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	HAL081007	A. BUILDING: _____ B. WING _____	R-C 07/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTWELL HOME	401 US 221 S HIGHWAY RUTHERFORDTON, NC 28139

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D 000	Initial Comments The Adult Care Licensure Section conducted a annual and follow-up survey on 07/22/26-07/24/26 and 07/27/26.	D 000		
D 049	10A NCAC 13F .0305 (d) Physical Environment 10A NCAC 13F .0305 Physical Environment (d) The requirements for the bedroom are: (1) the number of resident beds set up shall not exceed the licensed capacity of the facility; (2) live-in staff shall be permitted in facilities with a capacity of 7 to 12 residents provided all of the requirements of Section .0600 of these Rules are met; (3) there shall be separate bedrooms for any live-in staff and other persons living in the facility. Residents shall not share bedrooms with live-in staff and other live-in non-residents; (4) live-in staff shall not occupy a licensed bed or live in a licensed bed; (5) residents shall reside in bedrooms with residents of the same sex unless other arrangements are made with each resident's consent; (6) only rooms authorized by the Division of Health Service Regulation as bedrooms shall be used for bedrooms; (7) bedrooms shall be located on an outside wall and off a corridor. A room where access is through a bathroom, kitchen, or another bedroom shall not be approved as a resident's bedroom; (8) private resident bedrooms shall have not less than 100 square feet of occupiable floor area excluding accessory areas such as vestibules, closets, or wardrobes. For the purpose of this Rule, "private resident bedroom" is a resident bedroom occupied by one resident; (9) semi-private resident bedrooms shall have	D 049		

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D 049	Continued From page 1 not less than 80 square feet of occupiable floor area per bed excluding accessory areas such as vestibules, closets, or wardrobes. For the purpose of this Rule, "semi-private resident bedroom" is a resident bedroom occupied by two residents; (10) the total number of residents assigned to a bedroom shall not exceed the number authorized by the Division of Health Service Regulation for that particular bedroom; (11) a bedroom may not be occupied by more than two residents; (12) resident bedrooms shall be designed to accommodate all required furnishings; (13) resident bedrooms shall be ventilated with one or more windows which are maintained operable. The window area shall not be less than eight percent of the floor space and be equipped with insect-proof screens. The window opening may be restricted to a six-inch opening to inhibit resident elopement or suicide. The windows shall be low enough to see outdoors from the bed and chair, with a maximum 36 inch sill height; and (14) Residents' bedrooms shall have one closet or wardrobe per resident. A closet or wardrobe shall have clothing storage space of not less than 48 cubic feet per bed, approximately two feet deep by three feet wide by eight feet high, of which one-half of this space shall be for hanging with an adjustable height hanging bar. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to provide an operable bedroom window for 1 of 1 sampled resident rooms (Resident #2). The findings are:	D 049		

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D 049	Continued From page 2	D 049		

Review of Resident #2's current FL2 dated 09/19/25 revealed:
-Diagnoses included history of insomnia, schizophrenia and bi-polar.
-She was ambulatory and no level of orientation was documented.

Interview with Resident #2 on 07/22/26 at 9:07am revealed:
-She eloped from the facility in June 2026 by going through her bedroom window.
-Because she eloped, someone from the facility "locked up my window" so she could not go through it again.

Observation of Resident #2's bedroom window on 07/22/06 at 9:17am revealed:
-There was one sliding window in Resident #2's bedroom.
-There was one rough-cut piece of wood wedged into the bottom of the window frame.
-There was one rough-cut piece of wood wedged into the top of the window frame.
-The two wedges of wood prevented the window from opening.

Observation of Resident #2's bedroom window on 07/22/06 at 5:38pm revealed:
-The piece of wood that was wedged into the bottom of the window frame was no longer there.
-The piece of wood that was wedged into the top of the window frame was still there.

Interview with the Manager on 07/22/26 at 4:22pm and 5:40pm and 07/24/26 at 9:10am revealed:
-Resident #2 eloped from the facility twice in one week in June 2026.
-Resident #2 eloped by climbing through her bedroom window.

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D 049	Continued From page 3 -At Resident #2's request the Maintenance Director put a piece of wood in the window frame the day after the second elopement to discourage her from going out the window again. -She knew a window could not be screwed closed but she thought it would be okay to do something temporarily to the window to prevent her from eloping again. -She was aware the Maintenance Director inserted the wood into the window frame. -She removed the piece of wood from the bottom of Resident #2's window frame earlier in the day (07/22/26) but she did not realize there was a second piece of wood wedged into the top of the window frame or she would have removed it also. -She instructed the Maintenance Director to remove the top board on the evening of 07/22/26. Interview with the Maintenance Director on 07/24/26 at 8:41am revealed: -Resident #2 wanted him to screw her window closed to discourage her from eloping again. -He told her he could not screw it closed so he offered to wedge wood into the window frame. -He inserted the wood in the window frame after the second time she eloped. -The Manager knew he put the wood into the window frame to make it inoperable. -At the Managers request he removed the wood on 07/22/26. Interview with the Administrator on 07/27/26 at 1:47pm revealed: -Resident #2 eloped from the facility by going through her bedroom window. -He knew the window could not be closed permanently so it was "jammed shut". -He did not want residents opening the windows because it interfered with the heating and cooling system.	D 049		

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D 049	Continued From page 4 -To prevent Resident #2 from eloping through the window again he would have a window company insert limiters on it so it could still be opened but not enough to go through it.	D 049		
D 129	10A NCAC 13f .0404 (2) Qualifications Of Activity Director 10A NCAC 13f .0404 Qualifications Of Activity Director Adult care homes shall have an activity director who meets the following qualifications: (2) The activity director hired after September 30, 2022 shall complete, within nine months of employment or assignment to this position, the basic activity course for assisted living activity directors offered by community colleges or a comparable activity course as determined by the Department based on instructional hours and content. An activity director shall be exempt from the required basic activity course if one or more of the following applies: (a) be a licensed recreational therapist or be eligible for certification as a therapeutic recreation specialist as defined by the North Carolina Recreational Therapy Licensure Act in accordance with G.S. 90C; (b) have two years of experience working in programming for an adult recreation or activities program within the last five years, one year of which was full-time in an activities program for patients or residents in a health care or long term care setting; (c) be a licensed occupational therapist or licensed occupational therapy assistant in accordance with G.S. 90, Article 18D; (d) be certified as an Activity Professional by the National Certification Council for Activity Professionals; or	D 129		

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D 129	Continued From page 5 (e) the required basic activity course was completed prior to September 1, 2024. This Rule is not met as evidenced by: Based on interviews the facility failed to have an Activity Director who completed the basic activity course for assisted living Activity Directors. The findings are: Interview with the housekeeper on 07/22/26 at 10:35am revealed the facility did not have an Activity Director. Interview with the Manager on 07/22/26 at 10:45am revealed: -The facility was small and family operated and she and another family member provided activities but they did not have an Activity Director. -She never took the basic course to be an Activity Director. -She did not know the facility was required to have an Activity Director. Interview with the Administrator on 07/27/26 at 1:47pm revealed: -The Manager and the Assistant Manager conducted activities. -He did not know they needed to have an Activity Director.	D 129		
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages shall be offered in	D 298		

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accordance with each residents' prescribed diet or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews the facility failed to offer or make available three snacks per day.

The findings are:

Interview with a resident on 07/22/26 at 9:07am revealed snacks and drinks were not offered unless we asked for them.

Interview with a second resident on 07/22/26 at 9:21am revealed:
-Snacks were not offered very often, maybe once or twice a week.
-Snacks were sometimes offered in the evening after dinner depending upon who was working.
-She purchased her own snacks.
-She had a small refrigerator in her room where she kept her own snacks.
-She got hungry in the evening so she made herself a sandwich before she went to bed.

Observation of a resident's refrigerator on 07/22/26 at 9:21am revealed:
-There was lunchmeat and water bottles inside the refrigerator.
-There was bread and a box of cream-filled

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sponge cakes on top of the refrigerator.

Interview with a third resident on 07/23/26 at 8:09am revealed snacks were sometimes passed out in the afternoon.

