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	HAL056001	A. BUILDING: _____ B. WING _____	07/29/2026

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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 000	Initial Comments The Adult Care Licensure Section and the Macon County Department of Social Services conducted a follow-up survey and complaint investigation on 07/28/26 to 07/29/26. The complaint investigation was initiated by the Mason County Department of Social Services on 06/23/26.	D 000		
D 224	10A NCAC 13F .0702 (b) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (b) The discharge of a resident initiated by the facility at the direction of the administrator or their designee shall be based on one of the following reasons: (1) the discharge is necessary to protect the welfare of the resident and the facility cannot meet the needs of the resident, as documented by the resident's physician, physician assistant, or nurse practitioner in the resident's record; (2) the health of the resident has improved sufficiently so that the resident is no longer in need of the services provided by the facility, as documented by the resident's physician, physician assistant, or nurse practitioner in the resident's record; (3) the safety of the resident or other individuals in the facility is endangered as determined by the facility at the direction of the administrator or their designee in consultation with the resident's physician, physician assistant, or nurse practitioner; (4) the health of the resident or other individuals in the facility is endangered as documented by a physician, physician assistant, or nurse practitioner in the resident's record; or (5) the resident has failed to pay the costs of services and accommodations by the payment due date according to the resident's contract after	D 224		

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D 224	Continued From page 1 receiving written notice of warning of discharge for failure to pay. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to discharge a resident whose condition or circumstance endangered the health and safety of individuals in the facility related to 1 of 5 sampled residents (#2) who placed a blanket and pillow over a resident's face who was sleeping and blocked another resident in his room. The findings are: Review of Resident #2's current FL2 dated 05/28/26 revealed: -Diagnoses included Alzheimer's disease and disorientation. -Resident #2 was ambulatory with intermittent disorientation. -Resident #2's level of care was Special Care Unit (SCU). Review of Resident #2's Resident Register revealed an admission date of 05/29/26. Review of Resident #2's record revealed: -There was no care plan available to review. -Resident # 2 was discharged on 06/03/26.	D 224		

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D 224	Continued From page 2 Review of charting notes dated 05/29/26 through 05/30/26 for Resident #2 revealed: -On 05/29/26 Resident #2 was combative with staff and woke up other residents. -On 05/29/26 at 9:07pm, Resident #2 was found in another resident's room trying to smother her with a pillow and blanket. -On 05/30/26 Resident #2 blocked staff from removing another resident from his room. -Resident #2 was admitted to the emergency room (ER) three times within 24 hours from 05/29/26 to 05/30/26. -The facility accepted Resident #2 after each visit to the ER. Interview with the Memory Care Coordinator (MCC) on 07/29/26 at 10:00am revealed: -The hospital did not call her directly to say they were bringing Resident #2 back to the facility. -If we immediately discharged Resident #2, the hospital would just call the local county Department of Social Services (DSS) and make a report on the facility. -The facility does not just throw residents out with behaviors. -She could not say the resident was not appropriate. -Before the facility discharged a resident with behaviors, the facility called their Primary Care Provider (PCP) to adjust their medications. -The Executive Director was the only one who could make the decision to immediately discharge residents. Interview with the Administrator on 07/29/26 at 3:00pm revealed: -The facility did not discharged Resident #2 because they were trying to involuntary commit (IVC) her.	D 224		

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D 224	Continued From page 3 -The hospital refused to IVC Resident #2 because she had dementia. -She did not know the facility could immediately discharge a resident with behaviors. -She and the ED were the only people who could discharge a resident from the facility. Interview with the ED on 07/29/26 at 3:45pm revealed: -She did not give Resident #2 an immediate discharge because she thought all she needed was a medication adjustment. -She agreed Resident #2 was not appropriate at that time but did not know she could refuse to take her back once she was discharged from the hospital. Telephone interview with Resident #2's PCP on 07/28/26 at 2:20pm revealed: -She did not recall who Resident #2 was. -She reviewed her notes and said there was a call on 06/02/26 from another provider at the facility who requested an electronic order. -She may have called in an order but has no memory of what it was. Attempted interview with Resident #2's guardian on 07/29/26 at 9:00am was unsuccessful. _____ The facility failed to ensure the safety of all the residents in the Special Care Unit by not discharging a resident who placed a pillow and blanket over a resident's face while they were sleeping. When resident was accepted back into the facility a second time, she blocked another resident in their room. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in	D 224		

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D 224	Continued From page 4 accordance with G.S.131D-34 on July 29, 2026, for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 12, 2026.	D 224		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure resident's rights were maintained for all residents in the Special Care Unit (SCU) related to 1 of 5 sampled residents (#2) who placed a blanket and pillow over a resident's face who was sleeping and blocked another resident in his room. The findings are: Review of the facility's Resident on Resident Violence on 07/29/26 revealed: -In the case of physical assault by a resident or whenever there is risk of death or physical harm will occur due to the actions or behavior of a resident the facility shall immediately; -Call law enforcement. -Provide supervision of the threatening residents. -Seek emergency medical treatment. -Make a referral to mental health services.	D 338		

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Review of Resident #2's current FL2 dated 05/28/26 revealed:
-Diagnoses included Alzheimer's disease and disorientation.
-Resident #2 was ambulatory with intermittent disorientation.
-Resident's recommended level of care was memory care.

