mg on Tuesday, Thursday, Saturday, and Sunday.

Review of Resident #2's laboratory results for International Normalized Ratio (INR) (used to determine coagulation status and necessity for warfarin dose adjustments; the therapeutic range for mechanical heart valve replacement/atrial fibrillation should be between 2.0-3.0) revealed the following:
-On 03/30/26, Resident #2's laboratory results revealed an INR value of 1.3.
-On 04/06/26, Resident #2's laboratory results revealed an INR value of 1.4.
-On 04/13/26, Resident #2's laboratory results revealed an INR value of 1.4.
-On 04/20/26, Resident #2's laboratory results revealed an INR value of 2.4.
-On 04/29/26, Resident #2's laboratory results revealed an INR value of 2.6.
-On 05/11/26, Resident #2's laboratory results revealed an INR value of 1.6.
-On 05/18/26, Resident #2's laboratory results revealed an INR value of 1.8.
-On 06/02/26, Resident #2's laboratory results

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revealed an INR value of 1.2.
-On 06/08/26, Resident #2's laboratory results revealed an INR value of 1.2.
-On 06/15/26, Resident #2's laboratory results revealed an INR value of 1.3.
-On 06/29/26, Resident #2's laboratory results revealed an INR value of 2.4.
-On 07/06/26, Resident #2's laboratory results revealed an INR value of 2.1.

Review of Resident #2's warfarin order dated 03/31/26 revealed:
-There was an order for warfarin 6mg on Monday, Tuesday, Wednesday, Thursday, Saturday, and Sunday.
-There was an order for warfarin 3mg on Friday.

Review of Resident #2's warfarin order with an INR value of 1.4 dated 04/06/26 revealed:
-There was an order for warfarin 6mg on Tuesday, Wednesday, Thursday, Friday, Saturday, and Sunday.
-There was an order for warfarin 9mg on Monday.

Review of Resident #2's warfarin orders dated 04/13/26 (INR value 1.4), 04/20/26 (INR value 2.4) and 04/29/26 (INR value 2.6) revealed:
-There was an order for warfarin 6mg on Tuesday, Thursday, Friday, Saturday, and Sunday.
-There was an order for warfarin 9mg on Monday and Wednesday.

Review of Resident #2's warfarin orders dated 05/11/26 (INR value 1.6) revealed:
-There was an order to continue warfarin 6mg on Tuesday, Thursday, Friday, Saturday, and Sunday and warfarin 9mg on Monday and Wednesday.
-There was an order to take warfarin 3mg to

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D 358	Continued From page 18 equal warfarin 12mg on 05/11/26. Review of Resident #2's warfarin order dated 05/18/26 (INR value 1.8) revealed: -There was an order for warfarin 6mg on Tuesday, Thursday, Saturday, and Sunday. -There was an order to take warfarin 9mg on Monday, Wednesday, and Friday. Review of Resident #2's warfarin orders for June 2026 revealed: -On 06/08/26 (INR value 1.2), there was an order for warfarin 6mg on Tuesday, Thursday, Saturday, and Sunday and warfarin 9mg on Monday and Wednesday. There was an order to take additional warfarin 3mg to equal warfarin 12mg on 06/08/26. -On 06/15/26 (INR value 1.3), there was an order for warfarin 6mg on Tuesday, Thursday, Saturday, and Sunday and warfarin 9mg on Monday, Wednesday and Friday. There was an order to take additional warfarin 3mg to equal warfarin 9mg on Tuesday 06/08/26. -On 06/22/26 (INR value 1.2), there was an order for warfarin 9mg on Monday, Tuesday, Wednesday, Friday and Saturday and warfarin 6mg on Thursday and Sunday. There was an order to take additional warfarin 3mg to equal warfarin 12mg on Monday 06/22/26. Observation of Resident #2's medication on hand for administration revealed there were 40 tablets of a quantity of 70 tablets dispensed on 06/30/26 remaining in a bottle from an outside pharmacy. Review Resident #2's April 2026 electronic medication administration record (eMAR) from 04/01/26 to 04/20/26 revealed: -There was an entry for warfarin 6mg on Monday, Tuesday, Wednesday, Thursday, Saturday, and	D 358		