Interview with a fourth resident on 07/23/26 at 9:54am revealed:
-It depended on who was working in the afternoon if snacks were offered or not.
-Morning snacks were never offered and the one offered yesterday (07/22/26) was offered "because state was in the building".
-The snacks offered in the evening usually happened around 11:00pm but occasionally they were offered earlier around 9:30pm.

Interview with a dietary aide on 07/22/26 at 9:32am revealed:
-Snacks were listed on the menu three times a day.
-Staff came to the kitchen at 10:00am and 2:00pm and gathered things to distribute as snack.
-Staff were supposed to distribute snacks at 8:00pm but she was not here at that time of day so she could not say if that occurred or not.

Review of the facility menu for 07/22/26 revealed:
-There were three snacks a day listed on the menu.
-The regular diet morning snack was peanut butter cracker or cheese cracker.
-The regular diet afternoon snack was starch and juice.
-The regular diet evening snack was popcorn and juice.

Observation of a medication aide (MA) on 07/22/26 at 9:51am revealed:

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D 298	Continued From page 8 -She was pushing a rolling cart down the hall stopping at resident rooms offering the residents a snack. -Residents were offered one variety of cookie and one variety of juice. Observation of a MA on 07/23/26 at 9:57am revealed: -She was walking up and down the hall asking residents if they wanted a snack. -She was pushing a cart with crackers, a jar of peanut butter and a pitcher of juice. Observation of the dining room on 07/23/26 at 2:00pm revealed: -The Manager was playing Bingo with ten residents. -When the game was over she had each resident pick a bag of chips out of a large box. Interview with a MA on 07/27/26 at 1:22pm revealed: -Snacks were given at about 10:00am and in the afternoon during Bingo. -Night snacks were given after medication administration which was usually around 9:00pm or 9:45pm but not later than 10:00pm. Interview with the Manager on 07/23/26 at 11:09am revealed: -She thought snacks were offered three times a day. -She offered a snack in the afternoon after they played Bingo, which was scheduled four days a week. -She thought evening snack was at 9:00pm after medications were administered. -She was not in the building all the time to observe if snacks were being offered as scheduled.	D 298		

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D 298	Continued From page 9 Interview with the Administrator on 07/27/26 at 1:47pm revealed: -He thought snacks were offered in the morning and in the afternoon. -An evening snack did not make sense to him as the residents went to bed so early. -Residents did not always remember accurately what they got throughout the day.	D 298		
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be at least 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge, and learning of new skills. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a minimum of 14 hours of group activities were provided each week for the residents. The findings are: Observation of the July 2026 activity calender on 07/22/26 at 8:52am revealed: -The calendar was hanging on the wall in the hallway near the living room. -Bible study was scheduled as an activity every Wednesday. -One hour of Bingo was scheduled as an activity four days a week, on Monday, Tuesday, Thursday and Friday. -Three and a half hours of Religious activities	D 317		

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were scheduled on Sundays.
-Television shows were scheduled for all other days as activities.

Interview with a resident on 07/22/26 at 8:37am revealed:
-There were not a lot of activities to choose from.
-Bingo was offered regularly.

Interview with a second resident on 07/22/26 at 8:45am revealed she watched soap operas and other television as an activity.

Interview with a third resident on 07/22/26 at 8:57am revealed she watched television as her activity.

Interview with a fourth resident on 09/23/26 at 9:54am revealed:
-She played Bingo on Monday, Tuesday, Thursday and Friday.
-She attended a bible study on Wednesday.
-Everything else she did on her own and that included coloring, crafting and reading.

Interview with a medication aide on 07/27/26 at 1:22pm revealed:
-Residents did a lot of individual activities.
-Bingo was played daily and a bible study was done every Wednesday.
-Residents watch game shows on television.

Interview with the Manager on 07/22/26 at 10:45am and 07/23/26 at 11:09am revealed:
-She wrote the activities on the calendar each month.
-She lead Bingo four days a week.
-Another family member led a bible study once a week and residents were offered religious programs on Sunday.

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D 317	Continued From page 11 -She tried other activies and the residents were not interested so they started turning the television on to game shows and talk shows the rest of the time. -She thought the activities she put on the calendar were enough to keep them busy. -She did not know she needed to plan fourteen hours of activities each week. Interview with the Administrator on 07/22/26 at 1:47pm revealed: -The residents were offered Bingo and bible study as activities. -He was not aware the residents needed to be offered fourteen hours of activities a week.	D 317		
D 319	10A NCAC 13F .0905 (f) Activities Program 10A NCAC 13F .0905 Activities Program (f) Each resident shall have the opportunity to participate in at least one outing every other month. Residents interested in being involved in the community more frequently shall be encouraged to do so. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure all residents were offered at least one outing every other month. The findings are: Observation of the facility on 07/22/26 at 8:52am revealed: -There was a July 2026 activity calendar posted	D 319		

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on the wall in the hallway.
-There were no outings scheduled on the July 2026 calendar.

Interview with a resident on 07/22/26 at 8:37am revealed:
-The last time they went on an outing was in June 2026 when they were taken to a tractor show and that was the first place they went in a long time.
-She was told they were going on an outing because "someone had gotten onto them about not taking us places".
-She had not gone shopping in a long time.

Interview with a second resident on 07/22/26 at 8:45am revealed:
-She and several of the other residents were taken to a farm to look at the animals, not too long ago.
-She used to go to a local dollar store but it had been a long time since she was taken.

Interview with a third resident on 07/22/26 at 8:57am revealed:
-Some residents went to a fair last month but she did not want to go.
-The last time she went anywhere was in the fall when they drove us around the lake.

Interview with a fourth resident on 07/22/26 at 9:07am revealed the residents never went anywhere.

Interview with a fifth resident on 07/22/26 at 9:21am revealed the residents never went anywhere nor were they taken shopping.

Interview with a sixth resident on 07/23/26 at 9:54am revealed:
-They usually did not go anywhere.

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D 319	Continued From page 13 -Residents were taken to a farm a few months ago. -Prior to the farm, the last time they went any where was in the fall when they went to the lake to look at the leaves but they were still green so we just drove around. -Residents were not taken shopping any more. Interview with a medication aide on 07/27/26 at 1:22pm revealed: -Residents went to the lake to see Christmas lights in December 2025 and to a petting zoo in the Spring 2026. -She thought Residents would be taken somewhere in the Fall of 2026. Interview with the Manager on 07/23/26 at 11:09am revealed: -She took the residents somewhere every three months. -In the fall they went to see the leaves at the lake. -At Christmas they went to view lights. -In April 2026 she took them to a farm event. -She was told last year that they could not count shopping as an outing so she stopped doing that regularly. -She did not know the residents were supposed to go somewhere every other month. Interview with the Administrator on 07/27/26 at 1:47pm revealed: -The Manager planned an outing quarterly. -He was told last year that shopping could not count as an outing so they stopped planning shopping activities. -He did not know outings needed to be planned for every other month.	D 319		

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RESTWELL HOME	401 US 221 S HIGHWAY RUTHERFORDTON, NC 28139

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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D 338	10A NCAC 13F .0909 Resident Rights	D 338		

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 observations, interviews, and record reviews, the facility failed to ensure 1 of 3 sampled residents (Resident #1) was free of exploitation when charging a resident additional fees for a private room.

The findings are:

Review of the facility's rates, refund, discharge/transfer policy revealed:
-Rates for public assistance recipients will be the maximum amounts allowed and approve in budgets set forth by the North Carolina General Assembly and/or the Social Services Commission of North Carolina Department of Human Resources.
-Resident and/or responsible parties will be notified and will be reflected with a signed amendment to the contract.
-No gratuities in addition to the rate are permitted.

Review of Resident #1's current FL2 dated 11/06/25 revealed:
-Diagnoses included dementia, Parkinson's disease, and type 2 diabetes.
-Resident #1 was intermittently disoriented.
-The recommended level of care was domiciliary.

Review of Resident #1's Resident Register revealed:
-The resident was admitted on 03/01/13.

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-The resident was her own responsible person.

