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C 000	Initial Comments The Adult Care Licensure Section and the Robeson County Department of Social Services conducted an annual survey and complaint investigation on September 2 and 3, 2026. The complaint investigation was initiated by the Robeson County Department of Social Services on August 14, 2026.	C 000		
C 145	10A NCAC 13G .0406(a)(5) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure that 2 of 3 sampled staff (Staff A, Staff B) sampled had no substantiated findings on the North Carolina Health Care Personnel Registry prior to hire at the facility. The findings are: 1. Review of Staff A's personnel record revealed: -Staff B was hired on 10/07/25 as a personal care aide (PCA). -There was a Health Care Personnel Registry (HCPR) check completed on 11/04/25 with no substantiated findings. -There was no HCPR check prior to 11/04/25. Refer to interview with Administrator on 09/03/26 at 4:43pm.	C 145		

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C 145	Continued From page 1 2. Review of Staff B's personnel record revealed: -Staff B was hired on 10/15/24 as a personal care aide (PCA). -There was a Health Care Personnel Registry (HCPR) check completed on 11/07/24 with no substantiated findings. -There was no HCPR check prior to 11/07/24. Attempted telephone interview with Staff B on 09/03/26 at 4:30pm was unsuccessful. Refer to interview with the Administrator on 09/03/26 at 4:43pm. _____ Interview with the Administrator on 09/03/26 at 4:43pm revealed: -She was responsible for checking the HCPR upon hire of any new staff. -She did not remember why she had not checked the HCPR on or before Staff A's and Staff B's hire dates.	C 145		
C 147	10A NCAC 13G .0406(a)(7) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (7) have a criminal background check completed in accordance with G.S. 131D-40 and results available in the staff person's personnel file; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 3 staff sampled had a criminal background check completed prior to starting work at the facility for 2 of 3 sampled staff (Staff A and Staff B).	C 147		

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C 147	Continued From page 2 The findings are: 1. Review of Staff A's personnel record revealed: -Staff A was hired on 10/07/25 as a personal care aide (PCA). -There was a criminal background check completed on 10/23/25. -There was no criminal background check prior to 10/23/25. Refer to interview with Administrator on 09/03/26 at 4:43pm. 2. Review of Staff B's personnel record revealed: -Staff B was hired on 10/15/24 as a personal care aide (PCA). -There was a criminal background check completed on 11/07/24. -There was no criminal background check completed prior to 11/07/24. Attempted telephone interview with Staff B on 09/03/26 at 4:30pm was unsuccessful. Refer to interview with the Administrator on 09/03/26 at 4:43pm. _____ Interview with the Administrator on 09/03/26 at 4:43pm revealed: -She was responsible for checking the criminal background check upon hire of any new staff. -She did not remember why she had not checked the criminal background check on or before Staff A's and Staff B's hire dates.	C 147		
C 148	10A NCAC 13G .0406 (a)(8) Other Staff Qualifications	C 148		

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C 148	Continued From page 3 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (8) have an examination and screening for the presence of controlled substances completed in accordance with G.S. 131D-45 and results available in the staff person's personnel file; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure documentation of an examination and screening for the presence of controlled substances was completed for 1 of 3 sampled staff (Staff A). The findings are: Review of Staff A's personnel record revealed: -Staff A was hired on 10/07/25 as a personal care aide (PCA). -There was documentation Staff A completed a drug screening on 10/20/25. Interview with the Administrator on 09/03/26 at 4:43pm revealed: -She was responsible for checking the drug screens upon hire of any new staff. -She did not remember why she had not checked a drug screen on or before Staff A's hire date.	C 148		
C 153	10A NCAC 13G .0501 (a and b)) Personal Care Training And Competency 10A NCAC 13G .0501 Personal Care Training And Competency (a) The facility shall assure that staff who provide	C 153		

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C 153	Continued From page 4 or directly supervise staff who provide personal care to residents complete an 80-hour personal care training and competency evaluation program established by the Department. For the purpose of this Rule, "directly supervise" means being on duty in the facility to oversee or direct the performance of staff duties. A copy of the 80-hour training and competency evaluation program is available online at https://info.ncdhhs.gov/dhsr/acls/training/index.html#80hr, at no cost. The 80-hour personal care training and competency evaluation program curriculum shall include: (1) observation and documentation skills; (2) basic nursing skills, including special health-related tasks; (3) activities of daily living and personal care skills; (4) cognitive, behavioral, and social care; (5) basic restorative services; and (6) residents' rights as established by G.S. 131D-21. (b) The facility shall assure that training specified in Paragraph (a) of this Rule is completed within six months after hiring for staff hired after September 30, 2022. Documentation of the successful completion of the 80-hour training and competency evaluation program shall be maintained in the facility and available for review by the Division of Health Service Regulation and the county department of social services. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 2 sampled staff (A, B) who provided personal care to residents had successfully completed a	C 153		

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C 153	Continued From page 5 80-hour personal care training and competency evaluation program. The findings are: 1. Review of Staff A's personnel record revealed: -Staff A was hired on 10/07/25 as a personal care aide (PCA). -There was a Health Care Personnel Registry (HCPR) check completed on 11/04/25 with no substantiated findings and she was not listed as a certified nursing assistant. -There was no documentation for personal care training for Staff A. Refer to interview with Administrator on 09/03/26 at 4:43pm. 2. Review of Staff B's personnel record revealed: -Staff B was hired on 10/15/24 as a personal care aide (PCA). -There was a Health Care Personnel Registry (HCPR) check completed on 11/07/24, and she was not listed as a certified nursing assistant with no substantiated findings. -There was no documentation for personal care training for Staff B. Interview with Staff B on 09/03/26 at 8:00am revealed: -She worked on Friday and Saturday nights from 11:00pm to 9:00am. -She was the awake staff on night shift. -She performed personal care for the residents. Refer to interview with Administrator on 09/03/26 at 4:43pm. _____ Interview with the Administrator on 09/03/26 at 4:43pm revealed:	C 153		

