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	HAL073018	A. BUILDING: _____ B. WING _____	C 09/05/2025

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THE CANTERBURY HOUSE	1284 LEASBURG ROAD ROXBORO, NC 27573

(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 Licensure Section conducted a complaint investigation from 09/02/25 to 09/05/25.	D 000		
D 067	10A NCAC 13F .0305 (h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) in facilities with at least one resident who is determined by a physician or is otherwise observed by staff to be disoriented or exhibits wandering behavior, a continuously sounding device that is activated when the door is opened shall be located on each exit door that opens to the outside. The sound shall be audible in the facility. If a central system of remote sounding devices is provided, the control panel shall be powered by the facility's electrical system, and be in a location accessible by staff to operate the control panel. Notwithstanding the requirements of Rule .0301, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 3 of 7 exit doors that were accessible to three residents (#4, #7, #15) including one resident who was constantly disoriented (#4) and two residents who were intermittently disoriented (#7, #15), had a continuously sounding device that was activated	D 067		

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when the exit doors were opened to alert staff.

The findings are:

Interview with the Administrator on 09/02/25 at 9:30am revealed:
-His first day as the Administrator of the facility was 09/01/25.
-The former Administrator retired in March 2025.
-The Interim Administrator returned this week to help him with the state survey.

Review of the facility's Assisted Living (AL) roster on 09/02/25 revealed there was a census of 33 residents.

Observation of the exit door to the smoking area at intermittent times on 09/02/25 between 8:15am-5:00pm revealed:
-Residents entered and exited the door, which was located at the back of the kitchenette.
-No staff members were observed responding to the door when the alarm sounded.

Observation of the exit door to the smoking area on 09/02/25 at 6:02pm and on 09/03/25 at 10:13am revealed the door was ajar approximately one inch, and the door alarm was not engaged, which allowed residents to exit the facility without the door alarming.

Observation of the smoking area on 09/02/25 at 2:45pm revealed the area was not enclosed, and a resident could walk away from the facility through a field and/or walk around the facility to the front or side parking area.

Observation of the dining room exit door on 09/04/25 at 6:49pm revealed:
-The door was not locked.

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-An alarm sounded when the door was opened.
-The alarm only sounded for a few seconds and stopped before the door closed back.
-The area was not enclosed, and the side parking lot could be accessed.

Observation of the living room exit door on 09/04/25 at 7:29pm revealed:
-The door was not locked.
-An alarm sounded when the door was opened.
-The alarm only sounded for a few seconds and stopped before the door closed back.
-This door also led outside to the smoking area.

Interview with the Maintenance Director on 09/05/25 at 11:16am revealed:
-He had only worked at the facility for three weeks.
-He did not know the alarms were supposed to sound continuously.
-He had never used the living room door.
-He knew the dining room door only sounded for 3-5 seconds.

Telephone interview with a personal care aide (PCA) on 09/03/25 at 9:24am revealed:
-She was not told to check the door when the alarm sounded.
-She assumed it was a resident going outside to smoke.

Telephone interview with a second PCA on 09/03/25 at 7:06pm revealed:
-If she heard the door alarm, she tried to check to see who had gone outside.
-She could not always hear the door alarm when she was in the resident rooms and would not know if a resident went outside.

Telephone interview with a third PCA on 09/04/25

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at 10:54am revealed:
-First shift was hectic, so she may not go check to see who went outside every time she heard the alarm.
-She did not know of any residents who had been outside without supervision.

Interview with a fourth PCA on 09/04/25 at 3:46pm revealed the staff did not check the door alarms because they knew it was residents going outside to smoke.

Telephone interview with a medication aide (MA) on 09/03/25 at 3:22pm revealed:
-Sometimes, the staff saw who went out the door to the smoking area.
-Sometimes a resident would come and tell staff if a resident was outside who was not supposed to be out there.

Interview with a second MA on 09/04/25 at 2:49pm revealed:
-She did not usually check the door to she smoking area when the alarm sounded because the residents who were known to wander would not go out that door.
-If a resident went outside without supervision, the other residents would let staff know if there was a resident who should not be outside without staff.

Interview with a third MA on 09/04/25 at 7:04pm revealed:
-Every time a door alarm went off, staff were supposed to go and check the door.
-Staff did not check the doors every time, but the residents who smoked would come and let staff know if a resident was outside who needed supervision.

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Interview with a fourth MA on 09/05/25 at 1:58pm revealed:
-Staff usually looked to see who went outside, but they did not check the door every time they heard the alarm.
-She knew for the residents who smoked, the last time out was usually around 8:00pm, so she tried to keep that in mind when she heard the door alarm.

Telephone interview with a resident's primary care provider (PCP) on 09/04/25 at 11:45am revealed she expected staff members to monitor unlocked doors and check the doors when the alarm sounded.

Interview with the Interim Administrator on 09/04/25 at 6:12pm revealed there were three named residents who needed supervision because all three residents were always wanting to go home.

Interview with the Administrator on 09/04/25 at 5:03pm revealed:
-For residents who wandered, staff should do a walk-through and know where those residents were at all times.
-If the staff member was going to assist another resident, the staff member should let another staff member know so they could provide supervision to those residents.
-If a door alarm was heard, he expected staff to see who was going outside the door.

1. Review of Resident #15's current FL2 dated 03/04/25 revealed:
-Diagnoses included mild cognitive impairment.
-He was constantly disoriented.
-He was semi-ambulatory.

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Review of Resident #15's Resident Register revealed an admission date of 03/19/25.

Review of Resident #15's care plan dated 06/11/24 revealed:
-Resident #15 was always disoriented.
-Resident #15 had significant memory loss and had to be directed.

Review of Resident #15's progress notes dated 03/19/25-09/03/25 revealed there was no documentation that Resident #15 had been outside of the facility.

Review of Resident #15's incident reports and 72-hour reports revealed there was no documentation that Resident #15 had been outside of the facility.

Observation of Resident #15 at various times between 8:00am-5:00pm from 09/02/25-09/05/25 revealed Resident #15 walked to and from his room to the dining room for meals.

Confidential interview with a staff member revealed Resident #15 should not go out by himself because he would wander off.

Telephone interview with a personal care aide (PCA) on 09/03/25 at 9:24am revealed Resident #15 was found outside the facility without supervision 1-2 times that she was aware of.

Telephone interview with a second PCA on 09/03/25 at 7:06pm revealed:
-The first week Resident #15 was at the facility, he was found outside without staff.
-Resident #15 was always talking about going home.

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D 067	Continued From page 6 Interview with a third PCA on 09/04/25 at 3:46pm revealed: -Sometimes she would go and look and make sure Resident #15 was in his room. -She had to bring Resident #15 in from outside before. Telephone interview with Resident #15's family member on 09/03/25 at 10:26am revealed: -Resident #15 needed supervision if he went outside because he might try to walk away. -There was one time she was notified when Resident #15 was found outside the facility. -He had exited the facility through the "smokers" door. -She was told the staff would watch him "closer". Telephone interview with a medication aide (MA) on 09/03/25 at 3:22pm revealed: -Resident #15 should not be outside without supervision. -If Resident #15 went outside without supervision, she would be concerned that he would go to the road and be hit by a vehicle. Interview with a second MA on 09/04/25 at 11:08am revealed Resident #15 wandered and should not be outside of the facility by himself. Interview with a third MA on 09/04/25 at 2:49pm revealed staff had to keep an eye on Resident #15 because he was always looking for his family member. Interview with a fourth MA on 09/04/25 at 7:04pm revealed: -Resident #15 went out the smoking door and was in the back parking lot looking for his car. -An incident report was not done because staff saw him and brought him back inside.	D 067		

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D 067	Continued From page 7 Telephone interview with a housekeeper on 09/03/25 at 4:32pm revealed Resident #15 needed supervision to be outside the facility because he would wander off. Confidential telephone interview with a staff member revealed Resident #15 could not be outside without staff because he had dementia and thought he was going home. Interview with the Interim Administrator on 09/04/25 at 6:12pm revealed Resident #15 had been outside the facility, but staff always had an eye on him. Telephone interview with Resident #15's primary care provider (PCP) on 09/08/25 at 8:40am revealed: -Resident #15 was not aware of his situation. -She thought the facility was a locked facility. -If the door alarms were not fixed to keep Resident #15 safe, he would need to move to another facility, because he was at risk of wandering. -If Resident #15 was outside the facility, he needed supervision. -She was not notified that Resident #15 had been outside of the facility without supervision but she should have been. Based on observations, record reviews, and interviews, it was determined Resident #15 was not interviewable. 2. Review of Resident #4's FL2 dated 06/07/25 revealed: -Diagnoses included Alzheimer's disease. -Resident#4 was ambulatory. -Resident #4 was intermittently disoriented.	D 067		

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D 067	Continued From page 8 Review of Resident #4's care plan dated 06/11/24 revealed: -Resident #4 was always disoriented. -Resident #4 had significant memory loss and had to be directed. Review of Resident #4's Resident Register revealed an admission date of 03/10/22. Review of Resident #4's progress notes dated 04/11/25 revealed: -There was no documentation of any exit-seeking behavior or falls that occurred outside of the facility. -On 06/24/25, a care plan meeting was held with the resident's family and care staff to discuss increased wandering, not sleeping at night, and exit seeking. -The plan was for the family to find a memory care unit for Resident #4. Telephone interview with a former personal care aide (PCA) revealed: -She was told by another staff member that they could not find Resident #4; she did not recall when this occurred. -She started looking outside the facility. -When she found Resident #4, he was lying on the ground; he had fallen down the hill. -She got Resident #4 up and took him back inside the facility. -Resident #4 had a laceration on his forehead. -She told whoever was working what happened, but she did not recall who. Confidential interview with a staff member revealed she recalled a time when another resident reported Resident #4 was on the back porch, and staff brought the resident back inside	D 067		

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D 067	Continued From page 9 the facility. Telephone interview with a PCA on 09/03/25 at 9:24am revealed: -Resident #4 was found outside the facility after he had fallen down the hill in front of the facility. -The Interim Administrator was at the facility when it happened. Interview with a second PCA on 09/04/25 at 3:46pm revealed: -Resident #4 would "walk off". -Resident #4 would go out the door to the smoking area and would walk around the facility to another door. -Staff would check every shift to make sure Resident #4 was in the facility. -The medication aide (MA) said to keep an eye on Resident #4. Telephone interview with a former staff member on 09/03/25 at 9:36am revealed: -He had to come to the facility one evening; he did not remember the date, to help get Resident #4 back into the facility. -Resident #4 was out in the field behind the facility, soaking wet, with no shoes on, only socks. -On another day, -Resident #4 had a fall in front of the facility. Telephone interview with a former resident on 09/04/25 at 10:22am revealed: -He recently moved out of the facility into an apartment. -He smoked, and more than once, he had to let a staff member know Resident #4 was outside. -Several times, Resident #4 would walk around the building, and he was seen stumbling when he got to the front of the building.	D 067		

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D 067	Continued From page 10 Telephone interview with a MA on 09/03/25 at 3:22pm revealed: -Resident #4 went out of the smoking area and walked around to the front of the facility several times; the staff would bring Resident #4 back inside. -Resident #4 should not be outside without supervision. Telephone interview with a second MA on 09/03/25 at 4:04pm revealed: -Resident #4 was going down the hill in front of the facility and fell; he had a mark on his right eyebrow. -The Interim Administrator was working and assisted with getting Resident #4 up and back into the facility. -The Interim Administrator did not notify Resident #4's family. -Resident #4's family member asked what happened to his head, and the Interim Administrator said he hit his head. -The Interim Administrator did not tell the family member that Resident #4 fell outside the facility. -Another resident told Resident #4's family member what happened when they asked about the laceration on his forehead. Interview with a third MA on 09/04/25 at 2:49pm revealed: -Resident #4 went outside a lot without supervision before he died. -The staff were told to watch Resident #4. Interview with a fourth MA on 09/05/25 at 1:58pm revealed: -Resident #4 went outside, but toward the end, he "got outside" a lot. -They did not have enough staff to cover	D 067		

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Resident #4 to keep him from "escaping".
-She saw Resident #4 after he had his fall; the PCA had him by the arm in the grass by the facility's sign; he had a scratch on his forehead.
-The PCA told her Resident #4 fell.
-She could tell Resident #4 had fallen because he had dirt on him.
-She did not recall who was working as the Supervisor that night, but it was not her, and the Supervisor would have been responsible for doing an incident report.

Interview with a fifth MA on 09/04/25 at 11:08am revealed:
-Resident #4 went outside quite frequently.
-She had seen him in the smoking area.
-If Resident #4 was agitated, he would walk away from the smoking area, and staff would catch him on the side or front of the facility.
-She saw the laceration on Resident #4's forehead the next day after he fell in front of the facility.
-The incident happened on the second shift.
-The Interim Administrator was still in the facility at the time of the incident.
-She did not see a 72-hour report or an incident report for the fall.

Interview with a sixth MA on 09/04/25 at 7:04pm revealed:
-Resident #4 went outside the facility "all the time".
-Resident #4 had gone out the dining room door and the door to the smoking area.
-Staff had to constantly watch Resident #4.

Confidential telephone interview with a staff member revealed:
-Resident #4 would go out the side door, and staff would catch him in front of the facility.

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-Resident #4 stumbled by the sign in front of the facility.
-A staff member who no longer worked at the facility found Resident #4 and brought him back inside.
-The facility staff told Resident #4's family member the resident tripped over a mattress.

Telephone interview with Resident #4's primary care provider (PCP) on 09/04/25 at 11:45am revealed:
-She was not aware that Resident #4 had fallen down the hill in front of the facility.
-She expected staff to keep an eye out for the residents who were at risk for wandering.
-She thought the facility was locked.
-She knew Resident #4 had passed out once outside from the heat, but it was not until later that she found out he had wandered outside.
-She thought Resident #4 needed a higher level of care because of falls, and he had wandered off, but the family kept pushing back.
-Resident #4's needs were too much for the staff to handle.
-Resident #4 was not a candidate for a chair alarm because he was ambulatory.
-Resident #4 required more 1:1 supervision, moved closer to the nurse's station, and the staff to have kept him busy.
-She expected staff members to monitor unlocked doors and check the doors when the alarm sounded.

Interview with the Interim Administrator on 09/04/25 at 6:12pm revealed:
-Resident #4 had wandered outside of the facility.
-Resident #4 stumbled by the rose bush and hit his head; he did not fall.
-Resident #4 had a scratch above his eye after the incident.

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D 067	Continued From page 13 -She did not recall when the incident occurred. Based on interviews and record reviews, it was determined Resident #4 had been transferred to a local hospital, where he later passed away. Attempted telephone interview with Resident #4's family member on 09/04/25 at 12:43pm was unsuccessful. 3. Review of Resident #7's FL2 dated 04/11/25 revealed: -Diagnoses included dementia. -She was intermittently disoriented. -She was semi-ambulatory. Review of Resident #7's Resident Register dated 04/08/24 revealed: -Resident #7 was forgetful. -Resident #7 needed reminders. A request for Resident #7's care plan was made on 09/05/25 at 8:41am and it was not received by the survey exit date. Observation of Resident #7 at various times between 8:00am-5:00pm from 09/02/25-09/05/25 revealed Resident #7 walked to and from her room to the dining room for meals. Telephone interview with a housekeeper on 09/04/25 at 10:54am revealed Resident #7 did not go outside without supervision because the resident had dementia and talked about going home. Telephone interview with a personal care aide (PCA) on 09/04/25 at 2:20pm revealed Resident #7 could not go outside the facility by herself because she would wander off.	D 067		

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D 067	Continued From page 14 Interview with a medication aide (MA) on 09/04/25 at 11:08am revealed Resident #7 was a "wanderer" and could not go outside by herself. Telephone interview Resident #7's family member on 09/04/25 at 12:45pm revealed: -Resident #7 moved to the facility because she had wandered away from her home twice. -Resident #7 needed to be in a facility with doors locked, which was why she chose this facility. -She was told all the doors were always locked and Resident #7 would be safe. Telephone interview with Resident #7's primary care provider (PCP) on 09/04/25 at 11:45am revealed: -Resident #7 should not be outside the facility without supervision. -Resident #7 had cognitive impairment. Based on observations, record reviews, and interviews, it was determined Resident #7 was not interviewable. _____ The facility failed to ensure 3 of 7 exit doors were equipped with a sounding device that alerted staff when activated for residents who were identified by their physician to be intermittently or constantly disoriented, resulting in residents being found outside the facility on several occasions. (#4, #15). This failure resulted in a substantial risk for serious physical harm to the residents and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/04/25. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 5,	D 067		

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D 067	Continued From page 15 2025.	D 067		
D 254	10A NCAC 13F .0801 (c) Resident Assessment 10A NCAC 13F .0801 Resident Assessment (c) When a facility identifies a change in a resident's baseline condition based upon the factors listed in Parts (1)(A) through (M) of this Paragraph, the facility shall monitor the resident's condition for no more than 10 days to determine if a significant change in the resident's condition has occurred. The facility shall conduct an assessment of a resident within three days after the facility identifies that a significant change in the resident's baseline condition has occurred. The facility shall use the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows: (1) Significant change is one or more of the following: (A) deterioration in two or more activities of daily living including bathing, dressing, personal hygiene, toileting, or eating; (B) change in ability to walk or transfer, including falls if the resident experiences repeated falls, meaning more than one, on the same day, or multiple falls that occur over several days to weeks, new onset of falls not attributed to an identifiable cause, a fall with consequent change in neurological status, or physical injury; (C) pain worsening in severity, intensity, or duration, occurring in a new location, or new onset of pain associated with trauma; (D) change in the pattern of usual behavior, new onset of resistance to care, abrupt onset or progression of agitation or combative behavior,	D 254		

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deterioration in affect or mood, or violent or destructive behaviors directed at self or others;
(E) no response by the resident to the intervention for an identified problem;
(F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period;
(G) when a resident has been enrolled in hospice;
(H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crater, or any pressure ulcer determined to be greater than Stage II;
(I) a new diagnosis of a condition which affects the resident's physical, mental, or psychosocial well-being;
(J) improved behavior, mood or functional health status to the extent that the established plan of care no longer meets the resident's needs;
(K) new onset of impaired decision-making;
(L) continence to incontinence or indwelling catheter; or
(M) the resident's condition indicates there may be a need to use a restraint in accordance with Rule .1501 of this Subchapter and there is no current restraint order for the resident.
(2) Significant change does not include the following:
(A) changes that resolve with or without intervention;
(B) an acute illness or episodic event. For the purposes of this Rule "acute illness" means symptoms or a condition that develops quickly and is not a part of the resident's baseline physical health or mental health status;
(C) an established, predictable cyclical pattern; or
(D) steady improvement under the current course

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D 254	Continued From page 17 of care.	D 254		

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure an assessment and care plan was updated within 3 days following a significant change in condition for 2 of 2 sampled residents (#1 and #6) including a resident who was no longer ambulatory and required 2 to 3 staff assistance with transferring, standing, showering, and toileting (#1) and a resident who required 2 staff assistance with transferring, standing, showering and providing incontinence care after multiple falls (#6).