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D 358	Continued From page 19 Sunday scheduled for administration at 3:00pm documented as administered from 04/01/26 to 04/20/26. -There was an entry for warfarin 3mg on Friday scheduled for administration at 3:00pm documented from 04/01/26 to 04/20/26. -On Mondays 04/06/26, and 04/13/26, Resident #2 had documented administration for warfarin 6mg and should have received 9mg. -On Friday 04/10/26, Resident #2 had documented administration of warfarin 3mg and should have received 6mg. -On Wednesday 04/15/26, Resident #2 had documented administration of warfarin 6mg and should have received 9mg. -On Friday 04/17/26, Resident #2 had documented administration of warfarin 3mg and should have received 6mg. -On Monday 04/20/26, Resident #2 had documented administration of warfarin 6mg and should have received 9mg. Review of Resident #1's May 2024 eMAR revealed: -There was an entry for warfarin 6mg take one tablet daily on Tuesday, Thursday, Friday, Saturday, and Sunday, and warfarin 9mg on Monday and Wednesday scheduled for administration at 3:00pm with documentation for administration. -On 05/11/26, Resident #2 had documented administration of warfarin 9mg and should have received 12mg. -On Fridays 05/22/26 and 05/29/26, Resident #2 had documented administration of warfarin 6mg and should have received 9mg. Review of Resident #2's June 2026 eMAR from 06/08/26 to 06/22/26 revealed: -There was an entry for warfarin 9mg Monday,	D 358		

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Wednesday, and Friday and warfarin 6mg on Tuesday, Thursday, Saturday and Sunday scheduled for administration at 6pm daily and documented as administered.
-On 06/08/26, Resident #2 had documented administration of warfarin 9mg and should have received 12mg.
-On Tuesday 06/16/26, Resident #2 had documented administration of warfarin 6mg and should have received 9mg.
-On Tuesday 06/22/26, Resident #2 had documented administration of warfarin 9mg and should have received 12mg.

Review of Resident #2's June 2026 eMAR from 06/22/26 to 06/30/26 and July 2026 eMAR from 07/01/26 to 07/08/26 revealed:
-There was an entry for warfarin 9mg Monday, Wednesday, and Friday and warfarin 6mg on Tuesday, Thursday, Saturday and Sunday scheduled for administration at 5:00pm daily and documented as administered as ordered.

Interview with the Resident Care Coordinator (RCC) on 07/07/26 at 4:00pm revealed:
-A local home health (HH) agency laboratory was responsible for obtaining INR values performed routine blood work.
-The HH laboratory staff obtained the blood work for INR values and relayed information directly to Resident #2's warfarin clinic.
-The pharmacist at the warfarin clinic called her weekly with the changes and INR value, usually toward 5:00pm on INR value day.
-Resident #2's medications, including warfarin, were sent by the Veteran Administration (VA) pharmacy to the resident at the facility's address.
-The warfarin clinic faxed Resident #2's warfarin orders to the facility.
-Since she had been at the facility, the warfarin

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clinic was faxing the orders to the facility's contracted pharmacy for changes to be made to the eMAR if the warfarin dosage changed.
-She did not have a system in place to routinely audit eMARS compared to medication orders for accuracy and completeness.
-She was aware warfarin required close monitoring with changes in dosage related to INR values.
-The facility did not use a warfarin tracking system.
-She did not know Resident #2 had errors in his warfarin administration.
-She did not know there were orders in April 2026 and May 2026 sent to the facility but not faxed to the contracted pharmacy since she was not working at the facility at that time.

Interview with a medication aide (MA) on 07/08/26 at 11:30am revealed:
-All medication orders were entered on the eMAR by staff at the facility's contracted pharmacy.
-She administered resident's medication according to the entry on the eMAR.
-Resident #2 had warfarin 3mg tablets sent by his pharmacy used for administering his warfarin dose.
-All changes in doses were in 3mg increments so the MA administered 2 of the 3mg tablets for 6mg dose, 3 tablets for 9mg dose and such.
-She did not review medication orders, that was the responsibility of the Resident Care Coordinator (RCC).