Review of Resident #1's Care Plan dated 05/28/26 revealed:
-Resident #1 was sometimes disoriented, forgetful, and needed reminders.
-Resident #1 was totally dependent with ambulation/locomotion, bathing, dressing, and grooming/personal hygiene.
-Resident #1 required extensive assistance with transfers.

Review of the facility's census dated 07/22/26 revealed Resident #1 received State-County Special Assistance.

Review of Resident #1's handwritten contract dated 12/10/25 revealed:
-Resident #1 signed the contract agreeing to pay the facility $50.00 per month for a private room.
-Resident #1 agreed for the $50.00 to be collected from the State-County Special Assistance refund each month.
-The Manager and Assistant Manager signed the contract as witnesses.

Review of Resident #1's Special Assistance personal funds allowance receipts revealed:
-On 01/09/26, 02/10/26, 04/10/26, 05/12/26, 06/10/26, and 07/08/26 the amount of $50.00 was deducted from the resident's personal funds allowance as payment for a private room.
-On 03/09/26, the amount of $40.00 was deducted from the resident's personal funds allowance as payment for a private room.

Interview with the Manager on 07/23/26 at 2:55pm revealed:
-She was responsible for the accounting and disbursements of resident personal allowance

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funds each month.
-There were no personal funds ledgers because residents were refunded the left over balance each month after payment of their pharmacy bill.

Interview with Resident #1 on 07/24/26 at 3:39pm revealed:
-She did not remember if she received personal funds allowance money, because no one had ever told her.
-She did not have any family to help her.
-She had been led to believe that when things came due she had extra money available.

Observation of Resident #1's room on 07/24/26 at 3:56pm revealed:
-Resident #1 was the only resident occupying the room.
-The room was approximately six feet in width and contained a twin sized bed, bedside table, a recliner, and a three drawer chest.

Interview with a medication aide (MA) on 07/27/26 at 12:55pm revealed:
-Resident #1 was "easily confused" in her opinion.
-If you asked Resident #1 a simple question, she could not explain it to you.
-If you asked Resident #1 something related to a financial decision, she might make a decision and say that was what she wanted to do.
-But if you asked Resident #1 about the decision she had made 15 minutes later, she would not remember anything about it.

Interview with the Manager on 07/27/26 at 12:45pm revealed:
-Resident #1 received State-County Special Assistance.
-Resident #1 wanted to use $50.00 per month of

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D 338	Continued From page 17 her personal funds to pay in addition on a private room. -Resident #1 did not have a responsible person or guardian. -Resident #1 had a diagnosis of dementia and she was "forgetful". -Every month she would remind Resident #1 she was paying $50.00 out of her personal funds allowance to pay for a private room. -Resident #1 signed a receipt every month which detailed the deductions from her personal funds allowance. Telephone interview with the Administrator on 07/27/26 at 1:46pm revealed: -Resident #1 had recently been moved to a private room. -It was something Resident #1 had "agreed to do." -"We thought she should pay something." -He could not say Resident #1 was "cognizant of everything". -He planned to refund the money back to Resident #1.	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:	D 358		

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D 358	Continued From page 18 TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 3 sampled residents (Resident #1) related to two medications used to treat glaucoma and constipation. The findings are: Review of Resident #1's current FL2 dated 11/06/25 revealed diagnoses included atrial fibrillation, dementia, type II diabetes, and Parkinson's disease. a. Review of Resident #1's current FL2 dated 11/06/25 revealed there was an order for timolol maleate (used to treat glaucoma and lower pressure inside the eye to prevent vision loss) 0.5% eye drops one drop into each eye every morning. Review of Resident #1's primary care provider (PCP) order dated 01/02/26 revealed there was an order for timolol maleate 0.5% eye drops one drop into each eye every morning. Review of Resident #1's PCP orders dated 06/08/26 revealed there was an order for timolol maleate 0.5% eye drops one drop into each eye every morning. Review of Resident #1's March to June 2026 Medication Administration Records (MARs) revealed: -There were entries for timolol maleate 0.5% eye drops instill one drop into each eye every morning scheduled at 8:00am. -The timolol maleate 0.5% drops were	D 358		

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documented as administered daily at 8:00am.

Review of Resident #1's July 2026 MAR from 07/01/26-07/22/26 revealed:
-There was an entry for timolol maleate 0.5% eye drops instill one drop into each eye every morning scheduled at 8:00am
-The timolol maleate 0.5% drops were documented as administered daily at 8:00am.

Observation of Resident #1's medications on hand on 07/23/26 at 1:00pm revealed:
-There was one sealed bottle of timolol maleate 0.5% eye drops with an expiration date of June 2027 on the medication cart.
-The label directions were timolol maleate 0.5% instill one drop in each eye every morning with a dispense date of 04/09/26.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/23/26 at 1:37pm revealed:
-The pharmacy dispensed timolol maleate 0.5% for Resident #1 on 01/12/26 and 04/09/26.
-Each dispense date was for one bottle of timolol maleate 0.5% eye drops which provided a 31-day supply of the medication.

Interview with a medication aide (MA) on 07/23/26 at 12:50pm revealed:
-She did not know why Resident #1's timolol maleate 0.5% eye drops on the medication cart remained unopened.
-The only medication cart audit she was aware of was performed by the facility's contracted pharmacy "once or twice a year".
-She did not know what was involved in the pharmacy's cart audits.

Interview with Resident #1 on 07/23/26 at 2:00pm

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revealed sometimes she got her morning eye drops and sometimes not.

Interview with another MA on 07/27/26 at 12:55pm revealed:
-She routinely administered medications on the 7:00am-7:00pm shift.
-She did not know anything about why Resident #1's timolol maleate 0.5% eye drops dispensed 04/09/26 were unopened.

Interview with the facility Manager on 07/23/26 at 4:37pm revealed:
-She did not know why Resident #1's timolol maleate 0.5% eye drops were unopened on the medication cart.
-The facility did not perform medication cart audits.
-The facility's contracted pharmacy did however perform medication cart audits.
-The pharmacist last visited on 07/08/26.
-The pharmacy audits included looking at the medications on the medication carts.
-"Maybe" the pharmacist did not look at the medications on the cart "this last time."

Telephone interview with an ophthalmic technician from Resident #1's eye clinic on 07/23/26 at 2:09pm revealed the timolol maleate 0.5% eye drops were ordered to lower the pressure in Resident #1's eyes to prevent vision loss.

Refer to the telephone interview with the Administrator on 07/27/26 at 1:46pm.

b. Review of Resident #1's current FL2 dated 11/06/25 revealed there was an order for latanoprost (used to treat glaucoma by lowering eye pressure) 0.005% place one eye drop in

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each eye at bedtime.

Review of Resident #1's primary care provider (PCP) order dated 01/02/26 revealed latanoprost 0.005% eye drops one drop in each eye at bedtime.

Review of Resident #1's PCP order dated 06/08/26 revealed latanoprost 0.005% eye drops one drop in each eye at bedtime.

Review of Resident #1's March to June 2026 Medication Administration Records (MARs) revealed:
-There were entries for latanoprost 0.005% eye drops place one drop into each eye at bedtime scheduled at 8:00pm.
-The latanoprost 0.005% eye drops were documented as administered at 8:00pm nightly except for 04/28/26 and 05/16/26.

Review of Resident #1's July 2026 MAR from 07/01/26-07/22/26 revealed:
-There was an entry for latanoprost 0.005% eye drops place one drop into each eye at bedtime scheduled at 8:00pm.
-The latanoprost 0.005% eye drops were documented as administered at 8:00pm nightly.

Observation of Resident #1's medications on hand on 07/23/26 at 1:00pm revealed:
-There was bottle of latanoprost 0.005% eye drops on the medication cart with a handwritten open date of 04/09/26.
-The label directions were latanoprost 0.005% eye drops place one drop in each eye at bedtime with a dispense date of 04/09/26.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/23/26 at

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1:37pm revealed:
-The pharmacy dispensed latanoprost 0.005% eye drops for Resident #1 on 04/09/26 and 05/17/26.
-Each bottle of latanoprost eye drops was a 25-day supply.
-Latanoprost eye drops could be used for six weeks stored at room temperature.
-After six weeks, latanoprost lost its potency, was not as effective, and needed to be replaced.