The findings are

Interview with the Administrator on 09/02/25 at 9:30am revealed:
-His first day as the Administrator of the facility was 09/01/25.
-The former Administrator retired in March 2025.
-The Interim Administrator returned this week to help him with the state survey.

1. Review of Resident #1's current FL-2 dated 06/03/25 revealed:
-Diagnoses included peripheral vascular disease, muscle weakness, difficulty walking and right shoulder pain.
-The recommended level of care was a skilled

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nursing facility.
-She required assistance from staff with bathing, feeding and dressing.
-She was semi-ambulatory.
-She had an indwelling catheter and was continent to bowel.

Review of Resident #1 care plan dated 07/04/25 revealed:
-It was an annual care plan.
-Resident #1 required limited assistance from staff with eating.
-She required extensive assistance with toileting, ambulation, bathing, dressing, grooming/personal hygiene and transferring.
-Resident #1 ambulated with a wheelchair and required one staff member to propel it at all times.
-She had limited range of motion, limited strength and limited eye-hand coordination in her upper and lower extremities.
-There was nothing documented for assistance with transfers.

Telephone interview with Resident #1's Power of Attorney (POA) on 09/04/25 at 10:43am revealed Resident #1 had declined; the family recognized she had declined quickly over the last few months.

Telephone interview with Resident #1's primary care provider (PCP) on 09/03/25 at 2:32pm revealed:
-Resident #1 had a change in her condition and started to show a decline over the last two to three months.
-Her weight fluctuated, and she required two to three staff to assist her with transfers and bathing.
-Resident #1 had adaptive equipment for meals and required reminders, queuing and sometimes

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D 254	Continued From page 19 assistance when eating. Interview with a personal care aide (PCA) on 09/05/25 at 8:23am revealed: -It took two staff to give Resident #1 a shower. -Resident #1 could not bathe herself, dress herself, she could not go to the toilet, and she needed assistance from staff with standing and transferring. -Resident #1 used to only require one staff to help with everything but at some point, she started to decline, and it now took two staff. -Resident #1 used to be able to feed herself and now she needed feeding assistance. -Sometimes she had good days and bad days. -She told the previous Resident Care Coordinator (RCC) that Resident #1 had declined and required two staff for all her care. -She was in the shower room with Resident #1 a couple of months ago and she had to ring the call bell for assistance. -The previous RCC came to assist her; she told the RCC then that two staff were needed. Interview with a medication aide (MA) on 09/05/25 at 2:57pm revealed: -Resident #1 started to show a change in what she could do over the last two months. -Resident #1 required two staff for most of her care. -Resident #1 required two staff to transfer her from her bed, from her wheelchair and from the toilet seat. -Resident #1 required two staff to assist her to the toilet; one staff to stand her up and the other staff to wipe her clean. -Resident #1 required at least two staff to give her a shower. -She had reported the increased need for staff to the previous RCC and the Interim Administrator.	D 254		

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-The staff started doing two person assist with everything for Resident #1 because they had to; they could not do it alone anymore.

Refer to the interview with the Interim Administrator on 09/04/25 at 7:06pm.

2. Review of Resident #6's current FL-2 dated 06/16/25 revealed:
-Diagnoses included fracture of femur, dysphagia, rheumatoid arthritis, atrial fibrillation, heart failure, hypertension and dementia.
-Resident #6 was constantly disoriented, wandered and was semi-ambulatory.
-Resident #6 was incontinent to bladder and bowel.
-Resident #6 required personal care assistance with bathing, feeding and dressing.

Review of Resident #6's care plan and assessment dated 06/06/24 revealed:
-Resident #6 required limited staff assistance with eating, toileting, dressing, grooming and personal hygiene.
-She required staff supervision with ambulation, locomotion and transferring.
-She required extensive assistance from staff with bathing.

Telephone interview with Resident #6's Hospice nurse on 09/04/25 at 12:16pm revealed:
-Resident #6 was admitted to hospice on 05/09/25.
-Resident #6 had a fall on 05/22/25 and broke her hip and had multiple falls since 05/22/25.
-Resident #6 had hospice ordered because of her decline.

Interview with a medication aide (MA) on 09/05/25 at 2:57pm revealed:

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D 254	Continued From page 21 -Resident #6 went to the hospital after a fall on 05/22/25 and returned in July 2025. -Resident #6 then had multiple falls and started to decline. -Before her falls Resident #6 could stand, walk with a walker, toilet and only required one staff assistance for showers. -After her falls Resident #6 used a wheelchair to get around, could barely stand and she was more dependent on staff for showering and transfers. -Resident #6 wore an adult incontinence brief and could not toilet herself after her falls. Refer to the interview with the Interim Administrator on 09/04/25 at 7:06pm. _____ Interview with the Interim Administrator on 09/04/25 at 7:06pm revealed: -A new care plan should be completed as soon as there was a change in the level of care on an FL-2 or when there had been a significant change in the resident's condition. -A significant change included changes from walking to going into a wheelchair, and increased staff assistance with bathing, toileting and transferring. -She did not know why residents with a significant change did not have a new care plan done; she had simply missed it.	D 254		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for	D 269		

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themselves.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews, and record reviews, the facility failed to provide personal care assistance for 4 of 4 sampled residents (#1, #2, #9, #16), including three residents who required assistance with showers (#1, #9, #16); and one resident who needed assistance with transfers and catheter care (#2).

The findings are:

Interview with the Administrator on 09/02/25 at 9:30am revealed:
-His first day as the Administrator of the facility was 09/01/25.
-The former Administrator retired in March 2025.
-The Interim Administrator returned this week to help him with the state survey.

1. Review of Resident #2's FL2 dated 07/23/25 revealed:
-Diagnoses included type 2 diabetes, neuropathy, osteoarthritis, and hypertension.
-He required staff assistance with bathing and dressing.
-He was a total care.

Review of Resident #2's care plan dated 08/15/25 revealed:
-He required limited assistance from staff with toileting, dressing, grooming/personal hygiene, and ambulation.
-He required extensive assistance from staff with bathing and transferring.

a. Interview with Resident #2 on 09/05/25 at

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D 269	Continued From page 23 9:20am revealed: -The staff left him in the bathroom with his catheter bag lying on the floor all the time. -He had to drag the catheter bag back to his room. -He could not hook the catheter bag to the back of his wheelchair. -He was afraid the catheter was going to get pulled out. Interview with a housekeeper on 09/05/25 at 11:05am revealed: -He had helped Resident #2 with his catheter bag. -The catheter bag was lying on the floor, and Resident #2 asked him to hang it on the back of his chair. Confidential telephone interview with a staff member revealed staff members were supposed to secure his catheter bag to the wheelchair before leaving his room. Interview with a medication aide (MA) on 09/05/25 at 1:58pm revealed: -She had assisted with toileting Resident #2. -When Resident #2 was on the toilet, his catheter bag would be lying on the floor. -Staff would stand outside the bathroom door for privacy, but once the resident was finished, they would hook his catheter bag to the back of his wheelchair. -Staff should always make sure Resident #2's catheter bag was hooked to the back of his wheelchair before leaving the resident's room. Interview with the Interim Administrator on 09/05/25 at 10:41am revealed: -A catheter bag should not be left lying on the floor because of germs.	D 269		

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D 269	Continued From page 24 -Resident #2's catheter bag should have been hung on his wheelchair. Telephone interview with Resident #2's primary care provider (PCP) on 03/05/25 at 3:20pm revealed if Resident #2's catheter bag was on the floor, it increased the resident's risk of infection and could be pulled out by accident. b. Interview with Resident #2 on 09/05/25 at 9:20am and 11:11am revealed: -Every day, seven days a week, he sat in his wheelchair all day because the staff "fussed" about how hard it was to get him up. -He was afraid he was going to fall when the staff did not assist him with transfers, but he could not just keep sitting in his wheelchair. -He asked for help, and when the staff did not come back, he got tired of sitting up. -He made a dive for his bed and hoped he would hit the bed when the staff did not come in to assist him in bed at night. -Recently, he had the same pants on and the same incontinence brief for two days and had some poop in the brief. -At least once a week, the staff would leave him in the same incontinence brief for two days. -One day last week, he asked a staff member to "clean him up," and the staff member never came back. -His buttocks and groin had been irritated, and his home health nurse had applied a cream when she was in one day this week. -Last night, on 3rd shift, a staff member did "clean him up"; his buttocks were red, and the staff member placed cream on his buttocks, groin, and surrounding area. Interview with the facility's contracted therapy provider on 09/05/25 at 9:28am revealed that	D 269		

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D 269	Continued From page 25 transfers without assistance increased the risk of falls. Confidential telephone interview with a staff member revealed: -Resident #2 required two staff to transfer. -Staff were supposed to help Resident #2 transfer to the commode. -Staff members were supposed to assist Resident #2 from the commode back to his wheelchair. Telephone interview with a personal care aide (PCA) on 09/05/25 at 11:29pm revealed Resident #2 complained of his buttocks and groin hurting, so last night she "washed up" Resident #2 on 3rd shift and put cream on his buttocks and groin area. Interview with another PCA on 09/04/25 at 3:58 revealed: -Resident #2 required assistance from staff getting into his wheelchair from the bed. -Resident #2 did not need assistance getting back into his wheelchair. -She had left Resident #2 on the commode and would then go back after checking on other residents, and he would be back in his wheelchair and/or bed. Telephone interview with a medication aide (MA) on 09/03/25 at 4:04pm revealed: -Resident #2 needed assistance from staff with transfers to get out of bed. -The way the Interim Administrator put it was "if" Resident #2 called for assistance, staff members would assist the resident. -Some staff left Resident #2 in the bathroom. -A [named] staff member was heard saying Resident #2 got himself off the commode.	D 269		

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D 269	Continued From page 26 Interview with another MA on 09/05/25 at 1:58pm revealed: -Resident #2 required two staff to transfer, and sometimes three. -Resident #2 required assistance from staff with transferring out of bed in the morning and into bed at night. -She had only assisted Resident #2 into bed twice that she could recall. -She had assisted Resident #2 once by herself, but the resident was "kind of heavy". -She was not aware that Resident #2 was not being transferred to his bed. -She thought Resident #2 could get out of his wheelchair and into this bed. -Her concern would be what could happen if Resident #2 did not lock his wheelchair before transferring. Confidential interview with a staff member revealed Resident #2 had to sit in his wheelchair all day because no one put him in bed. Telephone interview with Resident #2's PCP on 09/04/25 at 11:45am revealed: -Resident #2 was at risk for falls and required supervision and assistance with transfers. -Resident #2's catheter tubing also increased his risk for falls. Telephone interview with Resident #2's PCP on 09/05/25 at 3:20pm revealed: -Resident #2 had a pressure sore 2-3 weeks ago. -If Resident #2 had complained of being in the same incontinence brief for 2 days, it was a huge risk for Resident #2's skin integrity. -Even if the brief was not soiled, the resident would have sweated in it.	D 269		

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Interview with the Resident Care Coordinator (RCC) on 09/04/25 at 5:15pm revealed:
-If a resident needed to be transferred to the toilet, staff should wait outside the bathroom and then transfer the resident back to the wheelchair.
-If staff had to leave the resident, the staff member should let another staff member know.
-She was concerned for Resident #2's safety, as it increased his risk of falls, and the catheter could have been pulled out.
-If a resident needed help going to the bathroom, the resident would need help coming out of the bathroom.
-If Resident #2 needed help with transfers and no one was there to assist, he might try to do the transfer himself.
-If a resident needed help with transfers out of bed, the resident would also need help getting back into bed.

Interview with the Interim Administrator on 09/05/25 at 10:41am revealed:
-If Resident #2's care plan showed he required extensive assistance with transfers, then he should have staff assistance with transfers.
-Resident #2 needed the assistance of two staff members for transfers.
-She did not believe Resident #2 could put himself to bed without staff assistance because he would be on the floor if he did.

2. Confidential interview with a staff member revealed residents complained of not getting showers at times; a [named] resident complained today, 09/04/25.

Confidential telephone interview with a staff member revealed the residents should be showered at least twice a week, but some residents only got one shower a week, and some

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D 269	Continued From page 28 did not even get one shower a week. Confidential interview with a third staff member revealed: -She was concerned the residents were not getting showers and being cleaned good enough. -She had washed residents who had dried stool in their buttocks and groin area that the previous shifts had not adequately washed. -Her washcloth would be dark when she washed under women's breasts and behind their ears. -Some staff used disposable bed pads to wipe residents. -She had put certain undergarments on the residents to see if the other shifts would change the residents, and she would come back in, and the residents still had the same items on. -She had seen residents with dried stool on their buttocks, and the incontinence brief would be dry as if the resident was not cleaned well after a bowel movement. Confidential telephone interview with a fourth staff member revealed: -There was no point in telling the Interim Administrator when residents complained of not getting baths. -The Interim Administrator did not care; she never did anything after it was reported. -After reporting things so many times and nothing was done, you think, "Why do it". Telephone interview with a personal care aide (PCA) on 09/03/25 at 9:24am revealed: -The PCAs were assigned resident showers. -The residents complained they did not get showers because the PCAs did not do them. -The PCAs marked that they gave showers even when they did not do the shower.	D 269		

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Interview with a medication aide (MA) on 09/04/25 at 11:08am revealed:
-Two [named] residents complained of not getting showers.
-The residents were told there was not enough staff to do showers.
-There were residents she thought were not bathed correctly because the resident had an odor.
-A [named] resident's family member had complained about her family member not getting baths.

Telephone interview with a resident's family member on 09/04/25 at 12:45pm revealed her family member had a build-up between her toes, and it was impossible that she was getting her showers and had that kind of build-up.

Interview with the Interim Administrator on 09/05/25 at 10:41am revealed:
-The Resident Care Coordinator (RCC) was responsible for completing the residents' care plans.
-Staff members knew what the residents' needs were through verbal communication.
-The RCC informed the Supervisor/Medication Aide (S/MA) that the person was responsible for telling all the other staff.

a. Review of Resident #16's FL2 dated 06/23/25 revealed:
-Diagnoses included intellectual disability, heart failure, and type 2 diabetes.
-He required assistance from staff with bathing and dressing.
-He was incontinent with his bladder.

Interview with Resident #16 on 09/05/25 at 9:32am revealed:

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-He was supposed to get showers on Tuesdays, Thursdays, and Saturdays.
-Every other week, he would only get one shower a week.
-He did not know why the staff did not assist with showers as scheduled; he thought maybe the staff were busy.
-He felt like the skin under his belly got raw when he missed showers.
-He tried to use wipes to wipe off the powder every day before the staff added new powder, but the shower got him cleaner.
-He fell in the shower when the personal care aide (PCA) left him; he did not hear her tell him to wait for her.

Confidential telephone interview with a staff member revealed Resident #16 complained about not getting showers.

Confidential telephone interview with another staff member revealed:
-Resident #16 required assistance with his showers, and two [named] staff members did not help him as they should.
-Resident #16 needed assistance with washing his back, legs, feet, and under his stomach.
-Resident #16 would hold his stomach up for her so she could wash under it, but the two [named] staff did not do that for the resident.
-The two [named] staff members made comments about Resident #16 that made the resident feel bad; he said he could not help that he needed help.

Confidential interview with a third staff member revealed:
-She had heard a [named] staff member say she was not at the facility to "wash nobody".
-A [named] personal care aide (PCA) would not

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wash Resident #16 when he took a shower and made him do it himself.
-The [named] staff member made it clear she was not washing Resident #16.

Interview with the [named] PCA on 09/04/25 at 3:58 revealed:
-She always washed Resident #16's legs.
-She also had to wash Resident #16's buttocks, and she would tell him he had to bend over more.
-She used a wet disposable bed pad to wipe Resident #16's buttocks because it worked better than a washcloth.

Interview with a second PCA on 09/05/25 at 1:51pm revealed:
-She assisted Resident #16 with a shower last night, and he had redness under his stomach on both sides.
-Resident #16 was a "bigger guy" and sweated a lot.
-Resident #16 complained a lot about not getting a shower.

Interview with a medication aide (MA) on 09/05/25 at 1:58pm revealed:
-She also worked as a PCA when needed.
-Resident #16 did not refuse showers.
-The only time she heard Resident #16 complain about not getting a shower was when the washing machine was broken from 08/28/25-09/02/25.
-Resident #16 usually had redness under his stomach when he was bathed.
-The redness had improved the last time she had seen it, which was the Tuesday before the washing machine broke, 08/26/25.

Interview with a second MA on 09/05/25 at 2:39pm revealed:
-Resident #16 had complained of "missing

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showers".
-When Resident #16 requested his nystatin powder (used to treat yeast or fungal infections of the skin), she would see the previously applied powder was "just piled up" and she would remind him the old powder had to be washed off, and he would say no one had given him a bath.
-He did not ask for his nystatin powder every day, but when she saw it, it was "crumbled up".