Telephone interview with the Clinical Pharmacy Practitioner (CPP) at Resident #2's warfarin clinic on 07/08/26 at 2:40pm revealed:
-Resident #2's diagnoses included mechanical aortic valve replacement, atrial fibrillation, history of multiple gastro-intestinal (GI) bleeds, and

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history of multiple strokes.
-She routinely managed the adjustments for Resident #2's warfarin therapy.
-Resident #2 received services through the Veterans Administration in one of 2 local locations.
-The warfarin clinic was part of the VA services and his therapy was routinely monitored by the resident's Primary Care Provider (PCP) at the VA.
-Resident #2's INR values were tested weekly or every 2 weeks to help maintain closer to 2.0 INR due mainly to the mechanical valve replacement and the increased risk for clotting complicated by a history of GI bleeding if his blood became too thin.
-The warfarin clinic contracted with a local home health agency to obtain his INR blood sample for convenience for the resident.
-The home health agency read the INR values and reported the results same day directly to the warfarin clinic.
-She reviewed the results and called the Resident Care Coordinator (RCC), as arranged with the facility, at the facility for changes the same day as the warfarin INR laboratory blood draw and faxed the INR results and warfarin dose to the facility as well.
-Due to inconsistent INR values and warfarin dose changes, in early June 2026 she started sending electronically the warfarin medication orders to the faciliy's contracted pharmacy, faxing the orders to the facility, and calling the facility as well each INR value review for orders to remain the same or change.
-A letter with the results was also mailed to the resident's current address.
-The orders for additional one-time doses were conveyed to the RCC.
-Resident #2's INR values were better the last 2 INR checks with no changes to therapy 06/29/26

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D 358	Continued From page 23 and 07/06/26 due to INR values of 2.4 and 2.1 respective and therapeutic goal of 2.0-3.0 maintained. Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/09/26 at 9:45am revealed: -The pharmacy routinely enters medication orders onto the residents' eMAR. -If a resident used the pharmacy services of an outside pharmacy, the facility's contracted pharmacy enters orders onto the resident's eMAR, created a resident's medication profile to monitor medication therapy and scanned the profile for possible medication interactions. -Resident #2 did not use the facility's contracted pharmacy for obtaining his medications. -The facility would still be responsible for sending current medication orders to the pharmacy for maintaining a current eMAR. -Resident #2 received orders for his warfarin therapy from the facility and electronically from his anticoagulate clinic (warfarin clinic). -Prior to June 2026 it appeared warfarin orders were sent by the facility to the pharmacy. -Resident #2's orders received by the facility's contracted pharmacy were dated 04/20/26, 05/11/26, 06/02/26, 06/08/26, and 06/22/26. -The pharmacy did not have documentation for Resident #2's INR values or warfarin orders for 04/09/26, 04/13/26, 04/29/26, and 05/18/26. -The facility was responsible for sending all Resident #2's INR results and warfarin orders to the pharmacy. -The facility was responsible for notifying the contracted pharmacy for any eMAR compared to order discrepancies. Refer to the interview with the Resident Care Coordinator (RCC) on 07/07/26 at 4:00pm.	D 358		

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D 358	Continued From page 24 Refer to the interview with a MA on 07/09/26 at 11:50am. Refer to the interview with the Administrator on 07/09/26 at 4:30pm. 2. Review of Resident #4's current FL2 dated 02/05/26 revealed diagnoses included vascular dementia, diabetes mellitus type II with diabetic polyneuropathy, heart disease, hyperlipidemia, essential hypertension, heart disease and unspecified chronic obstructive pulmonary disease. Observation of Resident #4 during the initial tour of the facility on 07/07/26 from 8:45am revealed: -Resident #4 was coughing and sneezing consistently while standing near the front desk. -Resident #4 had to sit in a chair near the front desk due to shortness of breath. Interview with Resident #4 on 07/07/26 at 8:56am revealed: -He had been having respiratory issues such as headaches, coughing, and sneezing for two weeks. -He sat down in a chair often due to being short of breath because he had coughed a lot. -He had told the medication aides (MA) within the last week about his respiratory issues and headaches but was not aware if they had advised his PCP. A second interview with Resident #4 on 07/08/26 at 3:30pm revealed: -He had an altercation with another resident on 06/29/26 who hit Resident #4 under his left eye. -He was ordered two medications during his ER visit on 06/29/26 for his left face bone but he was	D 358		

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not aware of which medication.
-He had not received any new medications from the MA recently since the visit to the ER or since the visit with his PCP.

a. Review of Resident #4's signed physician's order from an emergency room (ER) visit discharge dated 06/29/26 revealed there was an order for amoxicillin-clavulanate 500-125mg (an antibiotic used to treat bacteria) one tablet every 8 hours for 10 days to start on 06/29/26 due to to a zygomatic bone fracture sustained during an altercation.