Interview with Resident #1 on 07/23/26 at 2:00pm revealed she got her bedtime eye drops "sometimes" and not at other times.

Telephone interview with an ophthalmic technician from Resident #1's eye clinic on 07/23/26 at 2:09pm revealed:
-The latanoprost eye drops were ordered to lower Resident #1's eye pressure.
-Using latanoprost eye drops that had lost their potency was like not using the eye drops.

Interview with a medication aide (MA) on 07/23/26 at 12:50pm revealed:
-She worked the 7:00am to 7:00pm shift and did not routinely administer medications scheduled at 8:00pm.
-The only medication cart audit she was aware of was performed by the facility's contracted pharmacy "once or twice a year".
-She did not know what was involved in the pharmacy's cart audits.

Interview with another MA on 07/27/26 at 12:55pm revealed:
-She was not aware Resident #1's latanoprost eye drops were dated as having been opened on 04/09/26.
-She knew she would "get rid of" eye drops that

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were expired.
-She administered from an open bottle of eye drops until it was "empty."

Interview with the Manager on 07/23/26 at 4:37pm revealed:
-She was not aware Resident #1's latanoprost eye drops had been opened 04/09/26.
-The facility did not perform medication cart audits.
-The facility's contracted pharmacy did however perform medication cart audits.
-The pharmacist last visited on 07/08/26.
-The pharmacy audits included looking at the medications on the medication cart and checking for expired medications.
-"Maybe" the pharmacist did not look at the medications on the cart "this last time."

Interview with the Manager on 07/27/26 at 2:15pm revealed:
-The MAs were provided a guide from the pharmacy on how long they could use eye drops after opening.
-It was available to them in the medication room if they had questions.
-Latanoprost eye drops expired 42 days or six weeks after opening.

Refer to the telephone interview with the Administrator on 07/27/26 at 1:46pm.

c. Review of Resident #1's current FL2 dated 11/06/25 revealed there was an order for lactulose (used to treat constipation by drawing water into the bowel to soften stool) 10gm/15ml 30ml daily.

Review of Resident #1's primary care provider (PCP) order dated 01/02/26 revealed there was

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an order for lactulose 10gm/15ml 30ml once daily.

Review of Resident #1's PCP order dated 06/08/26 revealed there was an order for lactulose 10gm/15ml 30ml once daily.

Review of Resident #1's March to June 2026 Medication Administration Records (MARs) revealed:
-There were entries for lactulose 10gm/15ml 30ml once daily scheduled at 8:00am.
-The lactulose was documented as administered daily at 8:00am except for 05/29/26.

Review of Resident #1's July 2026 MAR from 07/01/26-07/22/26 revealed:
-There was an entry for lactulose 10gm/15ml 30ml once daily scheduled at 8:00am.
-The lactulose was documented as administered daily at 8:00am.

Observation of Resident #1's medications on hand on 07/23/26 at 1:00pm revealed:
-There was one open bottle of lactulose 10gm/15ml solution on the medication cart for Resident #1.
-The label directions were lactulose 10gm/15ml 30ml once daily with a dispense date of 04/09/26.
-There was a date opened sticker on the side of the bottle however there was not documented date of opening.
-Over three quarters of the lactulose solution remained in the bottle.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/23/26 at 1:37pm revealed:
-The lactulose was ordered to treat constipation.
-One bottle of lactulose was dispensed on

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D 358	Continued From page 25 11/30/23 and 04/09/26 for Resident #1. -One bottle was a 32-day supply. Telephone interview with Resident #1's PCP's nurse on 07/24/26 at 11:57am revealed: -Resident #1 was ordered lactulose daily for constipation. -The PCP was not "too concerned" Resident #1 was not receiving the lactulose daily as ordered. -Resident #1's constipation could be managed by diet. Refer to the telephone interview with the Administrator on 07/27/26 at 1:46pm. _____ Telephone interview with the Administrator on 07/27/26 at 1:46pm revealed: -All questions concerning medication administration should go through the Manager as she was a registered nurse. -He was more involved in the "overall running" of the facility. _____ The facility failed to administer pressure lowering eye drops to Resident #1 as prescribed including timolol which was unopened on the medication cart and latanoprost being administered after it should have been replaced due to loss of potency. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/23/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 10, 2026.	D 358		

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D 363	10A NCAC 13F .1004 (f) Medication Administration 10A NCAC 13F .1004 Medication Administration (f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage: (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container; (2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name; (3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and (4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section.	D 363		

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D 363	Continued From page 27 This Rule is not met as evidenced by: Based on observation and interviews,the facility failed to ensure medications prepared for administration in advance were kept in a sealed container that identified the name and strength of each medication prepared, identified up to the point of administration, and protected from contamination and spillage for 2 of 2 residents (#1 and #6). The findings are: Observation of a medication aide (MA) outside the facility dining room on 07/22/26 at 12:08pm revealed: -She was holding a plastic drawer in her hand. -There were seven medication cups inside the drawer. -The medication cups had handwritten labels with seven different resident names. -The medication cups contained loose and unsecured pills. -The medication cups with the loose pills were not labeled with the names of the medications. -The loose pills were not sealed; the medication cups did not have a covering. 1. Review of Resident #1's current FL2 dated 11/06/25 revealed diagnoses included atrial fibrillation, dementia, type II diabetes, and Parkinson's disease. Observation of a medication cup on 07/22/26 at 12:27pm revealed: -The medication cup had a handwritten label with Resident #1's first name. -There were two loose pills in the medication cup. -The medication cup was not labeled with the names and strengths of the two pills inside the	D 363		

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D 363	Continued From page 28 cup. -The medication cup was not sealed and protected from contamination and spillage. Refer to the interview with a MA on 07/22/26 at 12:09pm. Refer to the interview with a resident on 07/23/26 at 3:42pm. Refer to the interview with the Manager on 07/24/26 at 12:15pm. 2. Review of Resident #6's current FL2 dated 01/22/26 revealed diagnoses included hypertension, kyphosis of spine (curvature of upper back), peripheral neuropathy, and anxiety disorder. Observation of a medication cup on 07/22/26 at 12:28pm revealed: -The medication cup had a handwritten label with Resident #6's first name. -There was one loose pill in the medication cup. -The medication cup was not labeled with the name and strength of the pill inside the cup. -The medication cup was not sealed and protected from contamination and spillage. Refer to the interview with a MA on 07/22/26 at 12:09pm. Refer to the interview with a resident on 07/23/26 at 3:42pm. Refer to the interview with the Manager on 07/24/26 at 12:15pm. _____ Interview with a MA on 07/22/26 at 12:09pm revealed:	D 363		

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-She prepoured and documented administration of the residents medications before leaving the medication room.
-She would then take the prepoured medications to the residents in the dining room to administer.
-The medication cart was "too big and heavy" for her to push in the hallway so she left it in the medication room.
-It would take "too long" to walk back and forth to individually prepare and administer each residents medication from the medication room.
-She was not the only MA who prepoured and administered the residents medications in the same way.
-A former MA had shown her how to prepour medications for administration.

Interview with a resident on 07/23/26 at 3:42pm revealed:
-All the MAs, with the exception of the Assistant Manager, put our pills in medication cups.
-The cups have our names and the date on them.
-The MAs bring the cups with pills on a tray.
-Other medications like eye drops, the MAs put those in their pockets.
-The MAs carry the tray of pills around from room to room to administer them to the residents.
-The Assistant Manager was the only one that would bring the medication cart out to administer medications.