Interview with the Interim Administrator on 09/05/25 at 10:41am revealed:
-She knew Resident #16 fell in the shower, but she did not recall the details of the fall.
-She remembered a [named] staff member was there and asked the resident why he did not wait for her, and the resident stated he was trying to do it himself.
-The staff member should have stayed with Resident #16 and not let him be unattended in the shower.
-The staff member told her she had stepped out to get something, and she told the staff member next time, make sure she had everything she needed in the room.

Telephone interview with Resident #16's primary care provider (PCP) on 09/05/25 at 3:27pm revealed:
-Lack of showers affected a lot of the issues going on with Resident #16.
-Resident #16 had swelling in his legs and had falls.
-Fluid would build up in Resident #16's legs if he was not showered.
-Resident #16 needed showers because showers helped with healing.
-Resident #16 had raw skin, and the nystatin powder was not going to be effective if the skin was not cleaned before it was applied; the area

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was not going to heal and could become infected.
-If the nystatin powder was applied to an area that already had powder, it would cause the powder to "rub, rub, rub".
-She knew Resident #16 was not getting showers because he had come into the office and had an odor.
-He told her he was not getting showers.

Request for Resident #16's care plan on 09/05/25 was not provided by the survey exit date.

Refer to the interview with the Interim Administrator on 09/05/25 at 10:41am.

Refer to the interview with the facility's contracted PCP on 09/04/25 at 11:45am.

Refer to the interview with the RCC on 09/04/25 at 5:15pm.

Refer to the interview with the Administrator on 09/04/25 at 5:04pm.
3. Review of Resident #1's current FL-2 dated 06/03/25 revealed:
-Diagnoses included peripheral vascular disease, muscle weakness, difficulty walking and right shoulder pain.
-The recommended level of care was a skilled nursing facility.
-She required assistance from staff with bathing, feeding and dressing.
-She was semi-ambulatory.
-She had an indwelling catheter and was continent of bowel.

Review of Resident #1's care plan dated 07/04/25 revealed:
-She required extensive assistance from staff with toileting, ambulation, bathing, dressing,

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grooming/personal hygiene and transferring.
-Resident #1 ambulated with a wheelchair and required one staff member to always propel it.
-She had limited range of motion, limited strength and limited eye-hand coordination in her upper and lower extremities.

Interview with Resident #1 on 09/02/25 at 8:31am revealed:
-She was supposed to get a shower every other day in the mornings but sometimes the staff would skip her.
-It would depend on how many staff were working on her scheduled shower day.
-The staff helped her with her showers.
-She was supposed to get a shower yesterday, 09/01/25, but she did not get one.
-Sometimes when she was scheduled to get a shower she was just wiped down by the staff.
-The staff did not even change her underwear when they wiped her down.

Telephone interview with Resident #1's primary care provider (PCP) on 09/03/25 at 2:32pm revealed:
-Resident #1 required two to three staff to transfer and assist her with a shower.
-She was not sure if Resident #1 could take a shower and wash herself because she did not have use of one of her arms and hands.
-Resident #1 had not complained to her about not being showered.

Interview with a personal care aide (PCA) on 09/05/25 at 8:23am revealed:
-Today, 09/05/25, Resident #1 was scheduled for a shower.
-Resident #1 did not always feel well and did not always want a bath.
-It took two staff to give Resident #1 a shower.

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D 269	Continued From page 35 -She did not skip Resident #1's shower days. -Resident #1 could not bathe herself, she could not dress herself, and she needed assistance with standing and transferring. -Resident #1 used to only require one staff member to help with showering but at some point she started to decline, and it now took two staff. Telephone interview with a medication aide (MA) on 09/04/25 at 5:43am revealed: -Resident #1 required two staff to lift and transfer her. -Resident #1 had scheduled shower days on Mondays, Wednesdays, and Fridays. -She did not get Resident #1 dressed on the mornings she was scheduled a shower. -She had not heard Resident #1 complain about not getting a shower. Interview with a second MA on 09/04/25 at 11:50am revealed: -Resident #1 was hard to shower because she could not move one side of her body. -Resident #1 required two to three staff to assist with transferring her depending on the staffs' experience. -Resident #1 looked forward to her showers; she never refused to take one. -She did not document showers or skin assessments anywhere. Refer to the interview with the Interim Administrator on 09/05/25 at 10:41am. Refer to the interview with the facility's contracted PCP on 09/04/25 at 11:45am. Refer to the interview with the RCC on 09/04/25 at 5:15pm.	D 269		

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D 269	Continued From page 36 Refer to the interview with the Administrator on 09/04/25 at 5:04pm. 4. Review of Resident #9's current FL-2 dated 03/25/25 revealed: -Diagnoses included abnormalities of gait and mobility, muscle weakness, acute and chronic respiratory failure with hypoxia and chronic obstructive pulmonary disorder (COPD). -She was semi-ambulatory -She required personal care assistance with showering and dressing. Review of Resident #9's care plan dated 07/02/25 revealed: -Resident #9 used a walker to ambulate. -She required staff supervision for transferring. -She required staff set up and supervision for grooming and personal hygiene. -She required limited assistance from staff with showering and dressing. Interview with Resident #9 on 09/04/25 at 9:17am revealed: -Her shower days were supposed to be on Tuesday, Thursday and Saturdays. -Sometimes she did not get a shower. -She would ask the staff if she was going to get a shower today and they would tell her there was not enough staff. -She would like to take a shower on her scheduled shower days. -She always felt so much better after she had a shower. -She could bathe herself she. -She only had to have staff set her shower up and help her when she was done. -She got one shower maybe two a week. -She did not complain, she only asked why she could not have one.	D 269		

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D 269	Continued From page 37 Interview with a personal care aide (PCA) on 09/05/25 at 8:23am revealed: -Resident #9's showers were scheduled on Tuesday, Thursday and Saturdays. -Resident #9 just needed her shower set up and for the staff to be close by. -She would help Resident #9 dry off and get dressed. -Resident #9 would ask for her shower. -She did not know if staff skipped showers when they were short staffed. -She did not document showers. Refer to the interview with the Interim Administrator on 09/05/25 at 10:41am. Refer to the interview with the facility's contracted PCP on 09/04/25 at 11:45am. Refer to the interview with the RCC on 09/04/25 at 5:15pm. Refer to the interview with the Administrator on 09/04/25 at 5:04pm. _____ Interview with the Interim Administrator on 09/05/25 at 10:41am revealed: -Showers were done three times per week or as needed. -Showers were needed for personal hygiene. Telephone interview with the facility's contracted primary care provider (PCP) on 09/04/25 at 11:45am revealed: -She had observed at times that the residents' personal care was very poor. -Showers should be done 2-3 times per week. -Showers not only made residents feel better, but showers also reduced the risk of infections.	D 269		

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D 269	Continued From page 38 -She had residents who were constantly battling urinary tract infections (UTI). Interview with the RCC on 09/04/25 at 5:15pm revealed: -Her first day at the facility as the RCC was 09/02/25. -She expected showers to be done twice a week on either the first or second shift. -Third shift showers were only if the resident had an accident and a shower was needed. -Showers were scheduled by the MA by halls, and which residents needed a shower that day. -If residents were not getting showers as scheduled, it increased the residents' risk of skin breakdown, infections, odors, and bacteria. -Not giving a resident the care they needed was considered neglect. Interview with the Administrator on 09/04/25 at 5:04pm revealed: -If showers were not done correctly, dirt could crust up, and the residents' skin was already fragile. -He expected the showers to be done as scheduled. The facility failed to provide personal care assistance for 4 of 4 sampled residents (#1, #2, #9, #16), including a resident who required assistance with transfers and placement of his catheter bag to reduce the risk of falls and infection (#2). Three residents required assistance with showers and complained of often missing showers, placing the residents at increased risk for skin breakdown (#1, #9, #16). This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.	D 269		

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D 269	Continued From page 39 The facility failed to provide an acceptable plan of protection in accordance with G.S. 131D-34 on 09/26/25 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 20, 2025.	D 269		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews, record reviews, and observations, the facility failed to ensure referral and follow-up for 2 of 2 sampled residents (#3 and #6) related to a resident who had a fall, blood in his urine, and missed a urology appointment (#3) and a resident who had an unwitnessed fall (#6). The findings are: Interview with the Administrator on 09/02/25 at 9:30am revealed: -His first day as the Administrator of the facility was 09/01/25. -The former Administrator retired in March 2025. -The Interim Administrator returned this week to help him with the state survey. Review of the facility's Health Care Referral and Follow-Up policy dated September 2021	D 273		

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revealed:
-It was the policy of the facility to assure referral and follow-up to meet the routine and acute health care needs of residents, with notification to providers and documentation in the resident record.
-Documentation in the resident's record would include contacts with the physician/provider, other support licensed service providers, family, responsible parties, and guardians, when there were illnesses, incidents, accidents, and routine care or follow-up as needed, visits to the provider or onsite visits by providers, including any new orders, for medications, treatments, or procedures, hospital discharge follow-up care and medication reconciliation, labs, vitals, parameters, falls, and any other routine or acute health care needs of the resident.

Confidential interview with a staff member revealed that there had been numerous incidents where residents should have been sent to the hospital, but the Interim Administrator would instruct them not to.

1. Review of Resident #3's FL2 dated 07/30/24 revealed:
-Diagnoses included schizophrenia, type II diabetes, chronic kidney disease, chronic obstructive pulmonary disease (COPD), and hypertension.
-He required assistance with bathing and dressing.
-He was intermittently disoriented.
-He was ambulatory.
-He was incontinent of bladder and bowel.

Review of Resident #3's care plan dated 06/11/24 revealed:
-He required extensive assistance from staff with

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toileting, bathing, dressing, and grooming/personal hygiene.
-He required supervision from staff with transferring and ambulation.

Review of Resident #3's emergency medical services (EMS) report dated 05/23/25 at 5:45am revealed:
-EMS was dispatched to the facility for cardiac arrest.
-Resident #3 was lying on his side and was cold to the touch.
-Resident #3 had an active do-not-resuscitate (DNR) in place.
-Resident #3 had rigor mortis and was very cold and stiff.
-The time of death was marked at 5:45am on 05/23/25.

a. Telephone interview with a former staff member on 09/03/25 at 9:36am revealed:
-On 05/22/25, Resident #3 had a fall in the kitchenette.
-The Interim Administrator stated, "Get him up".
-The Interim Administrator told the Business Office Manager (BOM) that Resident #3 needed new shoes to prevent falls.
-Resident #3 was not sent out to the hospital; he was just put in his bed, and the resident could not even walk.
-The Interim Administrator stated there was nothing wrong with him, even though it was reported that Resident #3 was staggering.

Telephone interview with a housekeeper on 09/03/25 at 4:32pm revealed:
-He and a former staff member got Resident #3 off the floor in the kitchenette; he did not recall the date.
-The Interim Administrator and the previous

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Resident Care Coordinator (RCC) came into the kitchenette when Resident #3 fell and told them to get the resident up.
-The Interim Administrator said Resident #3 needed shoes, but it was not the shoes that caused the fall.
-The fall got "swept under the rug".
-He was not sure of the date of the fall.

Interview with the BOM on 09/04/25 at 8:53am revealed:
-She recalled Resident #3 was sitting on the floor of the kitchenette, and staff helped him up.
-She thought the previous RCC was in the room.
-She remembered someone talking about getting Resident #3 new shoes.
-She did not recall when the fall occurred.

Review of Resident #3's incident reports, progress notes, and 72-hour reports revealed there was no documentation the resident had any falls from 01/01/25-05/24/25.

Telephone interview with a medication aide (MA) on 09/04/25 at 3:26am revealed:
-The PCA told her Resident #3 had been very unsteady for the past two days (before he died).
-When she came into work the night Resident #3 died, the resident was already in bed.
-No falls were reported to her.
-The last thing she could see documented in Resident #3's progress notes was an entry on 05/20/25, and it was not about a fall.
-Someone should have put a note in if there was a fall.
-She only entered notes into the computer system if a supervisor told her to do so.
-She was the MA on duty when Resident #3 was found deceased in his bed.
-She thought it was between 5:00am-6:00am.

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-She did not know the date Resident #3 died.
-Someone should have documented in Resident #3's record when he died, but she did not.
-She notified the Interim Administrator and called 911.

Interview with a housekeeper on 09/04/25 at 10:39am revealed Resident #3 always appeared to be very unstable when he walked.

Telephone interview with a personal care aide (PCA) on 09/04/25 at 3:07am revealed:
-The morning before Resident #3 died, she had seen him walk into the door casing, like his balance was off; it was during the end of third shift and beginning of first shift.
-She reported what she observed to the first shift staff before she left the facility, but she did not recall who she told.
-Resident #3's balance being off was an everyday thing, but she had never seen him walk into anything.
-Resident #3 was found deceased in his bed around 6:00am; she could not recall the date.

Telephone interview with a second PCA on 09/04/25 at 10:54am revealed:
-Resident #3 was unbalanced when he walked, often stumbling, and frequently missed the chair when he went to sit down.
-He had been like that for a while.

Telephone interview with a third PCA on 09/04/25 at 2:14pm revealed:
-Resident #3 was very off balance.
-Resident #3 tried to get to places "really fast" if it was something he wanted.
-Resident #3 had a history of falls.
-She had noticed Resident #3's breathing had gotten worse right before he died; he was short of

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breath.
-She reported the shortness of breath to the previous RCC, but she did not know what was done.

Telephone interview with a second MA on 09/03/25 at 3:22pm revealed:
-The policy was that if a resident had a fall and hit their head, the resident would be sent to the hospital, and the PCP and family/guardian would be notified.
-She was not aware of Resident #3 having any falls.
-Resident #3 was not considered high risk for falls.
-She did not recall seeing an incident report for a fall for Resident #3.
-The MA was responsible for completing incident reports.
-The MA would give the incident report to the RCC and the Interim Administrator.

Interview with a third MA on 09/04/25 at 11:08am revealed:
-Resident #3 always had a very unsteady gait.
-Resident #3 would take his shoes off, and when he put the shoes back on, the shoes would hang off his feet.
-Resident #3 had frequent falls.
-Resident #3 would sometimes miss the chair and fall.
-More than once, Resident #3 had to be assisted off the floor; it was usually in the kitchenette.
-There was one time Resident #3 had a fall in his room; he was on his knees.
-The protocol was to do an incident report for a fall, even if there were no injuries.
-If the RCC or the Administrator was already there, the RCC or the Administrator would do the incident report.

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-The person who witnessed the fall or was told about the fall was responsible for creating an event, a progress note, and documenting every shift for 72 hours after the fall.
-She was working on 05/22/25 from 6:49am-2:47pm.
-She was not told Resident #3 had a fall on the first shift on 05/22/25.
-She found out days later that Resident #3 had died.

Interview with a fourth MA on 09/04/25 at 7:04pm revealed:
-She was not sure if Resident #3 had any falls in April 2025 or May 2025.
-Staff had been into his room and found him on the floor, and said the resident was tangled up in his bed sheets and slid to the floor, but she did not recall when that occurred.
-Nothing was reported to her on the second shift about Resident #3 having a fall.
-If a resident had a fall, staff would check the resident for bruises, get the resident up, and make sure nothing was broken.
-The PCP and guardian/family would be notified, and an incident report would be completed.
-Progress notes were automatically generated when an incident report was completed.
-A 72-hour report automatically populated on the electronic medication administration record (eMAR) after an incident report was completed.
-After a fall, the residents' blood pressure and pulse were checked every shift for 72 hours.

Interview with a fifth MA on 09/05/25 at 1:58pm revealed:
-Resident #3 had a lot of changes right before he died and was having difficulty standing up.
-Resident #3's coughing was worse, and she could look at his face and tell that something was

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not right.
-When staff did rounds at 10:30pm, she thought it was a day or two before he died, but she was not sure, Resident #2 could not stand up to change his incontinence brief and had to be changed in bed.
-Changes were reported to the next shift, and they would be responsible for telling the Interim Administrator.
-She worked second shift on 05/22/25, but she was not aware that Resident #3 had a fall that day.
-First shift would have told them at shift change, but if not, the eMAR and incident report would have instructed her to do 72-hour vitals; she did not recall seeing anything on the eMAR or an incident report.

Telephone interview with a former staff member on 09/04/25 at 9:32am revealed:
-Resident #3 fell several times during the staff's "short tenure" working at the facility.
-Resident #3 fell a lot and "I mean a lot".
-The previous Administrator had witnessed Resident #3 fall.
-Staff reported to her that Resident #3 fell all the time.

Interview with the Director of Dining Services on 09/04/25 at 10:10am revealed:
-She saw Resident #3 fall "plenty of times".
-Resident #3 would "flop down" in the chair and would fall against the glass window.
-One time, she was in the kitchen and Resident #3 hit the wall so hard she heard it all the way in the kitchen (across the hall).
-She would always report what she saw to a PCA or a MA.
-She saw Resident #3 fall one time in his room and hit his dresser; she did not recall when.

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D 273	Continued From page 47 Interview with the facility's Clinical Nurse Consultant on 09/04/25 at 4:24pm revealed: -She did not recall anyone telling her Resident #3 had any falls. -If a resident had a fall, the staff were to do an event report, and she would have seen it during her licensed health professional support (LHPS) quarterly reviews. -She was trained to read the residents' progress notes to see if there had been any falls. -If the fall was unwitnessed, staff would need to try to determine if the resident hit their head or not. -She thought Resident #3 could answer correctly if he hit his head. -Staff were to do an event report for anything out of the ordinary with a resident. Telephone interview with Resident #3's previous physical therapist on 09/05/25 at 12:03pm revealed: -Resident #3 was not making any progress toward goals and was discharged from services in April 2025. -Resident #3 was not a candidate for an assistive device due to his cognitive impairment. -Resident #3 did not have good judgment and would sit and not know where he was sitting. -If Resident #3 hit his head, she did not think he would be able to tell anyone. Telephone interview with Resident #3's court-appointed guardian on 09/04/25 at 9:03am and 9:56am revealed: -She was never notified of any falls for Resident #3. -She was notified Resident #3 died on 05/23/25. Telephone interview with Resident #3's PCP on	D 273		

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09/03/25 revealed:
-She was not made aware of any falls for Resident #3 prior to his death.
-Her concern was that Resident #3 should have been sent out if it was not confirmed that he did not hit his head.
-Resident #3 could have had swelling of the brain, and the first 24-48 hours were critical, especially if there was brain bleeding.