Review of Resident #4's primary care physician's (PCP) progress note dated 06/30/26 revealed:
-There was an order for amoxicillin-clavulanate 500-125mg one tablet every 8 hours for 10 days with a start date of 06/29/26 acknowledged by Resident #4's PCP.
-Resident #4 was seen due to a ER follow-up visit related to a zygomatic bone fracture from an altercation on 06/29/26.

Review of Resident #4's June 2026 electronic medication record (eMAR) from 06/29/26 to 06/30/26 revealed:
-There was no entry for amoxicillin-clavulanate 500-125mg one tablet every 8 hours
-There was no documentation amoxicillin-clavulanate 500-125mg was administered daily from 06/29/26 to 06/30/26.

Review of Resident #4's July 2026 eMAR from 07/01/26 to 07/06/26 revealed:
-There was no entry for amoxicillin-clavulanate 500-125mg one tablet every 8 hours.
-There was no documentation amoxicillin-clavulanate 500-125mg was administered daily from 07/01/26 to 07/06/26.

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D 358	Continued From page 26 Observation of medication on hand for Resident #4 on 07/09/26 at 11:20am revealed there was no amoxicillin-clavulanate available for administration. Telephone interview with a representative for the facility's contracted pharmacy on 07/09/26 at 9:00am revealed: -The pharmacy had not received an order for amoxicillin-clavulanate 500-125mg one tablet every 8 hours for Resident #4 on 06/29/26. -The pharmacy updated the eMAR's for the facility but the facility staff had not communicated with the pharmacy about Resident #4's amoxicillin-clavulanate. Telephone interview with Resident #4's PCP on 07/09/26 at 11:40am revealed: -Resident #4 was ordered the amoxicillin-clavulanate for a zygomatic bone fracture from 06/29/26 but the amoxicillin-clavulanate could have prevented the progression of Resident #4's current respiratory symptoms. -She was not aware Resident #4 had not received amoxicillin-clavulanate as ordered. -She was not aware of Resident #4's respiratory issues until she visited the facility on 07/07/26 and she ordered Resident #4 an antibiotic during that visit. -She expected Resident #4 to be administered amoxicillin-clavulanate as ordered. Interview with a MA on 07/09/26 at 11:50am revealed: -She was not aware Resident #4 was having respiratory issues or headaches. -Resident #4 did not have an entry in the eMAR for amoxicillin-clavulanate 500-125mg one tablet	D 358		

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	HAL099018	A. BUILDING: _____ B. WING _____	07/09/2026

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D 358	Continued From page 27	D 358		

every 8 hours.
-She only administered the medications that were entered into the eMAR.
-She did not know Resident #4 had an order for amoxicillin-clavulanate from his 06/29/26 ER visit or from his PCP on 06/30/26 that had not been entered into the eMAR or sent to the pharmacy.

Interview with the Administrator on 07/09/26 at 4:30pm revealed she was not aware Resident #4 was not administered his medications that were ordered from 06/29/26.

Refer to the interview with the Resident Care Coordinator (RCC) on 07/07/26 at 4:00pm.

Refer to the interview with a MA on 07/09/26 at 11:50am.

Refer to the interview with the Administrator on 07/09/26 at 4:30pm.

b. Review of Resident #4's signed physician's order from an ER visit discharge dated 06/29/26 revealed there was an order for ibuprofen 800mg (used to treat inflammation) one tablet every 8 hours as needed to start on 06/29/26 due to a zygomatic bone fracture sustained during an altercation.

Review of Resident #4's PCP progress note dated 06/30/26 revealed:
-There was an order for ibuprofen 800mg one tablet every 8 hours as needed with a start date of 06/29/26 acknowledged by Resident #4's PCP.
-Resident #4 was seen due to a ER follow-up visit related to a zygomatic bone fracture from an altercation on 06/29/26.