Interview with the Manager on 07/24/26 at 12:15pm revealed:
-The medication cart was changed out about three months prior.
-The cart was "bigger" and "harder to move" from the medication room.
-The MAs were putting the resident names on the prepoured medication cups.
-The MAs were now going to be administering the

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D 363	Continued From page 30 medications individually.	D 363		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a medication aide (MA) recorded the administration of the medications after she observed the residents to take their medications. The findings are: Observation of a medication aide (MA) outside the dining room on 07/22/26 at 12:08pm revealed: -She was holding a plastic drawer in her hand. -There were seven medication cups inside the drawer which contained oral medications. -The medication cups had handwritten labels with seven different resident names. Interview with the MA on 07/22/26 at 12:09pm revealed: -The MAs all "do this". -She always prepoured and documented	D 366		

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administration of the residents medications as she prepared them prior to leaving the medication room.
-She would then take the prepoured medications to the residents and administer them.

Observations of the MA in the dining room on 07/22/26 from 12:19pm to 12:28pm revealed:
-At 12:19pm, the MA handed a resident a medication cup with her first name handwritten on it and observed the resident to swallow the medications.
-The MA did not document the administration after observing the resident take the medication.
-At 12:25pm, the MA handed another resident a medication cup with her first name handwritten on it and observed the resident pour the crushed medication into the turkey salad she was eating.
-The MA watched as the resident consumed the crushed medication in two bites of the turkey salad.
-The MA did not document the administration after observing the resident take the medication.
-At 12:26pm, the same MA mixed a small amount of pudding into a crushed medication and then handed the medication cup with a spoon to the resident who's first name and last name initial was printed on the cup and observed the resident spoon out the pudding and medication and swallow it .
-The MA did not document the administration after observing the resident take the medication.
-At 12:27pm, the MA handed a third resident a medication cup with her first name handwritten on it and observed the resident swallow the two medications inside the cup.
-The MA did not document the administration after observing the resident take the medication.
-At 12:28pm, the MA handed a fourth resident a medication cup with her first name handwritten on

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D 366	Continued From page 32 it and observed the resident to swallow the one orange tablet inside the cup. -The MA did not document the administration after observing the resident take the medication. Interview with a resident on 07/23/26 at 3:42pm revealed: -All the MAs, with the exception of the Assistant Manager, put our pills in medication cups. -The cups have our names and the date on them. -The MAs bring the cups with pills on a tray. -Other medications like eye drops, the MAs put those in their pockets. -The MAs carry the tray of pills around from room to room to administer them to the residents. -The MAs would place the prepoured medications in cups at each resident's place at the table. -"Most" of the MA's did watch the residents take the medications from the cups. -The MAs brought bedtime medications around to the residents rooms. Interview with the Manager on 07/22/26 at 2:58pm revealed: -The MA should administer medications to one resident at a time. -The MA should document the administration of the medication after they observed the residents to take the medications.	D 366		
D 392	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate	D 392		

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reconciliation of controlled substances.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure one medication aide (MA) documented the administration of controlled substances after each administration.

The findings are:

Observation of a medication aide (MA) outside the dining room on 07/22/26 at 12:08pm revealed:
-She was holding a plastic drawer in her hand.
-There were seven medication cups inside the drawer which contained oral medications.
-The medication cups had handwritten labels with seven different resident names.

Interview with the MA on 07/22/26 at 12:09pm revealed:
-The MAs all "do this."
-She always prepoured and documented administration of all the residents medications before leaving the medication room.
-She documented scheduled controlled substances on the medication administration records (MARs).
-She documented as needed controlled substances on the back of the MARs with the date and time of administration.
-She would then take the prepoured medications to the residents to administer.
-She waited until the end of her shift to document all administrations of controlled substances on each residents controlled substance sheets.

Review of Resident 2's current FL2 dated 09/19/25 revealed diagnoses included a history of

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D 392	Continued From page 34 insomnia, schizophrenia and bi-polar disorder. Review of Resident #2's physician's orders revealed: -Clonazepam (used to treat anxiety) 1 mg, take 1/2 tablet at 8:00am. -Clonazepam 1 mg, take 1 tablet at noon, 4:00pm and 8:00pm. Review of Resident #2's 07/22/26 electronic medication administration record (eMAR) revealed: -There was an entry for clonazepam 1 mg, take 1/2 tablet at 8:00am and it was documented as administered. -There was an entry for clonazepam 1 mg, take 1 tablet at noon, 4:00pm and 8:00pm and it was documented as administered at noon. Observation of Resident #2's medications on hand on 07/22/26 at 4:07pm revealed: -There was a bubble pack containing 3 doses of clonazepam 1 mg, 1/2 tablet. -There was a bubble pack containing 11 doses of clonazepam 1 mg, 1 tablet. Review of Resident #2's controlled substance count sheets (CSCS) for clonazepam 1mg, 1/2 tablet revealed: -There was documentation it was last administered on 07/21/26 at 8:00am. -There was documentation there were 4 tablets left in the bubble pack. -There was no documentation it was administered on 07/22/26 at 8:00am. Review of Resident #2's CSCS for clonazepam 1mg, 1 tablet revealed: -There was documentation it was last administered on 07/21/26 at 8:00pm.	D 392		

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D 392	Continued From page 35 -There was documentation there were 13 tablets left in the bubble pack. -There was no documentation it was administered on 07/22/26 at noon or 4:00pm. Interview with the Manager on 07/22/26 at 2:58pm revealed the MAs were trained to document administration of controlled substances on the MARs and the controlled substance sheets with each administration. Interview with the Manager on 07/24/26 at 12:15pm revealed: -She told the MAs to document controlled substance administrations individually as they administer them. -She was not aware the MAs were not documenting all the controlled substances administrations until the end of their shifts.	D 392		
D 398	10A NCAC 13F .1008 (g) Controlled Substance 10A NCAC 13F .1008 Controlled Substance (g) A dose of a controlled substance accidentally contaminated or not administered shall be destroyed at the facility. The destruction shall be conducted so that no person can use, administer, sell, or give away the controlled substance. The destruction shall be documented on the medication administration record (MAR) or the controlled substance record showing the time, date, quantity, manner of destruction, and the initials or signature of the person destroying the substance. This Rule is not met as evidenced by:	D 398		

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D 398	Continued From page 36 TYPE B VIOLATION Based on observations and interviews, the facility failed to destroy individual doses of controlled substances prepared for administration, refused, and not administered. The findings are: Observation of a medication aide (MA) outside the dining room on 07/22/26 at 12:08pm revealed: -She was holding a plastic drawer in her hand. -There were seven medication cups inside the drawer which contained oral medications. -The medication cups had handwritten labels with seven different resident names. Interview with the MA on 07/22/26 at 12:09pm revealed: -The MAs all "do this." -She always prepoured and documented administration of the residents medications before leaving the medication room. -She prepoured the 8:00am and the 12:00pm medications. -She would then take the prepoured medications to the residents in the dining room to administer. -The medication cart was "too big and heavy" for her to push in the hallway so she left it in the medication room. -It would take "too long" to walk back and forth to individually prepare and administer each residents medication from the medication room. -When a resident refused a prepoured controlled substance, she notified the Manager or Assistant Manager and then put the controlled substance back into an open bubble pack location and "taped over " the paper on the back of the bubble with a change of direction sticker.	D 398		

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D 398	Continued From page 37 -She then would make a note on the residents controlled substance sheet to indicate the dose was returned to inventory due to refusal. -She would communicate the return of the controlled substance at shift change during the controlled substance count with the oncoming shift MA. -She only returned doses of controlled substances to inventory, because they had to keep a "strict count" of controlled substance medications. Interview with the Manager on 07/22/26 at 2:58pm revealed: -When a resident refused a prepoured controlled substance for administration the MAs "waste it". -The MAs had to get someone to verify the waste of a controlled substance. -They did not tape over locations on the back of controlled substance bubble packs to keep doses returned to bubble packs in place. Observation of the available controlled substances packaging on the medication cart on 07/22/26 at 4:05pm revealed: -There were eight residents who had bubble packages of controlled substances stored on the medication cart. -There were three bubble packages of controlled substances which had change of direction stickers affixed to the back of bubble packages, but the bubbles were empty. -The bubble pack medications with stickers on empty bubble locations included lorazepam 0.5mg tablet (used to treat anxiety), lacosamide 150mg tablet (used as an anti-convulsant medication), and pregabalin 150mg capsule (used to treat pain). Interview with another MA on 07/24/26 at 9:07am	D 398		