Telephone interview with Resident #3's PCP on 09/04/25 at 11:45am revealed:
-She had checked the computer system for any notifications of Resident #3 falling, and there was no documentation of a fall.
-She was concerned there was nothing documented about Resident #3's falls.
-She was notified on 05/23/25 of Resident #3's death.

Interview with the previous Administrator on 09/04/25 at 6:12pm revealed:
-She was quite sure Resident #3 had a fall in the last year, "he walked on the back of his shoes".
-If Resident #3 was found on the floor, a report should have been completed.
-If Resident #3 had a fall, she or the RCC would have done an incident report.
-She would have to look it up to see if an incident report was done.
-After a fall, vitals should be done, a report completed, and the PCP and guardian notified.
-The MA or RCC should do an assessment to see if the resident had an injury, and if not, the resident would not be sent to the hospital.

Interview with the Administrator on 09/04/25 at 5:03pm revealed:
-If a resident had a fall, staff should immediately get the Supervisor.

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-The Supervisor should do an assessment, notify the family/guardian, and the PCP.
-The resident would be sent to the hospital depending on the PCP's guidance, unless there was an emergency, and the resident would automatically be sent out.
-An incident report should have been completed, which would include a progress note and documentation of communication with the PCP and the resident's vitals.
-He was concerned about why the staff did not do what they were supposed to do.
-He would have investigated the incident if he had been the Administrator at the time of the incident.

b. Telephone interview with a former staff member on 09/03/25 at 9:36am revealed:
-Resident #3 had blood in his urine, and no one had done anything about it.
-The previous RCC was told about the blood, and the RCC did not even go to see the blood when she was told about it.

Telephone interview with a PCA on 09/04/25 at 3:07am revealed:
-She had seen blood in Resident #3's urine because he urinated all over the toilet and the wall.
-She always reported her observations to someone in management.

Telephone interview with a second PCA on 09/04/25 at 10:54am revealed:
-Resident #3 was "peeing blood out."
-She reported it to the previous RCC, and the RCC said it was normal.
-Resident #3's urine was "dark reddish".
-She told the Interim Administrator, too.

Telephone interview with a third PCA on 09/04/25

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D 273	Continued From page 50 at 2:14pm revealed: -She had seen blood in Resident #3's urine and reported it to the previous RCC. -It was a few months before Resident #3 died when she reported it to the RCC. -There was a lot of blood in the commode after Resident #3 used the bathroom. -It looked like more blood than urine. Telephone interview with a MA on 09/03/25 at 3:22pm revealed: -Resident #3 had blood in his urine. -She reported the blood in Resident #3's urine to the RCC and the Interim Administrator. -Resident #3 had a "significant" amount of blood loss. -The RCC was responsible for contacting Resident #3's PCP. -She did not document that Resident #3 had blood in his urine because she was not told to do so. -Resident #3 had blood in his urine for 1-2 months before he died; she was not sure of the date of death. Interview with a second MA on 09/04/25 at 11:08am revealed: -She recalled one day she assisted Resident #3, and he had blood in his incontinence brief. -She told the previous RCC, and the RCC said Resident #3 had a urology appointment. Interview with a third MA on 09/04/25 at 2:34pm revealed: -Resident #3 had blood in his urine; "like the whole commode was full of blood." -She reported it to the previous RCC and the Interim Administrator. -Resident #3 had blood in his urine every time he peed in March 2025, April 2025, and May 2025.	D 273		

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D 273	Continued From page 51 Interview with a fourth MA on 09/04/25 at 6:51pm revealed: -Resident #3 had blood in his urine all the time. -Sometimes Resident #3 had blood in his incontinence brief, enough to notice. -She had reported it to the previous RCC and the Interim Administrator. -Earlier in the year, the Interim Administrator said Resident #3 had a urology appointment; she did not know when the appointment was. -Several times after that, she reported the blood again to the previous RCC and the Interim Administrator. Interview with a fifth MA on 09/05/25 at 1:58pm revealed: -She had seen blood in Resident #3's urine often. -She had seen blood on the walls and the floor in Resident #3's bathroom because it had not been cleaned by housekeeping. -The blood was dried, but the wall was stained red. -She recalled the RCC talking about getting a urine sample, but she did not recall if it was done or not. Telephone interview with a housekeeper on 09/03/25 at 4:32pm revealed that he cleaned up blood every day in Resident #3's room. Interview with a second housekeeper on 09/04/25 at 10:39am revealed that she had seen Resident #3's urine, and it was "really dark". Interview with the Director of Dining Services on 09/04/25 at 10:10am revealed: -She had seen blood on Resident #3's pants several times, "heavy blood". -She reported it to the Interim Administrator, but	D 273		

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she did not know if she followed up or not.

Interview with the facility's Clinical Nurse Consultant on 09/04/25 at 4:24pm revealed:
-If staff members saw blood in Resident #3's urine, they should follow the chain of command for reporting.
-The PCAs and housekeepers should report the blood to the MA, who would then do an observation.
-The MA or someone in management should notify the PCP, and if no response, notify the Administrator.
-It was concerning that Resident #3 had blood in his urine; something should have been done, especially notifying the PCP for guidance.

Telephone interview with Resident #3's PCP on 09/03/25 at 1:46pm revealed:
-She was not made aware that Resident #3 had been bleeding for months.
-She received a message on 05/09/25 that Resident #3 had blood in his urine, and she requested a urinalysis; it showed as still pending in the system.
-She prophylactically treated Resident #3 with an antibiotic at that time for a urinary tract infection.
-For a small amount of blood, she usually ordered a urinalysis.
-Had she been told the amount of blood that was described, she would have sent Resident #3 to the hospital to be evaluated.
-Loss of blood could have caused Resident #3 to have weakness which could result in him being disoriented or having falls.

Telephone interview with Resident #3's PCP on 09/04/25 at 11:45am revealed:
-Resident #3 was seen by the urologist on 10/23/24 and was diagnosed with hematuria

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(blood in the urine), which was microscopic, not excessive.
-Resident #3 had a computed tomography (CT) scan on 11/13/24, and it was normal.
-Resident #3 had labs performed on 11/15/24, and the results were within normal range.
-Resident #3 had a follow-up appointment with the urologist on 05/13/25, but she did not see any after-visit summary indicating whether the resident went to the appointment or not.
-She expected Resident #3 to have gone to the follow-up appointment on 05/13/25.
-She was concerned that Resident #3 did not go to his follow-up appointment since the previous visit showed a microscopic amount of blood in his urine.
-If Resident #3's bleeding was excessive, going to the urologist and being treated may have prevented the resident from further declining.
-She would want to know if Resident #3 was bleeding heavily.
-She would be concerned if Resident #3's falls were from disorientation due to heavy bleeding.
-When she saw Resident #3 for a routine visit, no one mentioned anything about Resident #3 bleeding.
-Resident #3 could have had kidney stones or a mass.
-There was no communication to her about Resident #3 bleeding heavily.

Telephone interview with a representative from Resident #3's urologist office on 09/04/25 at 3:16pm revealed:
-Resident #3 was last seen in November 2024.
-Resident #3 had an appointment scheduled for 05/13/25, but the appointment was documented as a "no show".
-The appointment was not rescheduled.

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Telephone interview with a nurse from Resident #3's urologist office on 09/04/25 at 3:18pm revealed:
-Resident #3 was seen in the urology clinic in October 2024 and November 2024.
-During those visits, a cystoscopy was done, and there was no tumor.
-Resident #3's CT scan was normal; there was a right-sided cyst that was enlarged.
-Resident #3 should have had a follow-up appointment.
-If Resident #3 had bleeding after he was last seen by the urologist, someone should have scheduled a follow-up appointment because that was a change in condition.
-The urologist who was familiar with Resident #3 no longer worked in the clinic, and she would not be able to provide further information.

Telephone interview with Resident #3's court-appointed guardian on 09/04/25 at 9:56am revealed:
-She was not notified that Resident #3 had blood in his urine.
-She was always told Resident #3 was doing fine.

Interview with the previous Administrator on 09/04/25 at 6:12pm revealed:
-Resident #3 had blood in his urine, and it was reported to the resident's PCP.
-She had looked at Resident #3's urine in the past, but not since 2024.
-She did not recall the amount of blood in the urine that was reported to her.
-She had not heard there was a lot of blood in Resident #3's urine.

Interview with the Administrator on 09/04/25 at 5:03pm revealed:
-Blood in the urine would be a change in

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condition, and an incident report should have been completed.
-The PCP should be notified for guidance.
-The family/guardian, the RCC, and the Administrator should have been notified.
-The resident's PCP needed to know what was going on with the resident, to determine whether he had a blockage or something else.

Interview with the Interim Administrator on 09/04/25 at 6:12pm revealed:
-The RCC was responsible for the residents' appointments.
-She looked at the appointment calendar and did not see Resident #3 listed for a urology appointment in May 2025.
-Resident #3 needed to have gone to the scheduled appointment, and she was concerned he did not go.

Interview with the Administrator on 09/04/25 at 5:03pm revealed:
-The RCC and/or BOM coordinated appointments.
-If there was a reason Resident #3 was unable to go to his urology appointment, it should have been rescheduled.
-He was concerned that Resident #3's health care needs were not coordinated.
2. Review of Resident #6's current FL-2 dated 06/16/25 revealed:
-Diagnoses included fracture of femur, dysphagia, rheumatoid arthritis, atrial fibrillation, heart failure, hypertension and dementia.
-Resident #6 was constantly disoriented, wandered and was semi-ambulatory.
-Resident #6 was incontinent of bladder and bowel.
-Resident #6 required personal care assistance from staff with bathing, feeding and dressing.

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D 273	Continued From page 56 Review of Resident #6's care plan and assessment dated 06/06/24 revealed: -Resident #6 required limited staff assistance with eating, toileting, dressing, grooming and personal hygiene. -She required staff supervision with ambulation, locomotion and transferring. -She required extensive assistance from staff with bathing. Review of Resident #6's incident report dated 04/29/25 revealed: -Resident #6 had an unwitnessed fall in her room. -At 3:28am, Resident #6 was found by staff lying on the floor on her side in her room. -Resident #6 did not have any injuries so she was not sent out to the hospital. Review of Resident #6's incident report dated 04/30/25 revealed: -Resident #6 had an unwitnessed fall without injury in her room. -At 12:30am, Resident #6 was found by staff, lying on the floor stating her head and hip were hurting. -She had an injury to the left side of her head and her right hip. -First aid was not administered. -At 12:50am, she was transported by emergency medical services (EMS) to the local hospital. Review of Resident #6's progress notes from 04/29/25 to 05/09/25 revealed: -On 04/29/25, at 3:30am, Resident #6 had a fall. -The primary care provider (PCP) and the Power of Attorney (POA) were notified. -On 04/29/25, at 3:30am, Resident #6 had not complained of pain. -Resident #6 had increased confusion.	D 273		

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-The PCP was notified of the increased confusion at 3:30am.
-There was an entry for 04/29/25 marked as a late entry dated 04/30/25, at 10:47am.
-The entry was a follow up to the fall on 04/29/25.
-There were no complaints of pain and no signs of altered mental status.
-There was a second entry for 04/29/25 marked as a late entry dated 04/30/25, at 10:48am.
-The entry was a follow up to Resident #6's fall on 04/29/25.
-There were no complaints of pain and no signs of altered mental status.
-On 04/29/25, at 12:44pm, there was an entry for a new order for urinalysis (UA) due to altered mental status.
-On 04/30/25, Resident #6 was sent to the hospital at 12:50am, due to a fall.
-On 05/09/25, at 12:25pm, Resident #6 returned from the hospital.

Telephone interview with Resident #6's PCP on 09/03/25 at 2:20pm revealed:
-The facility did not immediately make her aware of things.
-She was not always made aware of resident falls.
-A resident should always be sent to the hospital if there was a concern or if staff were not sure if the resident hit their head when they fell.
-The first 24 to 48 hours were the most critical after a fall with a head injury because the resident could have a brain bleed or swelling of the brain.
-She was not made aware Resident #6 had a fall on 04/29/25.
-She knew Resident #6 went to the hospital after a fall on 04/30/25.
-Resident #6 was diagnosed with a brain bleed when she was seen at the hospital on 04/30/25.
-If she had known Resident #6 had an

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unwitnessed fall on 04/29/25 she would have recommended she be sent to the local emergency department (ED) for evaluation.
-The brain bleed found on 04/30/25 could have been from the fall Resident #6 had on 04/29/25 or 04/30/25, there was no way to tell.

Telephone interview with Resident #6's PCP on 09/04/25 at 1:57pm revealed:
-She did not have documentation of notification from the facility about Resident #6 having a fall on 04/29/25.
-She went through her telephone and looked for text messages, missed calls and voicemails and did not have anything from any of the staff from the facility.
-She was in the facility on 04/29/25 for her scheduled visits with residents.
-That morning Resident #6 was added to the list of residents as an acute visit due to altered mental status.
-While she was at the facility on 04/29/25, she was not told Resident #6 had a fall earlier that morning and there was no documentation of a fall.
-She ordered a UA for a suspected urinary tract infection (UTI); she thought it might have been the cause of Resident #6's altered mental status.
-If she had known Resident #6 was found on the floor earlier that morning and then had altered mental status she would have sent Resident #6 to the hospital.
-She did not know if it would have changed the outcome for Resident #6, but it would have changed her approach to Resident #6's care on 04/29/25 when she visited.
-If the facility had called her when Resident #6 was found on the floor at 3:30am on 04/29/25, she would have sent her to the hospital and the intervention could possibly have changed the

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outcome but now she would never know.

Telephone interview with Resident #6's POA on 09/04/25 at 10:54am revealed:
-He was contacted each time Resident #6 was sent to the hospital.
-He was not contacted about a fall on 04/29/25.
-He was contacted for a fall on 04/30/25 because he met EMS and Resident #6 at the hospital.
-Resident #6 had bleeding on the brain from a fall on 04/30/25 and stayed in the hospital until the beginning of May 2025.

Confidential interview with a staff revealed:
-The Resident Care Coordinator (RCC) contacted the PCP about residents.
-She was never told to contact a PCP about a resident.
-The facility sent residents to the hospital if they knew the resident hit their head during a fall.
-She looked for bleeding, lumps on the resident's head and vitals were always taken on a resident when the resident was found on the floor.
-When a resident was found on the floor it was not considered a fall because the resident could have slid to the floor; a slide to the floor was not considered a fall.
-She did not recall Resident #6 falling or having a brain bleed in April 2025.

Confidential interview with another staff revealed:
-Resident #6 was always trying to stand up.
-Resident #6 did not use the call bell because she did not think the resident could.
-Sometimes Resident #6 would "holler" for help.

Confidential interview with a third staff revealed:
-She was told by the previous Administrator and the Interim Administrator not to fill out an incident report if the resident did not have an injury.

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-She was also told not to mark a fall as unwitnessed on the incident report.
-A slide to the floor was not considered a fall so she was told not to fill out an incident report.
-She thought all residents who were found on the floor should automatically be sent to the hospital.
-There was no way to tell if a resident hit their head because some of them could not tell staff if they hit their head.
-She thought incident reports should always be filled out after a resident was found on the floor because it showed something happened; it showed lack of balance and a reason or cause needed to be investigated to prevent it from happening again.
-If an incident report was not filled out, the PCP was not notified.
-She filled out incident reports and gave them to the RCC or the Administrator and they notified the PCP.

Telephone interview with a medication aide (MA) on 09/03/25 at 8:38pm revealed:
-Incident reports were not done after every fall.
-When there was a slide to the floor without an injury, they did not do an incident report.
-They asked the resident how they got on the floor if they did not see the how the resident ended up on the floor.
-If a resident was found on the floor it was considered an unwitnessed fall, she did not touch the resident but looked them over for an injury and checked their vitals.
-If she saw bleeding or a bruise on the resident's head, if the resident complained of pain or if they said they hit their head, she would send them to the hospital.
-If the resident was not injured and they looked fine, she did not send the resident to the hospital.
-She filled out an incident report, contacted the

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family and the PCP and notified the RCC or the Administrator.
-She did not know about the fall on 04/29/25.
-She could contact the PCP about a resident or give the information about a resident to the RCC to put a note in the PCP's folder for her visit.

Telephone interview with a second MA on 09/04/25 at 5:00am revealed:
-On 04/30/25 Resident #6 slid off her bed and was found sitting on the floor.
-Resident #6 would try to stand up.
-Resident #6 was sent to the hospital on 04/30/25.
-She was complaining that her hip and her head hurt, so staff had to send her to the hospital.
-A slide to the floor was not considered a fall.
-Resident #6 did not come back to the facility for a while.

Interview with a third MA on 09/04/25 at 11:39am revealed:
-Resident #6 had multiple falls since she was at the facility.
-She did incident reports for all falls, even the unwitnessed ones.
-There were times when other staff did not do a report when a resident had an unwitnessed fall.
-Resident #6 had falls where she did not go out to the hospital.
-In April 2025, Resident #6 had back-to-back falls.
-She had three to four falls and was not sent to the hospital.
-She had one fall at the end of April 2025 and was sent to the hospital.
-The RCC called the PCP after a resident fell; she did not know if the PCP was called each time.

Interview with a fourth MA on 09/05/25 at 2:40pm

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revealed:
-Resident #6 had an unwitnessed fall or slid to the floor on 04/28/25, but no one completed an incident report.
-She completed the incident report on 04/29/25.
-No one saw Resident #6 fall, and she did not send her to the hospital.
-It looked like Resident #6 pulled the sheets halfway off her bed and she was wrapped up in them.
-She did not think she called the PCP or the family because it did not seem urgent, and she did not want to wake anyone up.
-Resident #6 did not have a bruise so she did not send her to the hospital.
-She texted the RCC, the Interim Administrator, and she let first shift staff know Resident #6 fell.
-The RCC or the Interim Administrator filled in and checked off the contact information on the incident report.