Review of Resident #2's Resident Register revealed an admission date of 05/29/26.

Review of Resident #2's record revealed:
-There was no care plan available to review.
-Resident # 2 was discharged on 06/03/26.

Review of charting notes dated 05/29/26 for Resident #2 revealed:
-Resident #2 was combative with staff and woke up the other residents.
-At 9:07pm, Resident #2 was found in another resident's room trying to smother her with a pillow and blanket.
-At 10:27pm Resident #2 was sent to the emergency room (ER) to adjust medications.

Review of Resident #2's first hospital discharge summary dated 05/30/26 revealed:
-Resident #2 presented to the ER on 05/30/26 at 11:05pm from the facility for an evaluation for aggressive behavior towards another resident.
-There was a brief history that Resident #2 spent 13 days in the ER psychiatric holding area for assaulting her spouse. She was evaluated by psychiatry and deemed not to be a psychiatric patient.
-Resident #2 had laboratory test that were not remarkable.
-Resident #2 was discharged and transported back to the facility.

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D 338	Continued From page 6 Review of charting notes dated 05/30/26 for Resident #2 revealed: -Resident #2 returned to the facility from the ER at 2:10am. -An incident report was faxed to the local county Department of Social Services (DSS). Review of an incident report for Resident #2 dated 5/30/26 at 8:30am revealed: -The report was written by a medication aide (MA). -Resident attempted to smother another resident. -The Administrator, Executive Director (ED) and police were notified of the incident. -The MA's attempt to reach the guardian was unsuccessful. -The ED would attempt to get an involuntary commitment (IVC) order. -Resident #2 was to be sent back to the ER. Review of Resident #2's second hospital discharge summary dated 05/30/26 revealed: -Resident #2 presented to the ER on 05/30/26 at 9:41am from the facility for an evaluation of alleged aggressive behavior. -Resident #2 remained calm throughout her stay. -The ER provider noted, that Resident #2 was sent to the ER because she was not taking her medications and she was back that morning. She had dementia and sundowning but was not suicidal or homicidal". -Resident #2 was discharged and transported back to the facility on 05/30/26. Review of charting notes dated 05/30/26 for Resident #2 revealed: -Resident #2 returned to the facility from the ER at 11:12am. -At 5:24pm Resident #2 was sitting on another	D 338		

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resident's bed and would not get up.
-Resident #2 blocked staff from removing the resident from his room.
-Resident #2 became combative with staff.
-Staff were able to remove resident from another resident's room.
-The ED went to get an IVC order and the police were called.

Review of a petition filed for IVC order dated 05/30/26 revealed:
-The ED filed a petition for an IVC order.
-The order was signed on 05/30/326 at 6:45pm.
-The order listed the local police department as the transport to the examination site.

Review of charting notes dated 05/30/26 for Resident #2 revealed the police arrived at the facility at 7:30pm and transported Resident # 2 to the ER.

Review of Resident #2's third hospital discharge summary dated 05/30/26 revealed:
-Resident #2 presented to the ER on 05/30/26 at 7:45pm from the facility with an IVC order.
-Resident #2 had reportedly been aggressive towards staff.
-This was the third visit within 24 hours.
-Resident #2 was calm, appropriate and denied any suicidal or homicidal ideation.
-The hospital did not agree to IVC Resident #2.
-Resident #2 was discharged and transported back to the facility on 05/31/26.

Review of charting notes dated 05/31/26 for Resident #2 revealed:
-Resident was transported back to the facility by the emergency medical service (EMS) at 12:00am.
-Resident #2 slept most of the day and aides kept

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a watch on her and kept her busy with small tasks.

Review of charting notes dated 06/01/26 for Resident #2 revealed:
-Resident #2 was seen by PCP.
-An order was placed for quetiapine 50mg at 4:00pm, lorazepam .05mg every 6 hours and lorazepam .05mg as needed.