Review of Resident #4's June 2026 eMAR from

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D 358	Continued From page 28 06/29/26 to 06/30/26 revealed: -There was no entry for ibuprofen 800mg one tablet every 8 hours as needed. -There was no documentation ibuprofen 800mg was administered daily from 06/29/26 to 06/30/26. Review of Resident #4's July 2026 eMAR from 07/01/26 to 07/06/26 revealed: -There was no entry for ibuprofen 800mg one tablet every 8 hours as needed -There was no documentation ibuprofen 800mg was administered daily from 07/01/26 to 07/06/26. Observation of medication on hand for Resident #4 on 07/09/26 at 11:20am revealed there was no ibuprofen available for administration. Telephone interview with a representative for the facility's contracted pharmacy on 07/09/26 at 9:00am revealed: -The pharmacy had not received an order for ibuprofen 800mg one tablet every 8 hours as needed for Resident #4 on 06/29/26. -The pharmacy updated the eMAR's for the facility but the facility staff had not communicated with the pharmacy about Resident #4's ibuprofen 800mg. Telephone interview with Resident #4's PCP on 07/09/26 at 11:40am revealed: -Resident #4 was ordered the ibuprofen 800mg for a zygomatic bone fracture from 06/29/26 but the ibuprofen 800mg have prevented the progression of Resident #4's current headaches. -She was not aware Resident #4 had not received ibuprofen 800mg as ordered. -She expected Resident #4 to be administered ibuprofen 800mg as ordered.	D 358		

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D 358	Continued From page 29 Interview with a MA on 07/09/26 at 11:50am revealed: -She was not aware Resident #4 was having respiratory issues or headaches. -Resident #4 did not have an entry in the eMAR for ibuprofen 800mg one tablet every 8 hours as needed. -She only administered the medications that were entered into the eMAR. -She was not aware Resident #4 had an order for ibuprofen 800mg from his 06/29/26 ER visit or from his PCP on 06/30/26 that had not been entered into the eMAR or sent to the pharmacy. Interview with the Administrator on 07/09/26 at 4:30pm revealed she was not aware Resident #4 was not administered his medications that were ordered from 06/29/26. Refer to the interview with the Resident Care Coordinator (RCC) on 07/07/26 at 4:00pm. Refer to the interview with a MA on 07/09/26 at 11:50am. Refer to the interview with the Administrator on 07/09/26 at 4:30pm. _____ Interview with the Resident Care Coordinator (RCC) on 07/07/26 at 4:00pm revealed: -She has been working at the facility since early June 2026 due to staff turnover in the RCC position. -The facility did not have a full-time nurse on staff. -The facility's contracted pharmacy entered all orders onto the eMARs. -She did not have a system in place to routinely audit eMARS compared to medication orders for accuracy and completeness.	D 358		

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D 358	Continued From page 30 -She was responsible for ensuring all medication orders were correct on the eMAR and medications on the medication carts matched the orders. Interview with a medication aide (MA) on 07/09/26 at 11:50am revealed: -The Resident Care Coordinator (RCC) was responsible for reviewing physician's orders and emergency (ER) discharge orders. -The MAs and the RCC were responsible for sending physicians orders to the pharmacy. Interview with the Administrator on 07/09/26 at 4:30pm revealed: -The RCC was responsible for reviewing physicians' orders and both the MAs and the RCC were responsible for sending any orders to the pharmacy. -She expected the RCC to review new orders from a primary care physician (PCP) visit or an ER visit. -She expected the MAs to administer medications as ordered by the physician. _____ The facility failed to administer medications as ordered including a resident with diagnosis of mechanical heart valve with an order for a blood thinning medication (warfarin) not administered correctly for 12 doses in April 2026, May 2026, and June 2026 placing the resident at increased for blood clots and stoke (#2); Another resident was not administered an antibiotic along with an anti-inflammatory and experienced respiratory issues which included coughing, sneezing, and headaches for a week and a half (#4). This failure was detrimental to the welfare of the residents which constitutes a Type B Violation. This facility provided a plan of protection in	D 358		