Interview with the Interim Administrator on 09/04/25 at 6:42pm revealed:
-The MA on the shift created the incident report.
-The staff who created the incident report notified the PCP by either calling or texting.
-The MA or staff who contacted the PCP documented instructions on the incident report if any were given by the PCP.
-The staff who created the incident report would take vitals and document them on the incident report.
-It was considered a fall anytime a resident was found on the floor.
-On 04/29/25, Resident #6 was found on the floor.
-She was not bleeding, had no visible injury and she did not have any complaints of pain, so she was not sent to the hospital.
-If the PCP was notified after a fall, the PCP

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would put the resident on her schedule to be seen at the next visit.
-The RCC could put the resident on an acute visit list for the PCP and put a fall as the reason for the visit.
-Sometimes the PCP would forget she had been notified after a resident fell.
-On 04/29/25, the fall should have been included on the acute list along with the information of change in mental status for Resident #6.
-The PCP should always be contacted after an incident report and put on a request for a visit list.
-If the PCP had known Resident #6 had a fall earlier on 04/29/25, she could have looked at Resident #6 differently during the acute visit.

Interview with the RCC on 09/05/25 at 4:45pm revealed:
-Incident reports were completed depending on the incident.
-She was not sure what was considered a fall.
-She was not sure when a resident should be sent to the hospital because she was new and still learning.
-The PCP should always be notified after a fall just so they were aware.

Interview with the Administrator on 09/05/25 at 3:27pm revealed:
-The incident reports were expected to be filled out by the MA on the shift.
-The MA should notify the PCP so there could be direction on what to do for the resident.
-It was considered a fall anytime a resident was found on the floor.
-After an unwitnessed fall the resident should always be checked for consciousness, vitals taken, checked for bleeding, bumps or bruises and complaints of pain.
-If the resident had no complaints of pain, the MA

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D 273	Continued From page 64 should call the PCP. -When residents had an unwitnessed fall, they should always be sent to the hospital because staff would not know if the resident hit their head. Based on observations, record reviews, and interviews, it was determined Resident #6 was not interviewable. _____ The facility failed to ensure referral and follow-up for two sampled residents (#3, #6). Resident #3 had blood in the urine for several months, but the primary care provider (PCP) and urologist was not notified, and a scheduled follow-up appointment with the urologist was missed. The resident sustained a fall the day before his death, and the PCP indicated that weakness associated with ongoing bleeding could have been a contributing factor (#3). A second resident (#6) was found on the floor and the PCP was never notified of the fall but was notified about the resident's altered mental status and ordered a UA. The following day the resident was found on the floor again and sent to the hospital due to complaints of head pain. This failure resulted in serious physical harm and neglect to the residents which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on September 5, 2025. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 5, 2025.	D 273		
D 292	10A NCAC 13F .0904(c)(3) Nutrition And Food Service	D 292		

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	HAL073018	A. BUILDING: _____ B. WING _____	C 09/05/2025

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D 292	Continued From page 65 10A NCAC 13F .0904 Nutrition and Food Service (c) Menus In Adult Care Home: (3) Any substitutions made in the menu shall be of equal nutritional value, in order to maintain the daily dietary requirements in Subparagraph (d)(3) of this Rule, appropriate for therapeutic diets, and documented in records maintained in the kitchen to indicate the foods actually served to residents. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to maintain a record of menu substitutions documenting what was served to residents. The findings are: Review of the daily menu for 09/02/25 revealed: -The lunch meal listed a bacon cheeseburger, lettuce, tomato, onion, French fries, fudge brownie, and milk were to be served. -The dinner meal listed a BBQ pork rib patty, baked potato, corn, green beans, and grapes were to be served. Observation of the lunch meal on 09/02/25 at 12:00pm revealed the residents were served crab patties, white northern beans, green beans and corn mix, a slice of bread, and canned pears. Observation of the dinner meal on 09/02/25 at 5:35pm revealed:	D 292		

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D 292	Continued From page 66 -The residents were served a cheeseburger, French fries, a slice of tomato, a slice of onion, and pineapple tidbits. -The staff offered ketchup, mayonnaise or mustard to the residents with regular meals. Review of the item substitution log on 09/03/25 at 12:12pm -The cook had a daily production sheet to follow for the each meal. -The daily production sheet dated 09/02/25, included each item to be served and the portion size for the lunch and dinner meals. -The production sheet listed a bacon cheeseburger, lettuce, tomato, onion, French fries, fudge brownie, and milk were to be served for the lunch meal. -The production sheet listed a BBQ pork rib patty, baked potato, corn, green beans, and grapes were to be served for the dinner meal. -There was a column for listing substitutions for each item on the lunch and the dinner meals. -There was nothing documented on the substation list for the lunch meal or the dinner meal served on 09/02/25. Interview with a cook on 09/02/25 at 11:51am revealed she prepared crab cakes, white northern beans, green beans and corn mixed, a slice of bread and canned pears for the residents for the lunch meal. Second interview with a cook on 09/02/25 at 5:00pm revealed: -She prepared a cheeseburger, French fries, tomato, onion and pineapple tidbits for the residents for the dinner meal. -She was supposed to document everything she substituted on the menu. -She did not have the substitution log to	D 292		

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D 292	Continued From page 67 document the meal on. Interview with a cook on 09/04/25 at 10:14am revealed: -She had to substitute items on the menu quite often because she did not have the food she needed to prepare the menu items. -She basically came up with her own menu from meal to meal. -She looked at the food she had available in the kitchen and planed her meal for the day. -She always tried to substitute like items for like items on the menu -Half the time she could not find the production sheet to log the substitutes on. -She would document on the substitution log if she had one to document on. Interview with the dietary manager (DM) on 09/03/25 at 8:45am revealed: -The cooks were supposed to document any food they substituted from the menu on a column on the production sheet. -She could not find the sheet from the day before with the substitution log. -She was not aware the cooks were substituting items on the menu. -She ordered the food and ordered everything they needed for the menu. -She was not aware they served the lunch meal at dinner and substituted the entire lunch meal the day before. -She was not aware the cooks were not writing down food substitutions on the log. Telephone interview with the facility's Regional Chef on 09/05/25 at 2:26pm revealed: -The cooks should always follow the menu. -If the cook had to substitute an item on the menu, they were supposed to substitute	D 292		

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D 292	Continued From page 68 something of the same nutritional value. -The cooks were required to substitute a meat for a meat, a vegetable for a vegetable, and carbohydrates for carbohydrates [starch]. -His concern was when items were eliminated from the menu or not substituted correctly the residents' nutritional goals might not be met long term. -If there were menu items substituted the substitution items were required to be documented on the production sheet the cooks used. Interview with the Administrator on 09/04/25 at 4:02pm revealed: -The cooks should follow the regular cycle menu. -If the cooks had to substitute a menu item, then they should substitute a similar item, starch for a starch, protein for a protein and a vegetable for a vegetable. -The cooks should let him know if they had to substitute an item on the menu. -The cooks should document everything they substituted on the substitution log.	D 292		
D 297	10A NCAC 13F .0904(d)(1) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (1) Each resident shall be served a minimum of three nutritionally adequate meals based on the requirements in Subparagraph (d)(3) of this Rule. Meals shall be served at regular times comparable to normal meal times in the community. There shall be at least 10 hours between the breakfast and evening meals.	D 297		

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This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to ensure residents received nutritionally adequate meals when they did not follow the cycle menu.

The findings are:

Review of the facility's regular five week cycle menu revealed:
-The menu was written and signed by a registered dietitian.
-Hot dogs were on the cycle menu for two meals.
-A bologna sandwich was on the menu for one meal.
-There were no other cold sandwiches on the cycle menu.
-Potato chips were not on the menu for any of the lunch and dinner meals.
-Pasta salad was not on the menu for any of the lunch and dinner meals.

Interview with two residents on 09/02/25 at 8:38am revealed:
-They did not get enough to eat.
-They asked for double snacks at snack time.
-They got a lot of sandwiches and hot dogs.
-They were "sick" of sandwiches.
-There was one [named] cook who always served sandwiches when she worked.
-The sandwiches were cold, and it was just meat and bread; sometimes they got a slice of cheese.
-They were served potato chips with their sandwiches.
-They ate sandwiches 3 to 5 times a week.
-They complained to staff, but no one listened.

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D 297	Continued From page 70 Interview with a third resident on 09/03/25 at 8:53am revealed: -The kitchen staff did not post the daily or weekly menus for the residents to see any more because they did not serve what was on the menu anyway. -She ate sandwiches three to five times a week. -Dinner was usually a sandwich, chips and fruit or pudding. -They never got brownies or cake. -She was hungry at night because she did not get enough to eat at dinner. -Her family brought food and snacks when she told them she was hungry. -She was served a thick piece of cold bologna between two pieces of bread with no cheese. -She had cold ham sandwiches with no cheese. -They always had chips with their sandwiches. -She was sick of sandwiches. -She told the cook she was sick of sandwiches, and she was not offered anything else to eat. Interview with a fourth and a fifth resident on 09/04/25 at 9:17am revealed: -They got hot dogs on the weekends and cold sandwiches for dinner during the week. -The [posted] menu on the wall was not always what they were served to eat at meals. -They got a lot of sandwiches, ham and cheese or bologna and cheese with potato chips. -The bologna was thick and cold. -Sometimes they got a slice of tomato with their sandwich. -They got sandwiches two to three times a week, but it felt like it was so much more often. -They preferred something besides a sandwich and chips. -No one had asked them if they liked the sandwiches. -When they complained they were told "the [food	D 297		

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delivery] truck had not come in yet".

Interview with a sixth resident on 09/02/25 at 8:38am revealed:
-Sometimes she "barely" got enough to eat.
-Sometimes she had to wait an hour before she got her food.
-Sometimes she got a little food, but sometimes she got a lot.

Interview with a sixth resident on 09/02/25 at 9:16am revealed sometimes he did not get enough food to eat; he had to rely on eating his own snacks.

Interview with a seventh resident on 09/02/25 at 9:37am revealed there were times he could use more food.

Confidential interview with a staff member revealed residents were not given second helpings of the food because they heard a staff member say if the residents ate too much the residents would [expletive] every where.

Telephone interview with the facility's contracted primary care provider (PCP) on 09/04/25 at 2:17pm revealed:
-The residents complained to her about eating a lot of hot dogs.
-The residents complained they got the same food repeatedly.
-The meals needed to be well balanced.
-Some of the residents had experienced increased triglyceride levels, and increased lipids over the last four to five months.
-Eating foods high in sodium and fats like deli meats, hot dogs and potato chips would raise the residents' triglycerides and lipids.
-There were a lot of residents on high blood

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pressure medications and medication for fluid retention and they should be limiting the amount of processed foods they ate.
-Long term consumption of processed food and lack of a balanced diet could cause the residents' health issues.

Interview with a personal care aide (PCA) on 09/02/25 at 8:18am revealed:
-She had seen a lot if sandwiches served to the residents.
-The residents had complained to her and the kitchen staff about all the sandwiches for a couple of weeks.
-The kitchen served sandwiches about two or three days a week.
-The sandwiches were bologna and cheese or ham and cheese.

Telephone interview with a medication aide (MA) on 09/03/25 at 8:53pm revealed:
-There was a [named] cook who did not follow the menus when she worked.
-The residents were served a lot of sandwiches at meals when the [named] cook worked.
-The residents were served sandwiches three to five times a week.
-The cook was not following the menu and she did not post the menu so the residents could not see what they were supposed to be served.
-The residents were not served enough to eat when they were served sandwiches; they were only served a sandwich, potato chips and fruit or pudding.
-Sometimes the residents did not even get the fruit or pudding.
-The sandwiches were cold ham and cheese or thick cut bologna on bread.
-The residents were complaining about the cold sandwiches so at one of the meals the cook put

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the sandwiches in the oven and the bread did not toast it just got hard; the residents could not eat the hard bread.
-The residents complained about being hungry because they were not getting enough to eat.
-The residents would ask for double snacks at snack time because they said they were hungry.

Interview with a cook on 09/04/25 at 10:14am revealed:
-The menu did not change much they got the same food delivered every week.
-The residents told her they were tired of the same food.
-If the cooks could follow the cycle menu the residents would have more variety.
-She did not understand why they could not get the food that was on the cycle menu.
-They served the residents a lot of sandwiches.
-There was one [named] cook who served most of the sandwiches.
-The other cook served two slices of meat and chips with her sandwiches.
-The bologna was precut and was about a half an inch thick.
-She did not know about hot dogs; the other cooks must have served them.

Interview with the Dietary Manager (DM) on 09/05/25 at 1:06pm revealed:
-The kitchen staff did not serve hot dogs on the weekends.
-Hot dogs were on the menu so there were hot dogs available at the facility.
-She did not work every weekend, so she did not know if the other cooks were serving hot dogs.
-She thought hot dogs were only on the menu once a month at lunchtime.
-Sandwiches with potato chips and pasta salad were on the menu 3 times a week.

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D 297	Continued From page 74 -Sandwiches were always served with a side of tomato, onion, pickle, and sometimes lettuce. -Sandwiches always had cheese on them. -The air conditioner was broken in the kitchen and in the dining room in the spring and she replaced hot items with cold plates because it was too hot to cook in the kitchen. -She had not heard any residents complain about sandwiches or being served too many sandwiches. -The residents at Resident Council had requested more sandwiches a while ago. -If the residents had come to her and complained she would have changed the menu back the way it was. Telephone interview with the facility's Regional Chef on 09/05/25 at 2:26pm revealed: -The cooks should always follow the menu. -Sandwiches were not on the regular cycle menu and should never have been substituted for an entree item. -Sandwiches were not considered a menu item because they were an "always available item". -If a resident did not like what was on the menu and wanted something else to eat, they could request a sandwich. -Hot dogs should only be served when they were on the menu. -Potato chips were not a menu item because they had no nutritional value and should not have been served in place of a side. -He was concerned the residents were being served hot dogs, sandwiches and potato chips three to five times a week because their nutritional goals would not be met. Interview with the Administrator on 09/04/25 at 4:02pm revealed: -The cooks should follow the regular cycle menu.	D 297		

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D 297	Continued From page 75 -The menus should be posted for the current day and the next two days so the residents knew what would be served. -The menu should be followed because it offered a variety of foods. -Menu items should never be eliminated from any of the resident meals because they would miss items they needed for complete nutrition. -If residents did not eat because they did not like sandwiches and were still hungry, they could have weight loss.	D 297		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure that therapeutic diets were served as ordered for 1 of 3 sampled residents (#12), who had an order for a pureed diet. The findings are: Review of the facility's therapeutic diet menu for 09/02/25 revealed: -The regular lunch menu listed a bacon cheeseburger, lettuce, tomato, onion, French fries, fudge brownie, and milk were to be served. -The pureed therapeutic diet menu for lunch listed a pureed cheeseburger with no bacon, pureed mashed potatoes with gravy replaced the	D 310		

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D 310	Continued From page 76 French fries, pureed vegetables were to be served in place of the lettuce, tomato and onion, and a pureed brownie were to be served. -The regular dinner menu listed Bar-B-Que pork rib patty, baked potato, corn, green beans and grapes were to be served. -The pureed therapeutic diet menu for dinner listed a pureed BBQ pork patty, mashed potatoes with gravy, pureed vegetables replaced the corn with a note not to puree corn, pureed green beans and a pureed fruit replaced the grapes. Review of Resident #12's current FL-2 dated 10/08/24 revealed: -Diagnoses included Alzheimer's disease, osteoarthritis, and gastroesophageal disease (GERD). -There was an order for a pureed diet. Observation of the lunch meal on 09/02/25 at 12:00pm revealed: -Resident #12 was served pureed meat, pureed greens and pudding. -Resident #12 ate 75 percent of the pureed meat, 100 percent of the pureed greens and 100 percent of the pudding. Interview with the morning cook on 09/02/25 at 11:51am revealed: -She pureed the white northern beans and the crab patty together because the residents would not eat the meat alone. -She was told to always puree something in with the protein so the residents would eat. -She pureed collard greens to replace the green beans and corn mix. -She served pudding to replace the canned pears. -She did not serve bread to the residents with a pureed diet ordered.	D 310		

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D 310	Continued From page 77 -She was told not to puree bread. Observation of the dinner meal on 09/02/25 at 5:35pm revealed: -The residents were served a cheeseburger, French fries, a slice of tomato, a slice of onion, and pineapple tidbits. -The staff offered ketchup, mayonnaise or mustard to the residents with regular meals. -Resident #12 was served pureed meat, mashed potatoes, and pudding. -Resident #12 ate 75 percent of his burger, 100 percent of his mashed potatoes and pudding. -Resident #12 was not served any condiments for his meal. Interviews with the evening cook on 09/02/25 at 5:00pm and 5:57pm revealed: -She prepared a cheeseburger, French fries, tomato, onion and pineapple tidbits for the residents for the dinner meal. -She pureed the hamburger patty without the cheese or any vegetables; she prepared the mashed potatoes but did not prepare gravy. -She did not puree the cheese, bread or condiments in with the hamburger patty; she did not think of doing it. -She had a therapeutic diet menu, but she did not look at it when she prepared the food for the pureed diet because she served the same thing to all the residents. -She knew not to puree things like corn. -She pureed another menu item into some of the proteins because the residents did not like the plain meat or eggs. Interview with the Dietary Manager (DM) on 09/03/25 at 8:45am revealed: -The therapeutic diet menus showed the cooks what to puree for the meals.	D 310		

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D 310	Continued From page 78 -The therapeutic diet menu showed what to mix when pureeing food, like when to use water and bread in the puree. -The menus were the same from week to week and did not change so the cooks knew what to do and what needed to be pureed. -The cooks were supposed to puree bread by using milk; they were not supposed to eliminate the bread. -The northern white beans and the crab cakes should not have been pureed together; the white beans were a side. -Only one resident wanted protein items pureed together; the other residents' food should have been pureed separately unless the therapeutic diet menu told them to puree together. -The morning cook was new, and she did not know to puree items separately. -The cooks all followed the therapeutic diet menu. -The bacon cheeseburger was supposed to be pureed together, including the bacon, the cheese, the meat and the bun. -She would have used soft bacon. -She did not know the therapeutic diet menu did not include the bacon for the pureed meal. -She was not aware the residents with a pureed diet did not get a vegetable the night before. -The cook should have substituted a vegetable; she should not have omitted the vegetables from the pureed meal. -The therapeutic diet menu was a guideline for the cooks to know what to make; they were supposed to follow that menu. -She was not aware the entire lunch meal was swapped out for something else. -She was not aware the lunch menu was moved to the evening for the dinner meal. -She was concerned that the residents did not get a full meal and would still be hungry after they ate.	D 310		

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-The residents with a pureed meal should have been offered condiments for their meal like the other residents.