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D 398	Continued From page 38 revealed: -She administered doses of controlled substances stored in bubble packs that were taped over on the back with change of direction stickers. -She would flip the bubble pack of controlled substance over and compare the medication in the taped over location to the other medication in the bubble pack before administering it to the resident. Interview with a third MA on 07/27/26 at 12:55pm revealed: -When she found a controlled substance secured in place by a change of direction sticker over an open bubble pack location, she would assume another MA had prepared the controlled substance for administration by "accident or it came out" of the bubble pack. -If the taped over dose of controlled substance was the next bubble pack location in line to be used, she would administer it to a resident. Interview with the Manager on 07/24/26 at 12:15pm revealed: -She was not aware the MAs had been administering doses of controlled substances that had been returned to the bubble packages and secured into the package by change of direction stickers. -She did not pay "any attention." Telephone interview with the Administrator on 07/27/26 at 1:46pm revealed: -All questions concerning medication administration should go through the Manager as she was a registered nurse. -He was more involved in the "overall running" of the facility.	D 398		

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D 398	Continued From page 39 The facility failed to waste prepared doses of controlled substances instead reinserted the dose into bubble packaging with change of direction stickers to secure them and the medication aides would then administer those controlled substances. This was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/22/26. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 10, 2026.	D 398		
D 421	10A NCAC 13F .1104 (c) Accounting For Resident's Personal Funds 10A NCAC 13F .1104 Accounting For Resident's Personal Funds (c) The facility shall provide each resident or the resident's authorized representative a written monthly accounting of the resident's funds handled by the administrator or the administrator's designee. The facility shall maintain at the facility a record signed by the resident or their authorized representative indicating whether the resident or their authorized representative agrees that the monthly accounting is accurate. The records shall be maintained by the facility for at least one year.	D 421		

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D 421	Continued From page 40 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to provide each resident a monthly accounting of the resident's funds for 2 of 4 sampled residents (Resident #1 and #4) related to residents not being shown their pharmacy bills and not allowing the residents to choose how much of their personal funds allowance to be paid to the pharmacy each month. The findings are: 1. Review of Resident #4's current FL2 revealed diagnoses included dementia, hypokalemia, anxiety, and depression. Review of Resident #4's Resident Register revealed an admission date of 12/15/25. Review of Resident #4's representative payee form dated 12/15/25 revealed: -She agreed for the facility to become her representative payee. -She agreed to ensure her cost of care, pharmacy and other bills would be paid. -She agreed to inform the Social Security Administration of a change of address when she moved from the facility. Review of Resident #4's Personal Funds Agreement revealed: -She chose to manage all personal spending funds. -The facility would not be held liable for any expenses incurred. Review of Resident #4's record revealed there was no personal funds ledger available for review for January 2026-July 2026.	D 421		

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Review of Resident #4's personal funds allowance receipts revealed:
-Resident #4 signed the personal allowance receipts dated 03/09/26, 03/26/26, 04/10/26, 05/12/26, 06/10/26, and 07/08/26.
-On 03/09/26, $90.00 was received, $30.00 was deducted to pay the pharmacy, and $60.00 was refunded to the resident.
-On 03/26/26, $90.00 was received for the February refund.
-On 04/10/26, $90.00 was received, $30.00 was deducted to pay the pharmacy, and $60.00 was refunded to the resident.
-On 05/12/26, $90.00 was received, $30.00 was deducted to pay the pharmacy, and $60.00 was refunded to the resident.
-On 06/10/26, $90.00 was received, $30.00 was deducted to pay the pharmacy, and $60.00 was refunded to the resident.
-On 07/08/26, $90.00 was received, $30.00 was deducted to pay the pharmacy, and $60.00 was refunded to the resident.

Review of Resident #4's record revealed the pharmacy invoices were not available and had to be requested from the pharmacy.

Review of Resident #4's pharmacy invoice dated 01/31/26 revealed:
-The invoice was for charges from 01/01/26-01/29/26.
-The beginning balance was $3.86.
-The total charges were $18.75 and $0.06 in finance charges.
-The ending balance was $22.67.

Review of Resident #4's pharmacy invoice dated 02/28/26 revealed:
-The invoice was for charges from 01/29/26-02/26/26.

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-The beginning balance was $22.67.
-The total charges were $39.39 and $0.32 in finance charges.
-The ending balance was $60.98.

Review of Resident #4's pharmacy invoice dated 03/31/26 revealed:
-The invoice was for charges from 03/04/26-03/28/26.
-The beginning balance was $60.98.
-The total charges were $26.30 and $0.46 in finance charges.
-There was a payment of $30.00 on 03/09/26.
-The ending balance was $60.98.

Review of Resident #4's pharmacy invoice dated 04/30/26 revealed:
-The invoice was for charges from 03/23/26-04/28/26.
-The beginning balance was $57.74.
-The total charges were $138.49 and $0.22 in finance charges.
-There was a credit of $12.10.
-There was a payment of $30.00 on 04/10/26.
-The ending balance was $154.35.
-On 03/23/26, there was a charge for $100.09 for benzonatate 100mg capsule RX#6130562
-On 03/23/26, there was a credit for $12.10 for benzonatate 100mg capsule RX#6130562
-On 04/08/26, there was a charge for $12.10 for benzonatate 100mg capsule RX#6130562
-On 04/23/26, there was a charge for $12.10 for benzonatate 100mg capsule RX#6130562

Review of Resident #4's account information provided by the pharmacy on 07/27/26 revealed:
-On 05/11/26, there was a charge for $12.10 for benzonatate 100mg capsule RX#6130562
-On 05/11/26, there was a credit of $100.09 for benzonatate 100mg capsule RX#6130562.

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D 421	Continued From page 43 -There was no additional account activity for May 2026. Review of Resident #4's pharmacy invoice dated 06/30/26 revealed: -The invoice was for charges from 06/01/26-06/30/26. -The beginning balance was $70.83. -The total charges were $68.23 and $0.61 in finance charges. -There was a payment of $30.00 on 06/10/26. -The ending balance was $109.67. Interview with Resident #4 on 07/22/26 at 9:55am revealed: -She received $90 each month in personal funds allowance. -The facility required her to pay $30 every month to pay her pharmacy bill. -She was not given a choice about how much she wanted to pay on her pharmacy bill each month. Subsequent interview with Resident #4 on 07/24/26 at 4:50pm revealed: -The Manager made her pay $30.00 each month from her personal funds allowance to pay her pharmacy bill. -She was told if she did not pay her pharmacy bill the pharmacy would not send her medications. -That was why she wanted to go to the Social Security office and see if she could "get extra help". -The Manager did not show her the pharmacy bill she owed each month. -She did not understand why her medications cost so much when special assistance brand name drug copays were $4.00 and generic drug copays were $1.50 each. -She did not have money to buy deodorant, shampoo, conditioner, and body wash.	D 421		

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D 421	Continued From page 44 -She would like to have money to buy some cologne at the local discount store. Telephone interview with the facility's contracted pharmacy on 07/24/26 at 9:14am revealed: -Resident #4 had a balance due of $79.67. -The charges billed were $165.24. -There was a payment of $30.00 made on 06/30/26. Refer to the interview with the Manager on 07/23/26 at 2:55pm. Refer to the interview with the Manager on 07/23/26 at 4:37pm. Refer to the interview with the Manager on 07/24/26 at 12:15pm. Refer to the telephone interview with the Administrator on 07/27/26 at 1:46pm. 2. Review of Resident #1's FL2 dated 11/06/25 revealed diagnoses included dementia, Parkinson's disease, and type 2 diabetes. Review of Resident #1's Resident Register revealed: -The resident was admitted on 03/01/13. -The resident was her own responsible person. Review of the facility's census dated 07/22/26 revealed Resident #1 received State-County Special Assistance. Review of Resident #1's pharmacy agreement dated 03/01/13 revealed: -The pharmacy agreement was signed by Resident #1 on 03/01/13. -The pharmacy would bill the resident or	D 421		

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responsible party monthly.
-The statement would be mailed to the responsible party by the first day of the following month and statement will be due before the 21st day of the following month.
-Any statement not paid in full or within 30-days of the receipt of the statement shall accrue interest at the rate of 1.5% per month.
-If any payment is over 60-days past due, deliveries of medication, supplies, and/or equipment will be suspended until the bill is paid in full or other payment arrangements are made.