Interview with a MA on 07/28/26 at 9:00am revealed:
-She had worked with Resident #2.
-She was aware of the incident that occurred on 05/29/26 when Resident #2 was found trying to smother another resident with a blanket and pillow.
-She called the ED when the incident occurred, and the ED told her to send the resident out to the ER; which she did.
-A hospital staff called the facility to say the resident had been evaluated and was ready for discharge because there was no medical reason to keep her.
-She is unsure of the exact time the resident returned to the facility.

Interview with a second MA on 07/28/26 at 11:00am revealed:
-She was working with Resident #2 on 05/30/26.
-Around 5:50pm, she went into another resident's room to tell the other resident it was time for dinner.
-Resident #2 was sitting on the bed and would not get up.
-When she attempted to go around the bed to get the other resident, Resident #2 stood up and blocked her with her body.
-Resident #2 started cursing her and would not let the other resident go around her.

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-Another staff called the ED and she came down and talked to Resident #2 and finally got her out of the room.
-Resident #2 left the room with the ED and we were able to get the other resident out of the room.

Interview with a third MA on 07/28/26 at 12:00pm revealed:
-Resident #2 had thrown a water pitcher in the hall and was slamming doors on 05/30/26.
-She was unsure of the time.
-She called Resident #2's PCP and informed her of the incident.
-The PCP called in a verbal order to give Resident #2 lorazepam .5mg to calm her down.
-On the same day, 05/30/26, at dinner time, Resident #2 would not let another resident out of his room.
-The ED told her she was going to get an IVC order and called the police.
-The police came to the facility around 7:00pm and took Resident #2 to the ER to be committed.
-No one ever told her not to accept Resident #2 back into the facility.
-The ED was the only person that could make that decision.
-Resident #2 came back to the facility around midnight.

Telephone interview with Resident #2's PCP on 07/28/26 at 2:20pm revealed:
-She did not recall who Resident #2 was.
-She reviewed her notes and said there was a call on 06/02/26 from another provider at the facility who requested an electronic order.
-She may have called in an order but has no memory of what it was.

Telephone interview with a second PCP for

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Resident #2 on 07/28/26 at 2:30pm revealed:
-He remembered being notified by someone at the facility on 06/02/36 about Resident #2's behavior.
-He barely remembered Resident #2 but was unsure if he treated her.

Interview with the Memory Care Coordinator (MCC) on 07/29/26 at 10:00am revealed:
-She heard something about the smothering incident but was not sure because did not read chart notes.
-She did not recall what staff reported to her in detail about the incident.
-She did not think that Resident #2 attempting to smother another resident made her a threat to other residents.
-She was aware that the ED got an IVC order on 05/30/36 for Resident #2 that the hospital denied.
-The ED is the only one who could make the decision to discharge residents.
-The policy for resident-on-resident violence was to call the police and send the resident out to the hospital if needed.
-Resident #2's guardian found a hospital that would accept the IVC order, and her spouse transported her to that hospital on 06/03/26.

Interview with the Administrator on 07/29/26 at 3:00pm revealed:
-She was aware Resident #2 tried to smother another resident on 05/29/26.
-She was aware Resident #2 tried to block another resident in his room on 05/30/26.
-She was not in the facility for either incident but was informed by the MCC when she returned.
-The policy on resident-on-resident violence was for whoever is the lead on duty to call the police and EMS if needed.
-She was aware the ED was granted an IVC

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order that the hospital denied because the resident had dementia.
-The Administrator and the ED were the only people who could discharge a resident from the facility.
-Resident #2's guardian found a hospital that would accept the IVC order, and her spouse transported her to that hospital on 06/03/26.
-The spouse was given discharge paperwork on 06/03/26 when he came to transport Resident #2 to give to the hospital.

Interview with the ED on 07/29/26 at 3:45pm revealed:
-She was aware of all the incidents that occurred with Resident #2.
-She thought the Resident #2 was appropriate because resident's FL2 paperwork listed memory care for her level of care.
-The hospital paperwork indicated she had some aggressive behaviors with only the spouse.
-When the resident returned from the hospital the second time, she tried to get an IVC order.
-The hospital said there was no medical reason to keep the resident, so she accepted her back.
-Resident #2 was discharged to a hospital that accepted the IVC order on 06/03/26.
-She believed she did everything possible to keep the other residents safe.

_____

The facility failed to ensure the safety of all the residents in the Special Care Unit from a resident who placed a pillow and blanket over a resident's face while they were sleeping and blocked another resident in their room. This failure was detrimental to the health, safety, and welfare of the other residents and constitutes a Type B Violation.

_____

The facility provided a plan of protection in

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D 338	Continued From page 12 accordance with G.S.131D-34 on July 29, 2026, for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 12, 2026.	D 338		