Telephone interview with the facility's Regional Chef on 09/05/25 at 2:26pm revealed:
-The cooks should always follow the menu.
-If the cook had to substitute an item on the menu, they were supposed to substitute something of the same nutritional value.
-The cooks were required to substitute a meat for a meat, a vegetable for a vegetable, and carbohydrates for carbohydrates [starch].
-The therapeutic menu was supposed to be followed to ensure the residents were served a nutritionally complete meal at the correct consistency.
-Nothing should have been eliminated from the pureed therapeutic menu.
-His concern was when items were eliminated from the pureed therapeutic diet menu then the residents' nutritional goals might not be met long term.

Interview with the Resident Care Coordinator (RCC) on 09/04/25 at 5:27pm revealed:
-The cooks should follow the therapeutic menu for pureed diets.
-They should not be eliminating anything from the menu.
-The residents on a pureed diet should not have menu items eliminated from their diet because it will take away their nutrition and over time will cause weight loss.

Interview with the Administrator on 09/04/25 at 4:02pm revealed:
-He expected the cooks to always follow the therapeutic menu, including the pureed diets.
-Menu items should never be eliminated from any

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D 310	Continued From page 80 of the resident meals because they would miss items they needed for complete nutrition. -Residents on a puree diet did not eat well anyway and removing items from their diet long term could cause weight loss.	D 310		
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 A1 VIOLATION Based on interviews and record reviews, the facility failed to treat the residents with respect and dignity as evidenced by the way staff (Staff A, B, C, D, E, F, G, and H) spoke to the residents; failed to provide services to a resident whose level of care was increased to skilled nursing (#1); and a resident being paid cash to answer telephones (#10) and another resident taking trash to the dumpster (#14); and a resident who was served last in the dining room because he was ordered a pureed diet (#12). The findings are: Interview with the Administrator on 09/02/25 at 9:30am revealed: -His first day as the Administrator of the facility was 09/01/25. -The former Administrator retired in March 2025. -The Interim Administrator returned this week to help him with the state survey.	D 338		

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D 338	Continued From page 81 1. Review of the facility's undated resident rights policy revealed residents were to be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. a. Confidential interview with a resident revealed: -He dreaded going to the bathroom because the staff fussed so much. -He could not help that he needed assistance. -He would like to be able to do things for himself. Confidential interview with a second resident revealed: -The staff were mean to her. -She could not recall examples because she tried to put them out of her mind, because it hurt her. -Staff treated her like a child. Interview with a third resident on 09/02/25 at 8:27am revealed staff "cussed and fussed" all the time. Interview with a fourth resident on 09/02/25 at 9:05am revealed staff members snapped at her and were hateful (no particular staff members were named). Interview with a fifth resident on 09/02/25 at 8:27am revealed the way staff spoke to him made him feel bad and embarrassed him. Interview with a sixth resident on 09/04/25 at 9:24am revealed that staff treated her horribly. Telephone interview with a former resident on 09/04/25 at 10:22am revealed: -He recently moved out of the facility because he was tired of the way residents were being treated.	D 338		

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D 338	Continued From page 82 -The staff were rude in the way they talked to the residents. -He had heard staff tell residents to "shut up, you do not know anything". -The previous Administrator let the staff members get by "with murder". Confidential interview with a resident's family member revealed: -He had seen the staff talking so badly to the residents; he would not talk to a dog that way. -He did not have confidence in the staff doing their jobs and treating residents the way they did. -He did not report staff behaving badly to the managers because he did not want staff to retaliate against his family member. Confidential interview with a staff member revealed: -Staff members talked to the residents inappropriately. -The staff member had thought about resigning because of the way the residents were treated. -Staff cursed at the residents. -It looked like the staff were at the facility for a paycheck, not for the residents. Confidential interview with a second staff member revealed she had heard staff speak harshly to the residents. Confidential telephone interview with a third staff member revealed residents were not being treated appropriately and that the situation needed to be investigated. Confidential telephone interview with a fourth staff member revealed some of the personal care aides (PCA) were hateful to the residents.	D 338		

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D 338	Continued From page 83 Confidential interview with a fifth staff member revealed: -The way she had seen the PCAs treat residents was disgusting. -A [named] resident said staff had talked ugly to her. -The same [named] resident would say the staff rushed her. -She reported concerns to the Interim Administrator, and she never did anything, so "why keep telling her when you know nothing was going to be done about it". Telephone interview with a sixth staff member on 09/03/25 at 4:32pm revealed the staff were rough with the residents; they grabbed the residents and used their strength to manhandle them. Telephone interview with the facility's contracted primary care provider (PCP) on 09/04/25 at 11:45am revealed: -If staff were speaking to the residents in a way that would be unkind, she would consider it neglect and abuse. -It was not acceptable to be unkind to the residents. -The residents could become depressed and shut down. Interview with the Interim Administrator on 09/05/25 at 10:41am revealed: -She was not aware of any other incidents of verbal abuse. -She expected staff to speak to residents respectfully and politely. Interview with the Resident Care Coordinator (RCC) on 09/04/25 at 5:15pm revealed: -Residents should be treated with respect. -Staff were in "the resident's home".	D 338		

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-She did not tolerate verbal abuse.
-Verbal abuse could cause depression, the resident could stop eating, and have other unmet needs.
-The residents could fear retaliation.

Interview with the current Administrator on 09/04/25 at 5:03pm revealed:
-If staff were not speaking to the residents with dignity, it was considered verbal abuse.
-Verbal abuse could cause stress, which could cause the residents to decline.

b. Confidential interview with a resident revealed:
-Staff A, medication aide (MA), would never help her get into bed.
-When Staff A worked, she told her she would get help to put her to bed and never come back.

Telephone interview with a former staff member on 09/03/25 at 9:36am revealed Staff A talked "ugly" to the residents; "not be nice".

Telephone interview with a former resident on 09/04/25 at 10:22am revealed Staff A was heard telling a resident to "shut your mouth and take your medicine".

Confidential interview with a resident's family member revealed Staff A was rude to the residents and gave them a "no care" attitude when she interacted and spoke to them.

Interview with Staff A on 09/04/25 at 6:51pm revealed:
-If someone had complained about her interactions with the residents, it was probably because of her voice; she talked loudly.
-She knew of one resident whom she had told staff not to lift because the resident could do it

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herself.
-She told the resident the staff were here to help her, not do it for her.
-Residents knew if they needed anything, to come to her because she was the only one who would help them.

c. Interview with a resident on 09/02/25 at 8:27am revealed:
-Staff B, personal care aide (PCA), raised her voice and cursed her.
-Staff B "fussed her out" in front of other people.
-She was so upset one night that she did not eat dinner.
-"She made me feel this big" (she demonstrated holding her fingers close together to show small).

Interview with another resident on 09/02/25 at 9:26am revealed:
-Every time she asked Staff B something, she "jumps on me", she hollered and raised her voice at her.
-She told the person who was filling in for the previous Administrator that Staff B hollered at her, but she did not know the staff member's name.

Interview with a third resident on 09/04/25 at 9:24am revealed Staff B cursed her out and made her feel terrible.

Telephone interview with Staff B on 09/04/25 at 2:20pm revealed:
-She never told a resident to do something for themselves.
-There had been times she would encourage or motivate a resident to do things for themselves.
-She never told a resident anything that was unkind.
-She did talk loudly to anyone who was hard of hearing.

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D 338	Continued From page 86 -She did not know why anyone would say she had mistreated a resident because she never would. d. Interview with a resident on 09/05/25 at 9:16am revealed Staff C, PCA, treated him like "crap". Interview with a second resident on 09/02/25 at 4:18pm revealed Staff C "jumps all over" her when she asked a question. Interview with a third resident on 09/04/25 at 9:10am revealed: -Staff C was rude to her. -Staff C did not want to do anything for her. -This had been going on for a long time, and no one had ever done anything about Staff C. -She would ask Staff C to do something for her, and Staff C would tell her to do it herself. Confidential interview with a fourth resident revealed: -Staff C would come into her room, turn her call bell off, and walk away without talking to her. -Sometimes Staff C would not ask the resident what she needed; Staff C would say she needed help with the resident and never came back. -Staff C turned her call bell off three times in a row and never helped her. -Staff C spoke harshly to her and would say, "What do you want now?" -Staff C should not work at the facility if she did not want to help the residents. Confidential interview with a fifth resident revealed: -Staff C was rough and always seemed angry; she used harsh tones when she spoke to the resident. -Staff C treated the resident as if she did not like the resident.	D 338		

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D 338	Continued From page 87 -The resident would rather not have Staff C help her because of the way Staff C treated the resident. Telephone interview with a housekeeper on 09/03/25 at 4:32pm revealed Staff C "talked junk" and was mean to the residents. Interview with a medication aide (MA) on 09/05/25 at 1:58pm revealed a [named] resident had requested that Staff C not assist with his baths, because of the way Staff C treated her, so she started doing the resident's baths herself. Confidential interview with a staff member revealed: -Staff C told a resident it was not her job to give the resident a bath. -Staff C told another resident to wash his own legs, and the resident had a fall. Confidential telephone interview with a second staff member revealed: -Multiple residents had complained about the way Staff C treated them. -Staff C talked to a [named] resident ugly, but the resident did not want to get anyone fired. -The [named] resident was upset about the way Staff C talked to her. Confidential interview with a third staff member revealed: -Staff C talked to the residents so nastily. -It was ridiculous how she treated the residents. -A [named] resident complained to her all the time about Staff C. -The [named] resident told her that Staff C treated her so badly. - The [named] resident was nervous to report it because Staff C would be nasty to her.	D 338		

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D 338	Continued From page 88 Confidential telephone interview with a fourth staff member revealed: -She heard Staff C tell a resident to stand your fat [expletive] up; the resident had memory loss. -Two named residents complained to her about Staff C. Interview with Staff C on 09/04/25 at 3:58 revealed: -She did not think she had said anything unkind to the residents. -She did not know why anyone would say that she had said those things to the residents. -No one in management had ever talked to her about the way she talked to the residents. -She remembered asking a [named] resident why she put her light on, making her run up and down the hall; she laughed, and the resident laughed. -She did not "joke" like that with any other residents. e. Confidential interview with a resident revealed Staff D, housekeeper, had made a comment to him about stool being on his toilet; it made him feel bad because he could not do things for himself. Confidential interview with a staff member revealed: -They heard Staff D tell residents to sit their [expletive] down. -Staff D was heard saying, "What the [expletive] are you doing" because he did not want any residents to sit in the front foyer. Confidential interview with another staff member revealed Staff D had cursed at a [named] resident because the resident had stool on his commode.	D 338		

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Confidential telephone interview with a third staff member revealed:
-Staff D told a [named] resident there was no reason you are so messy at your age.
-The resident and Staff D were then going back and forth.

Interview with Staff D on 09/04/25 at 3:22pm revealed:
-He may have gotten frustrated when cleaning a resident's room, but he had never said anything to a resident.
-He did recall the previous Administrator giving a resident a bucket of water and making him clean his own toilet.
-He did not know why anyone would say he said something to a resident about their room.

f. Interview with a resident on 09/02/25 at 4:18pm revealed Staff E, a cook, made her feel "down and out" because the staff member told her she could get in the kitchen and cook herself when she made a comment about the food.

Confidential interview with a staff member revealed:
-They observed Staff E curse a resident.
-The resident complained about the food, and Staff E told the resident she could bring her [expletive] in the kitchen and cook.
-It happened in the hallway near the dining room.

Interview with the Director of Dining Services on 09/04/25 at 10:10am revealed:
-She was with Staff E when a [named] resident complained about the food.
-Staff E asked the resident if she wanted to come into the kitchen and cook, and laughed; the [named] resident laughed too.
-The Interim Administrator asked about the

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incident, and she told her the same thing.

Interview with Staff E on 09/04/25 at 10:41am revealed:
-She knew a resident had accused her of cursing them.
-She had not cursed at the resident.
-The resident told her the meatloaf was dry, and she told the resident that next time she could come into the kitchen and cook.
-The resident could have taken the comment as sarcastic now that she thought about it.
-The resident's comment about the meatloaf did not offend her.
-The resident complained a lot.

Interview with the Interim Administrator on 09/05/25 at 10:41am revealed:
-She had heard the allegation that Staff E had said something inappropriate to a resident, so she went to the cook, and the cook denied saying it.
-The resident said she thought Staff E said it.
-The resident was hard of hearing and wore a hearing aid, but did not always have it in.
-The resident said it happened, the cook denied it, and there were no witnesses.

g. Telephone interview with a former staff member on 09/03/25 at 9:36am revealed:
-Staff F, MA, took residents to their rooms, shut the door, and would verbally "go off" on the residents.
-He had heard a resident say Staff F was hurting her arm.
-This was done to residents who were confused.

Confidential telephone interview with a staff member revealed:
-Staff F was the only staff member whom she

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was told by residents had not been kind to them.
-A lot of the staff did not have the heart for this job.

Interview with Staff F on 09/04/25 at 11:30am revealed:
-She did pick at the residents, but nothing in a mean way.
-She had been "firm" with some residents but did not raise her voice or anything.
-She did not know why anyone would say she had been.

h. Confidential interview with a resident revealed:
-Staff G, MA, would tell the resident to "hurry up" while she was helping the resident with her shower; it made her feel rushed and anxious.
-Staff G would walk off without acknowledging the resident if the resident asked Staff G a question or for help.
-Staff G made her nervous because of the tone she used and the way she talked to her.

Confidential interview with a resident's family member revealed he and another family member saw Staff G tell a resident, "you need to shut up" and "you need to sit down and stop talking".

Confidential telephone interview with a staff member revealed:
-Staff G was hateful to whatever resident she came in contact with.
-She had witnessed Staff G say things to a [named] resident about his weight, about the size of his stomach, and about what the resident ate.
-Staff G told the resident that if he were not so big, he could wipe his own "butt".

Confidential interview with a second staff member revealed a [named] resident had told her Staff G

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D 338	Continued From page 92 spoke nastily to her. Confidential interview with a third staff member revealed a [named] resident had complained about how Staff G treated her. Confidential interview with a fourth staff member revealed: -A [named] resident complained about Staff G. -The resident also complained to her family member. Confidential interview with a fifth staff member revealed: -Staff G spoke to a [named] resident, "terrible". -She observed Staff G hollering at a [named] resident to hurry up to get their weight. -The resident walked with a walker and was slow, and when the resident got there, Staff G did not even weigh her. Confidential interview with a sixth staff member revealed: -A [named] resident complained that Staff G was rude to her. -She did not report the complaint to her supervisor. Interview with Staff G on 09/05/25 at 2:12pm revealed: -If her name came up about the way she treated the residents, she could only think of one resident who would have said something. -The incident was about the resident's hair not being washed, and the resident was complaining to everyone. -The resident would not "let the incident go," so she made sure she did not do anything with the resident without another staff member because she did not want anything misconstrued.	D 338		

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-She may have said something to a resident, but it would have been a joke.
-She did recall making a joke to a resident one time, but she did not think the resident took it as a joke based on her facial expression.
-She told the Interim Administrator what happened, and she then apologized to the resident.

i. Confidential interview with a staff member revealed:
-Staff H, Interim Administrator, cursed at the residents.
-She could not believe how Staff H talked to the residents.
-She heard Staff H tell a resident to go sit your [expletive] down.
-Staff H told the residents they were not going to [expletive] and [expletive] in the front lobby.
-Staff H was observed hollering at residents sitting in the front lobby.
-The staff member saw a resident cry because of the way she was talked to by Staff H.

Interview with the Staff H on 09/05/25 at 10:41am revealed:
-She did not know why someone would say she had spoken to a resident inappropriately.
-She spoke to the residents firmly.
-Maybe it was her tone.
-She spoke firmly, but she did not mean to be mean.

2. a. Review of Resident #10's current FL-2 dated 02/11/25 revealed diagnoses included diabetes mellitus, hypertension, and schizophrenia.

Interview with Resident #10 on 09/02/25 at 3:09pm revealed:
-She worked at the facility.

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-Her job was to sit at the front desk in the nurses' station and answer the telephone.
-She had the job at the front desk since 2009.
-She wrote down names of people who called on a piece of paper.
-She got paid to work at the front desk.
-She did not want to say how much she got paid because she wanted to keep her job.
-She received her sixty-dollar funds once a month, but she also got paid once a month for her job.
-Taxes were not taken out of the money she was paid by the facility for working there.
-The previous Administrator hired her and paid her in cash.
-The business Office Manager (BOM) was paying her now.
-She worked from 4:00pm to 8:00pm, Monday through Friday; she did not work on holidays or weekends.
-She needed her job and did not want to lose it.
-She needed the money.
-She would not work if she did not get paid to answer the telephone.

Second interview with Resident #10 on 09/02/25 at 4:23pm revealed:
-She was not working today, but she would not say why she was not working today, 09/02/25, at the front desk.
-She would not say if she was told not to come to work today.
-She was "okay", and she would not say if she wanted to work today.