Review of Resident #1's record revealed there was no representative payee form.

Review of Resident #1's record revealed there was no personal funds agreement form.

Review of Resident #1's record revealed there was no personal funds ledger available for review for January 2026-July 2026.

Review of Resident #1's personal funds allowance receipts revealed:
-Resident #1 signed the personal allowance receipts dated 01/09/26, 02/10/26, 03/09/26, 04/10/26, 05/12/26, 06/10/26, and 07/08/26.
-On 01/09/26, $90.00 was received, $7.03 was deducted to pay the pharmacy, $50.00 was deducted to pay for a private room, and a balance of $32.97 was refunded to the resident.
-On 02/10/26, $90.00 was received, $40.00 was deducted to pay the pharmacy, $50.00 was deducted to pay for a private room, and there was no money refunded to the resident.
-On 03/09/26, $90.00 was received, $50.00 was deducted to pay the pharmacy, $40.00 was deducted to pay for a private room, and there was no money refunded to the resident.

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D 421	Continued From page 46 -On 04/10/26, $90.00 was received, $40.00 was deducted to pay the pharmacy, $50.00 was deducted to pay for a private room, and there was no money refunded to the resident. -On 05/12/26, $90.00 was received, $40.00 was deducted to pay the pharmacy, $50.00 was deducted to pay for a private room, and there was no money refunded to the resident. -On 06/10/26, $90.00 was received, $40.00 was deducted to pay the pharmacy, $50.00 was deducted to pay for a private room, and there was no money refunded to the resident. -On 07/08/26, $90.00 was received, $40.00 was deducted to pay the pharmacy, $50.00 was deducted to pay for a private room, and there was no money refunded to the resident. Review of Resident #1's record revealed the pharmacy invoices were not available and had to be requested from the pharmacy. Review of Resident #1's pharmacy invoice dated 01/31/26 revealed: -The invoice was for charges from 01/01/26-01/29/26. -There was a payment of $7.03 on 01/08/26. -The total account balance was $86.17. Review of Resident #1's pharmacy invoice dated 02/28/26 revealed: -The invoice was for charges from 02/12/26-02/26/26. -There was a payment of $40.00 on 02/09/26. -The total account balance was $72.60. Review of Resident #1's pharmacy invoice dated 03/31/26 revealed: -The invoice was for charges from 03/06/26-03/30/26. -There was a payment of $50.00 on 03/09/26.	D 421		

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D 421	Continued From page 47 -The total account balance was $61.97. Review of Resident #1's pharmacy invoice dated 04/30/26 revealed: -The invoice was for charges from 04/06/26-04/27/26. -There was a payment of $40.00 on 04/10/26. -The total account balance was $67.18. Review of Resident #1's pharmacy invoice dated 05/31/26 revealed: -The invoice was for charges from 05/07/26-05/26/26. -There was a payment of $40.00 on 05/11/26. -The total account balance was $73.96. Review of Resident #1's pharmacy invoice dated 06/30/26 revealed: -The invoice was for charges from 05/12/26-06/29/26. -There was a payment of $40.00 on 06/10/26. -The total account balance was $96.75. Interview with Resident #1 on 07/24/26 at 3:39pm revealed: -The Manager did not show her the balance on her pharmacy bills each month. -She would like to be "kept in the loop" as to how much it was going to be. -The Manager did not ask her how much she wanted to pay the pharmacy each month. Refer to the interview with the Manager on 07/23/26 at 2:55pm. Refer to the interview with the Manager on 07/23/26 at 4:37pm. Refer to the interview with the Manager on 07/24/26 at 12:15pm.	D 421		

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D 421	Continued From page 48 Refer to the telephone interview with the Administrator on 07/27/26 at 1:46pm. Interview with the Manager on 07/23/26 at 2:55pm revealed: -She was responsible for the accounting and disbursements of resident personal allowance funds each month. -She was also responsible for taking cash payments on behalf of the residents to the pharmacy to pay towards their pharmacy balances. -Residents who received personal funds allowance were refunded the left over balance each month after payment of their pharmacy bill. -She took out $30.00 from the residents $90.00 personal allowance funds each month to pay towards the resident's pharmacy bill balances. Interview with the Manager on 07/23/26 at 4:37pm revealed: -The facility's contracted pharmacy sends a monthly bill for each resident. -She would go up to the pharmacy with each resident's $90.00 personal allowance funds. -If the resident's pharmacy bill had a balance greater than $30, she would just pay $30.00 on the balance. -She had to pay "a little bit" each time on the pharmacy bill so the residents could continue to get their medications. -She then gave the residents what was left of their personal funds allowance. -The residents were required to sign a receipt indicating what monies were received, how they were disbursed, and the amount the resident was refunded. Interview with the Manager on 07/24/26 at	D 421		

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D 421	Continued From page 49 12:15pm revealed: -She did not show the residents the bills she received on their behalf from the pharmacy each month. -She did not show th resident their pharmacy bills unless a resident asked to see their bill. -"I just never have bothered them with it." -There was no set amount she required the residents to pay towards their pharmacy bill, but she tried to keep their pharmacy payments up to date. -The residents seemed to be "fine with that." -A couple of the residents did not think they needed to have a pharmacy bill. -It was not as if she was trying to keep the pharmacy bill information from the residents. -She tried to keep it where the residents were paying something towards their pharmacy bill. -The pharmacy worked with the residents with balances. Telephone interview with the Administrator on 07/27/26 at 1:46pm revealed: -We just give the residents $90.00 each month in personal allowance funds. -Then we try to pay the pharmacy out of the $90.00. -Then the resident received what was left over. -He had never had a resident ask for anything they cannot buy. -He was not aware the residents should be shown their pharmacy bills each month. -The Manager was responsible for paying the residents pharmacy bills each month and disbursing the funds to each resident. -He guessed if the residents wanted to see it they could show them their pharmacy bills, but most of them would not know what they were looking at. -He could have the residents sign the pharmacy bill each month to verify they saw them.	D 421		

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D 421	Continued From page 50 -The pharmacy bills may have been shown to some of the residents, but the residents "may not remember."	D 421		
D 456	10A NCAC 13F .1212(g) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (g) In the case of physical assault by a resident or whenever there is a risk that death or physical harm will occur due to the actions or behavior of a resident, the facility shall immediately: (1) seek the assistance of the local law enforcement authority; (2) provide additional supervision of the threatening resident to protect others from harm; (3) seek any needed emergency medical treatment; (4) make a referral to the Local Management Entity for Mental Health Services or mental health provider for emergency treatment of the threatening resident; and (5) cooperate with assessment personnel assigned to the case by the Local Management Entity for Mental Health Services or mental health provider to enable them to provide their earliest possible assessment. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to seek the assistance of local law enforcement for 2 of 2 sampled residents (Resident #5 and #6) related to a physical assault. The findings are: Review of Resident #6's current FL2 dated	D 456		

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D 456	Continued From page 51 01/22/26 revealed diagnoses included hypertension, kyphosis of spine, peripheral neuropathy, and anxiety disorder. Review of Resident #6's Resident Register revealed: -There was an admission date of 03/18/24. -Resident #6 was her own responsible person. Review of Resident #6's Care Plan dated 04/16/26 revealed: -Resident #6 required extensive assistance with ambulation/locomotion and bathing. -Resident #6 required limited assistance with dressing and grooming/personal hygiene. -Resident #6 was oriented but was forgetful and needed reminders. Review of Resident #5's current FL2 dated 03/26/26 revealed diagnoses included mental handicap, epilepsy and psychophysiologic insomnia (a chronic sleep problem driven by learned anxiety about sleep). Review of Resident #5's Resident Register revealed: -There was an admission date of 04/24/25. -A family member was Resident #5's power of attorney. Review of Resident #5's Care Plan dated 03/23/26 revealed: -Resident #5 required extensive assistance with bathing and grooming. -Resident #5 required limited assistance with toileting and dressing. -Resident #5 needed supervision with eating, ambulation and transfers. -Resident #5 was monitored for behaviors and seizure activity.	D 456		