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D 358	Continued From page 31 accordance with G.S. 131D-34 on 07/09/26. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 23, 2026.	D 358		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (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 record reviews and interviews, the facility failed to notify the local county Department of Social Services (DSS) of an incident/accident that required emergency medical evaluation for 2 of 5 residents (#4 and #6) and required emergency treatment. The findings are: 1. Review of Resident #4's current FL2 dated 02/05/26 revealed: -There was a diagnosis of vascular dementia, type 2 diabetes mellitus with diabetic polyneuropathy, heart disease, hyperlipidemia, essential hypertension, and general anxiety disorder.	D 451		

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D 451	Continued From page 32 -Resident #4 was semi-ambulatory. Review of Resident #4's accident/incident report dated 06/29/26 revealed: -At 1:30pm, Resident #4 was involved in an altercation with another resident. -Resident #4 was transferred to the Emergency Department (ED) via Emergency Medical Services (EMS) at 1:45pm for evaluation. -Resident #4 returned to the facility with a diagnosis of a zygomatic bone fracture. Interview with a representative from the local county DSS on 07/08/26 at 3:58pm revealed: -She had not received the accident/incident report dated 06/29/26 for Resident #4. -She was not aware of the accident/incident for Resident #4 until yesterday (07/07/26). Interview with a medication aide (MA) on 07/09/26 at 11:50am revealed: -She was not aware if an accident/incident report was completed for Resident #4 for 06/29/26. -She was not aware that an accident/incident report from 06/29/26 for Resident #4 was not sent to the local country DSS. Refer to the interview with a representative from the local county DSS on 07/08/26 at 3:58pm. Refer to the interview with a MA on 07/09/26 at 11:50am. Refer to the interview with the Administrator on 07/09/26 at 4:30pm. Attempted interview with the Resident Care Coordinator (RCC) on 07/09/26 at 4:00pm was unsuccessful.	D 451		

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D 451	Continued From page 33 2. Review of Resident #6's current FL2 dated 01/20/26 revealed: -Diagnoses included schizophrenia. -Resident #6 was intermittently disoriented. -Resident #6 was ambulatory. Review of Resident #6's accident/incident report dated 06/29/26 revealed: -At 1:30pm, Resident #6 was involved in an altercation with another resident. -Resident #6 was transported to the Emergency Department (ED) via Emergency Medical Services (EMS) at 1:45pm for evaluation. -Resident #6 returned to the facility with a diagnosis of a hand fracture. Interview with a representative from the local county Department of Social Services (DSS) on 07/08/26 at 3:58pm revealed: -She had not received the accident/incident report dated 06/29/26 for Resident #6. -She was not aware of the accident/incident for Resident #6 until yesterday (07/07/26). Interview with a medication aide (MA) on 07/09/26 at 11:50am revealed: -She was not aware if an accident/incident report was completed for Resident #6 for 06/29/26. -She was not aware that an accident/incident report from 06/29/26 for Resident #6 was not sent to the local county DSS. Refer to the interview with a representative from the local county 07/08/26 at 3:58pm. Refer to the interview with a MA on 07/09/26 at 11:50am. Refer to the interview with the Administrator on 07/09/26 at 4:30pm.	D 451		

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D 451	Continued From page 34 Attempted interview with the Resident Care Coordinator (RCC) on 07/09/26 at 4:00pm was unsuccessful. _____ Interview a representative from the local county DSS on 07/08/26 at 3:58pm revealed: -The facility should fax all accident/incident reports that require more than first aid to DSS. -The facility should fax all accident/incident reports that require the resident to be sent to the ED. -She expected to receive the reports within 24 to 48 hours of the accident/incident. Interview with a medication aide (MA) on 07/09/26 at 11:50am revealed: -The MAs or RCC were responsible for completing accident/incident reports. -Reporting accident/incident reports to the local county DSS was the responsibility of the Resident Care Coordinator (RCC) and the Administrator. Interview with the Administrator on 07/09/26 at 4:30pm revealed: -The reportable accident/incident reports were faxed to the local county DSS by the RCC. -The accident/incident reports should be faxed within 24 to 48 hours. -Reportable accident/incident reports were anything above first aid. -She was not aware that the accident/incident reports from 06/29/26 were not sent to the local county DSS.	D 451		