Observation of the nurses' station on 09/02/25 at 4:22pm revealed Resident #10 was not at the desk.

Confidential interview with a staff revealed:

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-He had seen Resident #10 work at the front desk in the afternoons.
-Resident #10 did not work on the weekends.
-Resident #10 answered the telephone and passed out cigarettes to the residents.
-The previous Administrator told him she paid Resident #10 five dollars a week to work at the front desk.
-Everybody knew Resident #10 worked at the front desk and got paid cash for it; it was not a secret.

Interview with two residents on 09/04/25 at 9:31am revealed:
-Resident #10 sat at the nurses' station in the afternoons after 4:00pm and answered the telephones.
-Resident #10 called it her job.
-They did not know if she got paid to work.

Telephone interview with a former staff on 09/02/25 at 10:07am revealed:
-Resident #10 was working in an administrative capacity and asked when she was going to get paid.
-Resident #10 told her she got paid cash every two weeks for the job she worked at the facility.
-When she questioned the BOM about how to pay Resident #10 the BOM told her she would pay Resident #10 out of the resident's monthly funds.
-Resident #10 worked at the front desk from 4:00pm to 7:00pm to fill a gap in the staff schedule.
-She answered the telephone and took messages.

Telephone interview with another former staff on 09/03/25 at 3:15pm revealed:
-Resident #10 answered the telephone in the

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evenings during the week.
-She was paid a dollar a day for working at the front desk.
-Resident #10 was paid cash out of the previous Administrator's pocket at first, but then they started to take it out of her account because she was not spending the money in her account and there was a concern she was accumulating too much money.
-There were discussions at the stand-up meetings between the Interim Administrator, the BOM and the previous Resident Care Coordinator (RCC) about paying her out of her own funds.
-Resident #10 was paid out of her own funds around March 2025 or April 2025.
-Resident #10 put cigarettes for the residents into baggies, answered telephones and took messages at the nurses' station.

Telephone interview with a medication aide (MA) on 09/03/25 at 4:04pm revealed:
-She had seen Resident #10 answering phone calls at the front desk.
-Resident #10 would sit at the front desk from around 3:00pm to 7:00pm.
-Resident #10 said she worked at the facility and the BOM and the Interim Administrator paid her 12 dollars a week.
-The BOM said they paid her to answer the telephones.
-She never saw Resident #10 get paid but she thought she was paid once a month when the residents got their monthly funds.

Telephone interview with a second MA on 09/03/25 at 8:53pm revealed:
-Resident #10 was depressed and was sleeping a lot.
-She needed something to do so the previous

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Administrator let her sit at the front desk and answer the telephone, cut up paper for scraps and do little things to help.
-Resident #10 stopped about a week or two ago because she was told she could not work at the desk anymore.
-She thought someone from corporate told Resident #10 she could not work anymore.
-Resident #10 had worked in the nurses' station at the front desk for a long time.
-She did not think Resident #10 got paid to answer the telephone and work at the desk.
-Resident #10 wanted to help, and now she was going to get depressed again and sleep a lot again.

Interview with the BOM on 09/03/25 at 10:33am revealed:
-There were no residents working at the facility.
-She answered the telephone until 5:00pm.
-Whoever was at the nurses' station would answer the telephone if she was not there.
-If a resident was at the nurses' station they were sitting with a personal care aide (PCA) and the PCA answered the telephone not the resident.
-There was not a resident who came to the nurses' station every night to answer telephones; she did not know why someone would say there was.
-Resident #10 would come to the nurses' station to be near the staff and to have someone to talk to but she did not answer the telephones.
-Resident #10 would sit at the nurses' station and put counted cigarettes together in resealable bags for the residents.
-Resident #10 would bag cigarettes for the whole week at one time.
-The only money Resident #10 received was her monthly spending money from her funds.
-Resident #10 got $66 a month.

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-Resident #10 would ask for more here and there; she would ask for $10 or $20 at a time in addition to the $66.
-She always documented when she gave Resident #10 extra money.
-She was not sure why Resident #10 would not talk about working at the facility.
-She had not spoken to Resident #10 about a job or working at the facility.

Interview with the Interim Administrator on 09/05/25 at 7:06pm revealed:
-She did not know why Resident #10 would say she had a job at the facility answering telephones from 4:00pm to 7:00pm.
-It was not Resident #10's job to answer the telephones at the facility.
-Resident #10 liked to help out and would sit at the desk at the nurses' station and write in a notebook.
-She would give the residents their cigarettes.
-She took notes of things going on.
-She was paid $20 every so often for helping out.
-Resident #10 was paid out of the previous Administrator's pocket, her pocket and the RCC's pocket for working at the front desk.
-Money was never taken out of Resident #10's own funds and given to her; they always gave her money out of their pockets.
-Resident #10 had been sitting at the desk for years.
-She did not know residents could not be compensated for helping around the facility.

Interview with the RCC on 09/05/25 at 4:53pm revealed:
-Residents should not work at the facility.
-She believed in engaging the resident in activities they enjoyed doing but answering the telephones was not one of them.

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-The residents should not be sitting at the front desk because the information that was at the nurses' station could be a Health Insurance Portability and Accountability Act (HIPAA) violation and general resident privacy issue.

Interview with the Administrator on 09/05/25 at 3:27am revealed:
-He was not aware Resident #10 was answering the telephone or sitting at the nurses' station.
-Residents should not be doing jobs that the facility staff should be doing.
-Residents should not be paid or compensated with things like snacks and sodas for doing things for staff.
-When residents were compensated or paid then it became a job.
-Residents could do task that were part of an activity like making decorations and helping to decorate for a party.
-He never wanted a resident to feel like they had to do something for the staff.

Attempted telephone interview with Resident #10's guardian on 09/03/25 at 10:00am was unsuccessful.

b. Review of Resident #14's current FL-2 dated 04/09/25 revealed diagnoses included hypertension, wheezing, schizophrenia disorder, vitamin B12 deficiency and vitamin D deficiency.

Interview with Resident #14 on 09/05/25 at 9:52am revealed:
-He took the trash out of the kitchen and put it in the outside dumpster.
-He had been taking the trash out since he started living at the facility years ago.
-Another resident used to get paid to take the trash out, but he took over the job when the other

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resident left.
-He took the trash out two to three times a day.
-He checked on it and sometimes the housekeeper told him it needed to be emptied.
-Different staff would give him money to buy soda out of the vending machine.
-He was paid just about every day for taking the trash out.
-He had been getting paid since he started taking the trash out.
-He would take the trash out for nothing; it gave him something to do that was important and it was better than sitting around all day.

Telephone interview with a medication aide (MA) on 09/03/25 at 8:38pm revealed:
-Resident #14 took the kitchen trash to the dumpster because the housekeeper said it was too heavy for him to put into the dumpster.
-The housekeeper gave Resident #14 a couple of dollars to buy sodas out of the vending machine for emptying the trash.
-Resident #14 told her about taking the trash out and getting paid to do it.
-She told the Interim Administrator about Resident #14 taking the trash out and nothing was said or done.
-It had been a while since she told the Interim Administrator.
-All the staff knew Resident #14 was doing the housekeepers' job by taking the trash out.

Interview with a housekeeper on 09/04/25 at 3:26pm revealed:
-Resident #14 took the kitchen trash out and put it in the dumpster.
-The staff would give Resident #14 $1 to $2 for taking the trash out.
-Whoever was working would give Resident #14 the money.

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-Resident #14 liked to buy sodas out of the vending machine.
-Resident #14 took the trash out pretty much every day.
-Resident #14 would ask if he could take the trash out.
-He did not know how Resident #14 began taking the trash out.
-Resident #14 had been taking the trash out for a long time, several months.
-Resident #14 would probably take the trash out without being paid.
-He had paid Resident #14 a $1 or $2 for taking the trash out for him too.
-Resident #14 had not asked for money he just gave it to him.

Interview with the Interim Administrator on 09/05/25 at 7:06pm revealed:
-Resident #14 took the kitchen trash out to the dumpster.
-He was given some change from the staff pockets for taking the trash out.
-He emptied the trash four to five days a week.
-Resident #14's family gave him money, so she did not know if he needed money.
-It was not a paid job, but she did not know if he would do it for free.
-She did not know residents could not be compensated for helping around the facility.

Interview with the RCC on 09/05/25 at 4:53pm revealed:
-Residents should not work at the facility.
-She believed in engaging the resident in activities they enjoyed doing like napkin folding.
-Residents should not be taking out trash, doing physical work and not be doing the work the staff should be doing.
-Residents should not be compensated for doing

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D 338	Continued From page 102 the staff jobs or any part of a staff job. Interview with the Administrator on 09/05/25 at 3:27am revealed: -He was not aware Resident #14 was taking trash out for the housekeeper. -Residents should not be doing jobs that the facility staff should be doing. -Residents should not be paid or compensated with things like snacks and sodas for doing things for staff. -When residents were compensated or paid then it became a job. -Residents could do tasks that were part of an activity like making decorations and helping to decorate for a party. -He never wanted a resident to feel like they had to do something for the staff. 3. Review of Resident #12's current FL-2 dated 10/08/24 revealed: -Diagnoses included Alzheimer's disease, osteoarthritis, and gastroesophageal disease (GERD). -There was an order for a pureed diet. Observation of the lunch meal on 09/02/25 from 12:00pm to 12:45pm revealed: -There were 48 residents in the dining room; some of the residents ate in their rooms and one of the residents was out with family. -At 12:03pm, the staff began to pass the residents in the dining room their trays. -Resident #12 was seated at a table with two other residents. -The two other residents at the table were served their meals at 12:05pm and 12:13pm; Resident #12 did not have his food. -Resident #12 sat without a plate while the other two residents ate their lunch.	D 338		

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-Resident #12 was served his pureed meal at 12:24pm.
-At 12:27pm, the two other residents at the table left the dining room.
-Resident #12 ate his meal alone at the table.
-At 12:46pm, Resident #12 was still eating and was sitting at the table alone.

Interview with Resident #12 at 12:19pm revealed:
-He did not know why he did not have his meal yet.
-He was hungry too.
-He usually got his meal last.

Observation of the dinner meal on 09/02/25 from 5:35pm to 6:20pm revealed:
-There were 44 residents in the dining room.
-Resident #12 was seated at the table with two other residents.
-At 5:35pm, the staff began serving the dinner meal to the residents.
-The staff offered ketchup, mustard, and mayonnaise to the residents for their cheeseburgers and French fries.
-At 5:54pm, the two residents at the table with Resident #12 left the dining room.
-At 5:57pm, the cook was pureeing the food for the residents on a pureed diet.
-At 6:02pm, the staff began to serve the residents on a pureed diet their meals.
-The staff did not offer the residents who were served a pureed meal any of the condiments.
-At 6:13pm, Resident #12 left the dining room; he ate 75 percent of his burger, 100 percent of his mashed potatoes and pudding.

Interview with Resident #12 on 09/02/25 at 5:45pm revealed:
-He did not know where his food was.
-He just waited for his food.

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THE CANTERBURY HOUSE	1284 LEASBURG ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 104 -His friends at the table left when they were done. -He did not like to eat by himself because it was lonely. Interview with a medication aide (MA) on 09/05/25 at 2:57pm revealed: -At mealtime the kitchen staff put the food on trays and pushed them out on a tall cart. -The pureed food used to come out first but that changed in March 2025; she did not know why. -The plates with the pureed food came out last. -There were times that residents were sitting at a table with no food and the other residents were eating. -The resident without food would ask where their food was or when were they going to get their food. -The resident would get upset when they had to watch the other residents eat. -The staff could not ask the kitchen for the pureed food because they would get upset. -Resident #12 was always eating by himself because the other residents at his table did not have a pureed diet. Interviews with the evening cook on 09/02/25 at 5:00pm and 5:57pm revealed: -She was told by the Dietary Manager (DM) when she was training to prepare the pureed food for the residents after she had served everyone else their plates. -She had to puree the food items and then plate them. -She did not know why she had to puree the food for the residents after the other residents were served. -It only took her a few minutes to puree the meals; there were only four residents on a pureed diet.	D 338		

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D 338	Continued From page 105 Interview with the DM on 09/03/25 at 9:12am revealed: -She was told to prepare the pureed food after all the residents with regular diet were served; she could not recall who told her. -She did not know why she was told to serve the pureed food last. -She thought it was because the residents who needed feeding assistance were fed last. -She did not know there were residents who had an order for pureed diets and could feed themselves. -She had been serving the pureed food last for a while; she did not recall who told her to prepare it last. Interview with the RCC on 09/05/25 at 4:53pm revealed: -The residents at a table should all be served at the same time. -It could upset a resident, it could hurt their feelings, and it could cause decline by watching the other residents at the table eat or eat after the other residents left. -When the other residents at the table left, a resident who was confused or frustrated might not wait for their food, get up from the table and not eat their meal. Interview with the Administrator on 09/05/25 at 3:27am revealed: -Residents had the right to choose where they sat in the dining room. -All the residents at one table should be served their meals together. -One resident should not be watching the other residents at the table eat. -It was a dignity issue to sit and watch other residents eat their food. -The social aspect of the mealtime was not being	D 338		

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D 338	Continued From page 106	D 338		

met if a resident was not served their food and ended up eating alone.

4. Review of Resident #1's current FL-2 dated 06/03/25 revealed:
-Diagnoses included peripheral vascular disease, muscle weakness, difficulty walking and right shoulder pain.
-The recommended level of care was a skilled nursing facility (SNF).
-She required assistance from staff with bathing, feeding and dressing.
-She was semi-ambulatory.
-She had an indwelling catheter and was continent of bowel.

Review of Resident #1's care plan dated 02/04/25 revealed:
-Resident #1 required limited assistance from staff with eating.
-She required extensive assistance from staff with toileting, ambulation, bathing, dressing, grooming/personal hygiene and transferring.

Interview with Resident #1 on 09/02/25 at 8:31am revealed:
-She was supposed to get a shower every other day in the mornings but sometimes the staff would skip her.
-It would depend on how many staff were working on her scheduled shower day.
-The staff helped her with her showers.
-She was supposed to get a shower yesterday, 09/01/25, but she did not get one.
-Sometimes when she was scheduled to get a shower she was just wiped down by the staff.
-The staff did not even change her underwear when they wiped her down.

Telephone interview with Resident #1's Power of

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D 338	Continued From page 107 Attorney (POA) on 09/04/25 at 10:43am revealed: -Resident #1 had declined; the family recognized she had declined quickly over the last few months. -He and the rest of Resident #1's family were looking for a facility with a higher level of care for her. -They had been looking for another facility for a couple of months. -Resident #1 was on a waiting list for a facility in the area. -The facility had not given them a time frame to move Resident #1. Telephone interview with Resident #1's primary care provider (PCP) on 09/03/25 at 2:32pm revealed: -Resident #1 had a change in her condition and started to show a decline over the last two to three months. -Her weight fluctuated, and she required two to three staff to assist her with transfers and bathing. -Resident #1 had adaptive equipment for meals and required reminders, queuing and sometimes assistance when eating. -Resident #1's POA noticed the change in her condition and realized she needed a higher level of care. -She signed a new FL-2 and recommended a SNF for Resident #1's level of care. Interview with a medication aide (MA) on 09/04/25 at 11:50am revealed: -Resident #1 was hard to shower because she could not move one side of her body. -Resident #1 required two to three staff to assist with transferring her depending on the staffs' experience. -Resident #1 looked forward to her showers; she	D 338		

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D 338	Continued From page 108 never refused to take one. -She did not document showers or skin assessments anywhere. Interview with the Interim Administrator on 09/04/25 at 6:13pm revealed: -The PCP completed a new FL-2 recommending a SNF for Resident #1. -The family had Resident #1 on a waiting list at a SNF. -The family and the PCP had initiated the move for Resident #1 to a SNF. -The facility had not issued a discharge letter for Resident #1 because they could not discharge her to the street if she had nowhere to go. _____ The facility failed to protect residents from verbal abuse as evidenced by eight staff members (Staff A, B, C, D, E, F, G, and H) who spoke to the residents rudely, raised their voices, and cursed at a resident which made her so upset she did not eat dinner one night. Another resident felt Staff C "jumped all over" her. A resident (#10) was paid a dollar a day in cash to work her "job" at the front desk five days a week for three hours to answer the telephone, take messages and sort cigarettes and another resident (#14) took trash out of the kitchen for the housekeeper and tossed it into the dumpster multiple times a day and was paid cash to purchase soda from the vending machine. A resident (#12) was served his meal last, after his table mates had already eaten, and ate alone because he had an order for a pureed diet. A resident (#1) was determined by the PCP she required skilled care and the facility had not initiated the discharge process for the resident for 90 days. These failures resulted in neglect and exploitation and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in	D 338		

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D 338	Continued From page 109 accordance with G.S. 131D-34 on September 5, 2025. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 5, 2025.	D 338		
D 441	10A NCAC 13F .1208 Death Reporting Requirements 10A NCAC 13F .1208 Death Reporting Requirements (a) Upon learning of a resident death as described in Paragraphs (b) and (c) of this Rule, a facility shall file a report in accordance with this Rule. A facility shall be deemed to have learned of a resident death when any facility staff obtains information that the death occurred. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to complete a death report for 1 of 1 sampled resident (#3) who had a fall within 36 hours of his death. The findings are: Interview with the Administrator on 09/02/25 at 9:30am revealed: -His first day as the Administrator of the facility was 09/01/25. -The former Administrator retired in March 2025. -The Interim Administrator returned this week to help him with the state survey. Review of Resident #3's FL2 dated 07/30/24	D 441		

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revealed diagnoses included schizophrenia, type II diabetes, chronic kidney disease, chronic obstructive pulmonary disease (COPD), and hypertension.

Review of Resident #3's progress notes revealed there was no documentation of a fall or his death.

Review of Resident #3's progress notes, incident reports, and 72-hour reports revealed there were no falls documented from 05/22/25-05/24/25.