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D 456	Continued From page 52 Interview with a resident on 07/22/26 at 2:45pm revealed: -Resident #5 "constantly threatened to beat us up, kill us and hurt us". -We "have to walk on eggshells around her". -We should be able to feel safe here because this was our home and we paid to live here. -We told the Manager, but nothing was ever done about it. Interview with Resident #6 on 07/23/26 at 9:37am revealed: -Resident #5 was once her roommate. -Resident #5 punched her in the side of her head and "knocked me out." -When she "came to" Resident #5 had hold of her hair in both of her hands and was jerking her head back and forth by her hair "real hard". -Her hair "came out." -She managed to slam into Resident #5, and it knocked her across the bed. -She got on top of Resident #5 and hit her one time with her fist. -Resident #5 started crying and said, "Don't hit me." -The incident occurred two to three months before Resident #5 was moved to another room. -She tried to press charges against Resident #5 by calling the magistrate but because both she and Resident #5 lived in an assisted living facility the magistrate refused to do a warrant. -Resident #5 was "violent." -Resident #5 frightened several of the residents. -Resident #5 would say "I'm gonna start swinging. I'm not playing." Subsequent interview with Resident #6 on 07/24/26 at 9:45am revealed: -The medication aide (MA) on duty had opened	D 456		

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the door and then closed it during the altercation with Resident #5.
-The MA said she did not realize she and Resident #5 were fighting.
-The night of the incident or the next day, she had spoken with the MA and told her what had happened.
-The MA said she did not see them physically fighting.
-She called the local Sheriff's department to try to take out a warrant.
-She believed they would take Resident #5 to jail.
-She spoke to the magistrate over the phone.
-The magistrate asked for the address and when she gave it to him, he started laughing and informed her they would not issue a warrant for Resident #5 because she lived at the facility.
-She told the Manager about the incident, but it was at least a month after the incident before she told the Manager.

Review of Resident #6's record revealed:
-There was no incident report concerning the fight between Resident #6 and #5.
-There was no documentation detailing the incident in Resident #6's nursing note entries.

Telephone interview with Resident #6's family member on 07/24/26 at 4:29pm revealed:
-Some months back Resident #6 was in a room with another resident and the roommate was physically aggressive.
-Six months ago, the roommate was moved to another room due to ongoing altercations between the two residents.
-From telephone conversations she had with Resident #6, it sounded like Resident #6 was "assaulted" by the roommate.
-Resident #6 told her the roommate had assaulted her and she was unconscious.

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D 456	Continued From page 54 -She did not think Resident #6 was taken to the hospital for evaluation after the incident. Telephone interview with Resident #6's primary care provider (PCP) nurse on 07/24/26 at 4:00pm revealed: -There were no notes concerning a physical altercation involving Resident #6 being reported to the PCP from July 2025-December 2025. -The only other way the PCP would have known about the physical altercation would have been if Resident #6 had mentioned it to him during a visit. -They did not often hear from the facility unless they needed a refill on a medication for Resident #6. Interview with the Assistant Manager on 07/24/26 at 2:50pm revealed: -Resident #6 did not have a mental health provider (MHP). -The last time Resident #6 saw her PCP on 07/16/26, it was discussed the PCP would refer the resident to a local MHP. -The PCP's office staff were going to setup an appointment with the MHP for Resident #6. -She had not received a call back from the MHP with an appointment. -She contacted the PCP and he said he would send a second referral to the MHP for Resident #6. Interview with Resident #5 on 07/24/26 at 10:10am revealed: -She and Resident #6 got into a "big brawl" in November or December 2025. -Resident #6 threw a "jab" first and then tried to press charges with law enforcement. -She grabbed Resident #6 by the hair and threw her to the floor.	D 456		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081007	A. BUILDING: _____ B. WING _____	R-C 07/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 456	Continued From page 55	D 456		

-The MA on duty had her come to the living room to calm down.
-Two MAs knew about the incident between she and Resident #6.
-The Manager and Assistant Manager found out about the incident the next day.
-She was called into the office with the Manager and Assistant Manager and they told her Resident #6 was going to press charges.

Review of Resident #5's record revealed:
-There was no incident report concerning the fight between Resident #5 and #6.
-There was no documentation detailing the incident in Resident #5's nursing note entries.

Review of Resident #5's record revealed she was seen by a mental health provider on 01/05/26, 02/02/26, 03/05/26, 04/23/26 and 07/16/26.

Interview with Resident #5's mental health provider on 07/27/26 at 1:01pm revealed:
-She received a referral to start providing services on 10/27/25.
-The referral did not mention an incident between residents only that Resident #5 had mental health needs and they wanted her to get established with services.

Interview with a MA on 07/27/26 at 12:55pm revealed
-She worked during the supposed altercation involving Resident #5 and Resident #6.
-She did not witness the altercation.
-Resident #6 told her about the incident which prompted her to look for injuries on Resident #5 and Resident #6.
-She told Resident #5 and Resident #6 they had to figure out how to get along and to stay away from each other for the day.

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D 456	Continued From page 56	D 456		

-She did not recall either Resident #6 or #5 requesting to be taken to the magistrate to press charges.
-She had never witnessed Resident #5 to be physically aggressive.
-Resident #5 would get upset with her for enforcing rules like curfew.
-Resident #5 would say "I'm gonna whoop your butt."
-Resident #5 would act like she was going to "lunge" at her, but it was a "fake out".
-She knew Resident #5 was not going to hit her because Resident #5 knew she would get into "major trouble" if she did.

Interview with the Manager on 07/23/26 at 11:09am and 1:17pm revealed:
-Resident #5 got upset every once in a while.
-Resident #5 never hurt or attacked anyone that she was aware of.
-She could not remember if Resident #5 had a confrontation with Resident #6, but she knew they did not get along.
-Because she did not get along with her roommate, Resident #5 was moved to a different room.

Interview with the Assistant Manager on 07/24/26 at 11:01am revealed:
-Resident #5 and Resident # 6 said the other one physically attacked them.
-Each claimed they did not do anything.
-She checked both Resident #5 and Resident #6 and there were "no marks or anything."
-She moved Resident #5 to another room soon after.
-Resident #6 talked about pressing charges against Resident #5 over the incident but she did think Resident #6 ever did press charges.
-She had never known Resident #5 to touch

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D 456	Continued From page 57	D 456		

another resident.
-Resident #5 did yell and threaten residents when she was angry.
-Resident #5 had an "anger problem."
-She and the Manager did not call law enforcement out concerning the altercation between Resident #5 and Resident #6 because it was unwitnessed and there were no physical indications anything had happened.

Interview with the Assistant Manager on 07/24/26 at 3:20pm revealed:
-Incident and Accident reports were completed by the staff who were working at the time of the event and since no one witnessed the incident between Resident #5 and Resident #6 and an incident report was not completed.
-She did not contact law enforcement after the incident between Resident #5 and Resident #6 because Resident #6 would have needed to call law enforcement if she wanted to press charges.
-She would call law enforcement if she witnessed a physical altercation or if a resident was angry and refused to calm down.
-The facility did not have a policy for guidance on when to contact local law enforcement or when to complete an accident & incident report related to a behavioral incident.

Telephone interview with the Administrator on 07/27/26 at 1:46pm revealed:
-He preferred there to be a witness to a physical altercation between residents or physical evidence of like "a black eye" before contacting law enforcement.
-Without physical evidence somebody could just claim something happened.
-The incident between Resident #5 and Resident #6 had been unwitnessed.
-The staff should have completed an incident

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D 456	Continued From page 58 report. -Resident #5 had been "kind of aggressive", but he did not know if she had ever gotten physically into it with anybody. -He thought Resident #5's medical providers were still trying to adjust her medications. -If both Resident #5 and Resident #6 said the altercation was physical "then we should have called law enforcement."	D 456		