Review of Resident #3's emergency medical services (EMS) report dated 05/23/25 at 5:45am revealed:
-EMS was dispatched to the facility for cardiac arrest.
-Resident #3 was lying on his side and was cold to the touch.
-Resident #3 had an active do-not-resuscitate (DNR) in place.
-Resident #3 had rigor mortis and was very cold and stiff.
-The time of death was marked at 5:45am on 05/23/25.

Interview with the Business Office Manager (BOM) on 09/04/25 at 8:53am revealed:
-She recalled Resident #3 was sitting on the floor of the kitchenette, and staff helped him up.
-She thought the previous Resident Care Coordinator (RCC) was in the room.
-She did not recall when the fall occurred.
-Resident #3 died on 05/23/25.

Telephone interview with a former staff member on 09/03/25 at 9:36am revealed:
-On 05/22/25, Resident #3 had a fall in the kitchenette.
-The Interim Administrator stated, "Get him up".

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-Resident #3 was not sent to the hospital; he was just put in his bed, and he could not even walk.
-The Interim Administrator stated there was nothing wrong with him, even though it was reported that Resident #3 was staggering.

Second telephone interview with the former staff member on 09/05/25 at 12:08pm revealed:
-Resident #3 was sitting against the window facing the hall when he was found on 05/22/25.
-When he heard Resident #3 had died, he was concerned the resident had a fall and then died the following day.

Telephone interview with a housekeeper on 09/03/25 at 4:32pm revealed:
-He and a former staff member got Resident #3 off the floor in the kitchenette; he did not recall the date.
-The Interim Administrator and the previous RCC came into the kitchenette when Resident #3 fell and told them to get the resident up.
-He was not sure of the date of the fall.

Telephone interview with a personal care aide (PCA) on 07/04/25 at 3:07am revealed:
-The morning before Resident #3 died, she had seen him walk into the door casing, like his balance was off; it was during the end of third shift and beginning of first shift.
-She reported what she observed to the first shift staff before she left the facility, but she did not recall who she told.
-Resident #3's balance being off was an everyday thing, but she had never seen him walk into anything.
-Resident #3 was found deceased in his bed around 6:00am; she could not recall the date.

Interview with the Interim Administrator on

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D 441	Continued From page 112 09/05/25 at 10:41am revealed: -She did not do a death report when Resident #3 died. -She asked a [named] corporate manager and was told she did not need to do a death report. -She was asked if the resident had a fall, and she said no. -When asked by the surveyor about the alleged fall the day before he died, she responded Resident #3 was sitting on the floor, not lying on the floor, so she did not take it as a fall. -She did an assessment, and he was fine. -She did not think Resident #3's death was related to the fall. -She did not think she needed to do a death report. Telephone interview with the Corporate Manager on 09/05/25 at 1:45pm revealed: -She did not talk to the Interim Administrator about any resident's death. -If a resident had a fall and a death occurred within 24 hours, a death report was required. -There should have been an incident report completed for Resident #3's fall on 05/22/25 and a report for the death. -She expected the staff to have followed the process.	D 441		
D 482	10A NCAC 13F .1501 (a) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501Use Of Physical Restraints And Alternatives (a) An adult care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and	D 482		

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D 482	Continued From page 113 that restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms for which the resident's physician or physician extender has determined warrant the use of restraints and not for discipline or convenience purposes; (2) used only with a written order from a physician or physician extender except in emergencies where the health or safety of the resident is threatened, according to Paragraph (d) of this Rule; (3) the least restrictive restraint that would provide a safe environment for the resident and prevent physical injury; (4) used only after alternatives that would provide a safe environment for the resident to prevent physical injury and prevent a potential decline in the resident's functioning have been tried and documented by the administrator or their designee in the resident's record as being unsuccessful; (5) used only after an assessment and care planning process has been completed, except in emergencies where the health or safety of the resident is threatened, according to Paragraph (d) of this Rule; (6) applied correctly according to the manufacturer's instructions and the physician's or the physician extenders' order; and (7) used in conjunction with alternatives in an effort to reduce restraint use. For the purposes of this Rule, "physician extender" means a licensed physician assistant or licensed nurse practitioner. Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities	D 482		

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D 482	Continued From page 114 to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to obtain physician's orders for the use of physical restraints for 1 of 1 sampled residents (#6) related to the use of a recliner. The findings are: Interview with the Administrator on 09/02/25 at 9:30am revealed: -His first day as the Administrator of the facility was 09/01/25. -The former Administrator retired in March 2025. -The Interim Administrator returned this week to help him with the state survey. Review of the facility's Physical Restraint policy revealed: -The use of physical restraints referred to the application of a physical or mechanical device attached to or adjacent to the resident's body that the resident could not remove easily, which restricted freedom of movement or normal access to getting out of bed, as opposed to	D 482		

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enhancing mobility of the resident while in bed.
-Except in emergencies, residents should be physically restrained only with a written order from a physician.
-Restraints could not be used for discipline or staff convenience.
-The restraint could only be applied for medical symptoms such as, but not limited to, confusion with risk of falls and risk of abuse or injurious behaviors to self.
-Except in the event of an emergency, an alternative must be tried and documented.
-If alternatives to physical restraints failed, the least restrictive restraint would be used, as appropriate, within the immediate circumstances.
-Restraints would be verified that they were applied correctly in accordance with the physician's orders and used in conjunction with alternatives in an effort to reduce the use of the restraints.
-During restraint usage staff would document the care that was provided to residents during the time of the restraint usage and behaviors of the resident during use of the restraints.
-Emergency restraints would only be used in a temporary situation, and the physician would be notified within 24 hours.
-Physical restraints would only be applied by staff who had received training.
-The policy was not dated.

Review of Resident #6's current FL-2 dated 06/16/25 revealed:
-Diagnoses included fracture of femur, dysphagia, rheumatoid arthritis, atrial fibrillation, heart failure, hypertension and dementia.
-Resident #6 was constantly disoriented, wandered and was semi-ambulatory.
-Resident #6 was incontinent to bladder and bowel.

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D 482	Continued From page 116 -Resident #6 required personal care assistance from staff with bathing, feeding and dressing. Observation of Resident #6 on 09/04/25 at 5:04pm revealed: -Resident #6 was on the floor facing beside her recliner, the footrest was down and she was facing the doorway. -There was a medication aide (MA), three emergency medical services (EMS) and the Interim Administrator in the room with the resident. -Resident #6 was transported to the local emergency department (ED) via EMS. Observation of Resident #6 on 09/05/25 at 10:02am revealed: -She was reclined all the way back in her reclining chair with the footrest up. -She had a chair alarm clipped to her shirt. -The remote control for the recliner was lying in the chair with her. -Resident #6 was leaning forward and constantly moving her legs and feet. -Resident #6 moved her legs and feet to either side of the footrest and then back on the footrest. -Resident #6's family member moved the remote from the chair and placed it on the ground next to the chair and out of reach of Resident #6. Review of Resident #6's quarterly care plan and assessment dated 06/06/24 revealed: -Resident #6 required limited staff assistance with eating, toileting, dressing, grooming and personal hygiene. -She required staff supervision with ambulation, locomotion and transferring. -She required extensive assistance from staff with bathing.	D 482		

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D 482	Continued From page 117 Review of Resident #6's Licensed Health Professional Support (LHPS) evaluation dated 06/19/25 revealed: -Personal care tasks included suppositories, inhalations of medication by machine, ambulation using assistive devices that required physical assistance, and transferring semi-ambulatory or non-ambulatory residents. -Recommendations included completing a fall risk intervention care plan and documenting interventions. -There was a section for the types of restraints used (least restrictive); recliner was listed as an option but not checked as used. -There were no other restraints listed. -There was a section for the reason for the use of restraints; to prevent falls and to prevent sliding from a chair were listed but not checked as used. -The type of assistive device required for ambulation was wheelchair. -The type of transfer assistance was from the bed to the chair/chair to the bed. -The type of assistance required by staff for transferring was one and two person assist. -There was an observation where Resident #6 stood to her feet with the assistance of two staff, limited weight bearing due to complaint of hip pain; she stood and pivoted. -Resident #6 had a chair alarm due to three falls in the facility during the last quarter. -There was an observation of a wheelchair and a reclined chair in her room at the bedside. -Resident #6 was dependent upon staff for wheelchair mobility and transfers due to dementia and limited mobility. Review of Resident #6's incident report dated 09/04/25 revealed: -Resident #6 had an unwitnessed fall with an injury on 09/04/25 at 4:45pm.	D 482		

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	HAL073018	A. BUILDING: _____ B. WING _____	C 09/05/2025

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D 482	Continued From page 118 -She was found lying on the floor in her room. -Resident #6 complained of pain. -She had an injury to the right side of her forehead. -First aid was not administered. -She was sent to the local hospital via EMS at 5:10pm. Review of Resident #6's discharge report from the local hospital dated 09/04/25 revealed: -Resident #6 was seen at the local ED for a mechanical fall (a fall caused by external or environmental factors) at 5:53pm. -She had a hematoma to the right side of her head at the scalp. -Results from a Computerized Tomography (CT) scan did not show evidence of a fracture or an intracranial subdural hematoma. -Resident #6 was discharged and returned to the facility on 09/05/25. Confidential interview with a staff revealed: -Resident #6 tried to get out of her recliner a few months ago and it flipped over on her. -She saw Resident #6 with the recliner on top of her. -The family was told to get a heavier recliner for Resident #6 so it would not flip over on her when she tried to stand up. -Staff had to take Resident #6 around with them from resident room to resident room with them when she was awake or put her in her recliner and recline her because she tried to stand and would fall. -The alarms for her bed and chair worked, but staff had to be right next to her if she started to fall. Confidential interview with a staff revealed: -Resident #6 fell in her room and was found on	D 482		

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the floor in front of her recliner.
-A MA, and two other staff went to Resident #6's room.
-The MA told them to take the resident's vitals and see if she was okay.
-The protocol was if a resident hit their head they would automatically be transported to the hospital.
-Resident #6 was saying her head hurt.
-The MA told her and the other staff, "Let's act like this never happened because I do not feel like writing a report tonight".
-Resident #6 had a knot on her head.
-Resident #6 had been in her reclining chair in her room all day.
-Resident #6 had been reclined back with the footrest up and had been trying to stand up and get out of the chair all day.
-There were not enough staff to watch Resident #6 and the Resident Care Coordinator (RCC) said they were not allowed to keep her at the nurses' station anymore.

Interview with Resident #6's Power of Attorney (POA) on 09/05/25 at 10:02am revealed:
-On 09/04/25, he was notified Resident #6 hit her head and was sent to the hospital.
-He went to the hospital and Resident #6 had a knot on her head.
-The RCC told him Resident #6 was reclined in her reclining chair before the fall.
-The RCC told him Resident #6 had just been put into her recliner and the staff went two doors down and they heard the chair alarm go off and ran to her room, but she had already fallen on the floor.
-He wanted Resident #6 to recline back in her recliner if she could not be watched at the nurses' station.
-Resident #6 would fiddle with things so he did

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not want the remote control for the recliner in the chair with her.
-He did not want her to get out of the recliner.
-The hospital told him Resident #6 stood up and fell because her feet were tangled.

Telephone interview with Resident #6's hospice nurse on 09/05/25 at 1:06pm revealed:
-Hospice did not write orders for restraints.
-A recliner was not considered a restraint unless the sole purpose of the recliner was to keep Resident #6 from getting up.
-The facility had not discussed putting Resident #6 in a recliner to keep her from getting up.
-The recliner was considered a restraint once it was used to keep Resident #6 from getting up.

Telephone interview with a resident's family member on 09/05/25 at 11:06am revealed:
-At around 4:00pm on 09/04/25, she was on her way to her family member's room when she walked by Resident #6's room, the door was open and Resident #6 was on the floor.
-The resident looked at her and said, "help me it hurts".
-The resident was on the floor between the front of the recliner and the bathroom door.
-She started waving her hand and calling out for staff to come because there was a lady [Resident #6] on the floor.
-The MA, a personal care aide (PCA) and another [named] staff came to the room, so she left.
-She did not recall if the chair alarm was going off or if the recliner was reclined back when she found the resident.
-In the past whenever she saw the same resident in her room the door was open, and she was always in her recliner with the feet up.

Telephone interview with a PCA on 09/05/25 at

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D 482	Continued From page 121 10:22am revealed: -She was giving a resident a shower on 09/04/25, when a resident's family member told her there was a lady [Resident #6] on the floor of a resident room and she said her head was hurting. -A group of staff all got to Resident #6's room at the same time, the MA, the Business Office Manager (BOM) and another PCA. -Resident #6 was on the floor in front of the recliner, the chair was fully reclined and the footrest for the recliner was all the way up. -Resident #6 was complaining her head was hurting. -She could not recall if the chair alarm was going off. -She had seen Resident #6 in her room in the recliner earlier in the day and it was fully reclined, with the footrest up. -The last time she saw Resident #6 in the recliner was about 3:00pm, it was still reclined, and the resident was trying to get out. -She told another PCA to keep an eye on Resident #6 while she gave showers because Resident #6 had been trying to get out of her recliner all day. -Resident #6 used to sit at the nurses' station most of the day but was not allowed to sit there once the new RCC and Administrator started. -The only place to keep Resident #6 was in her recliner to keep her from falling. -She thought Resident #6 tried to get out her recliner, slid down and fell forward. Telephone interview with a MA on 09/03/25 at 8:29pm revealed: -Resident #6 was in a wheelchair. -Resident #6 would try to stand up and then fall because she could not support her own weight. -Resident #6 had a chair alarm that clipped to her, but she would still stand up and fall.	D 482		

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D 482	Continued From page 122 -She stood up and fell a few times with the chair alarm after two falls in June 2025. -Resident #6's family wanted her to stay in her wheelchair at the nurses' station all day until bedtime so the staff could keep an eye on her. -The family thought staff would be able to get to Resident #6 quicker if the alarm went off and she was at the nurses' station; they thought it would prevent falls. -Resident #6 had a recliner in her room. -She and the staff would put Resident #6 in her recliner and recline it back so she would go to sleep for a couple of hours before lunch. -She would clip Resident #6's chair alarm to her and recline her in the chair and she would go to sleep. -Resident #6 would try to get up from the recliner, that was why they would put the chair alarm on her and keep the door open so they could hear the alarm. -Resident #6 would move in the chair and the chair alarm would go off. -They could not always keep an eye on Resident #6 because they had other residents to care for. Telephone interview with a second MA on 09/04/25 at 5:04pm revealed: -On 09/04/25 at 4:50pm, when she was administering medication, she passed Resident #6's room,and saw Resident #6 in her recliner. -Resident #6 was awake and the chair was reclined back. -She was in another resident's room administering medication not five minutes later and Resident #6 fell. -A PCA and the BOM heard Resident #6's chair alarm and went to her room; one of them came to the resident room she was in and got her. -Resident #6 was on the floor in front of her recliner.	D 482		

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D 482	Continued From page 123 -The staff did not always have time to watch Resident #6. -Resident #6 had her chair alarm on, was reclined and she still fell in the 5 minutes she was alone. -The staff had other residents to take care of, and Resident #6 required so much attention. Interview with a third MA on 09/05/25 at 2:40pm revealed: -Resident #6 tried to stand up a lot and that was why she had a lot of falls. -There were not enough staff to watch Resident #6. -Resident #6 had a chair alarm helped but she would still fall. -The recliner was another way to keep her from falling. -They would put her in the recliner with the feet up and she would eventually fall asleep. -Resident #6 was constantly wiggling. -Resident #6 wanted to move or tried to stand if she was just sitting. -When the footrest was up on the recliner she would put her feet on either side, and it would set off the chair alarm. -She would wiggle, the staff would hear the alarm go off, and they would go into her room to check on her. Interview with the RCC on 09/05/25 at 4:53pm revealed: -She educated Resident #6's family and POA about the use of restraints. -She told them the staff could not set Resident #6 back in the recliner and move the recliner remote control away from her. -Resident #6 had falls from trying to stand up. -The family was setting her back in the recliner. -She saw Resident #6 two minutes before she fell the night before and she was not reclined back.	D 482		

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D 482	Continued From page 124 -The MA did not recline Resident #6 back in her recliner. -She was with the MA, and the MA put Resident #6's footrest up a little bit, but it was not all the way back. -Resident #6 could still put her feet on the ground with the footrest up a little bit and she had the chair alarm on. -The MA gave Resident #6 the remote control for the recliner, and the call bell. -She and the MA left Resident #6's room and went two doors down to another resident's room when they heard the chair alarm. -The MA got to Resident #6's room before her and Resident #6 had fallen. -Resident #6 went forward and face down; the alarm had stopped when she got into the room. -The MA put the recliner upright. -Resident #6 asked if anyone was going to help her, she said her head hurt, and she wanted to get up. -The recliner was not helping Resident #6; it was a way for staff not to have to check on her. -Resident #6 was not safe in the recliner when it was reclined and staff were not watching her. -She told the staff not to put Resident #6 in the recliner with the feet up anymore. -She told Resident #6's family the staff could not recline her in the recliner because it was considered a restraint. -Resident #6 needed to be engaged in activities. Interview with the Administrator on 09/05/25 at 3:27pm revealed: -Residents had to have an order from the primary care provider (PCP) for a restraint. -Restraints included putting a recliner too far back so the resident could not get up. -None of the residents in the facility had orders for restraints.	D 482		

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D 482	Continued From page 125 -Staff should not be placing a resident who tries to stand up in a reclined reclining chair with the feet up. Based on observations, record reviews, and interviews, Resident #6 was not interviewable. _____ The facility failed to ensure a restraint was not used without an order for a resident (#6) who had a history of falls, was known by staff to constantly attempt to stand up and was placed by staff into a fully reclined recliner in her room to keep her from falling when staff could not watch her. She had a fall from her recliner when she attempted to stand up while the recliner was in a reclined position with the footrest up and staff were not around which resulted in the resident being sent to the hospital with a knot on her head. This failure resulted in a substantial risk for serious physical harm to the resident and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on September 5, 2025. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 5, 2025.	D 482		