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C 153	Continued From page 6 -She was responsible for completing the personal care aide training of any new staff. -She did not remember why she had not completed the training within 6 months of hire.	C 153		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .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 record reviews and interviews, the facility failed to ensure acute health care needs were met for 1 of 4 sampled residents (#4) by not contacting the residents' primary care provider (PCP) when the resident complained of leg pain, had bruising to her right leg, and was unable to bear weight on her right leg. The findings are: Review of Resident #4's current FL-2 dated 09/22/25 revealed: -Diagnoses included mild dementia, hypertension, chronic anemia, chronic kidney disease, and chronic obstructive pulmonary disease (COPD). -She was incontinent of bowel and bladder. -The current level of care was domiciliary. Review of Resident #4's Resident Register revealed the resident's admission date to the facility was 02/15/16. Review of Resident #4's current care plan dated	C 246		

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C 246	Continued From page 7 01/08/26 revealed: -Resident #4 used a wheelchair. -Resident #4's skin was documented as normal. -Resident #4 was totally dependent with eating, toileting, ambulation/locomotion, bathing, dressing, grooming/personal hygiene, and transferring. Review of Resident #4's primary care provider (PCP) note dated 07/08/26 revealed: -Resident #4 was seen for medical management. -There was no documentation related to Resident #4 having pain, swelling, or bruising to either of her legs. Review of Resident #4's record revealed there were no staff progress notes available for review. Review of Resident #4's emergency medical services (EMS) patient record dated 07/13/26 revealed: -The clinical impression was extremity pain. -The onset of the extremity pain was 07/10/26. -Resident #4 had right knee pain and swelling. -Resident #4 was sent out by staff for evaluation of pain, swelling and bruising of her right knee. -The facility denied that Resident #4 had fallen. -Resident #4 had been unable to bear weight on her right knee since 07/10/26. -Resident #4 could normally stand and walk. Review of Resident #4's Emergency Department (ED) record dated 07/13/26 revealed: -Resident#4 was a poor historian and could not ambulate independently. -Resident #4 arrived at the ED for right knee pain, no known fall or injury. -Resident #4 reported hip pain. -Final impression was closed fracture of distal end of left femur, unspecified fracture	C 246		

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morphology.
-Final impression was closed fracture of distal end of right femur, unspecified fracture morphology.
-Resident #4 was transferred to another hospital for surgical repair of bilateral distal femur fractures.

Review of Resident #4's hospital discharge notes dated 07/14/26 to 07/27/26 revealed:
-Resident #4 was admitted after being transferred from another hospital on 07/14/26 and discharged on 07/27/26.
-Resident #4 was admitted for bilateral distal femur fractures.
-Resident #4 had bilateral revision total knee arthroplasty with distal femur replacement on 07/16/26.

Telephone interview with Resident #4's orthopedic surgeon on 08/21/26 at 3:20pm revealed:
-He was the surgeon who repaired Resident #4's fractured femurs of both legs on 07/16/26.
-Resident #4 arrived with bilateral distal femur fractures that were bleeding internally.
-He could not tell how Resident #4's femurs were fractured or how long the injury had occurred but Resident #4 also had osteoporosis and her weak bones played a role.
-There had to be some type of trauma that caused the fractures.
-He nor his team ever got a clear understanding of what happened to cause the fractures.
-This type of injury could occur in people who may have fallen on both knees or if the person was being assisted with a transfer and was accidentally dropped on their knees.

Second telephone interview with Resident #4's

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orthopedic surgeon on 09/03/26 at 5:36pm revealed:
-Resident #4 was in critical condition when she arrived at their hospital on 07/14/26.
-Resident #4's femur fractures were considered a medical emergency due to the amount of blood loss that Resident #4 sustained.
-Resident #4's blood count and blood pressure were low and she had to be stabilized in the intensive care unit before they could perform surgery.
-Resident #4 could have experienced shock, stroke, heart attack or death from the bilateral femur fractures due to being anemic.
-The goal was to control Resident #4's pain.
-The longer Resident #4's femur fractures were left untreated, the bleeding continued and contributed to her condition.

Telephone interview with Resident #4's family member on 08/10/26 at 11:00am revealed:
-Resident #4 went to ED on 07/10/26 and returned on the same day.
-He visited Resident #4 on Sunday, 07/12/26.
-On 07/12/26, he observed that both of Resident #4's feet were on the floor because she did not have the foot pedals on her wheelchair.
-He pushed Resident #4's wheelchair to the living room and she could not hold her legs up, so he had to move her very slowly.
-He could tell something was wrong because when Resident #4 was at the dining room table it was hard to move her.
-Previously, Resident #4 could take her feet and move herself but she was unable to do this on 07/12/26 and he wondered why she could not move her feet.
-He assisted the staff to transfer Resident #4 from her wheelchair to her Geri chair on 07/12/26.
-The Supervisor in Charge (SIC) realized on

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C 246	Continued From page 10 07/13/26 after they had gotten Resident #4 in the chair that she needed more care so she said that she was going to have her sent out to the hospital. -He was not told how Resident #4 was injured. Second telephone interview with Resident #4's family member on 09/02/26 at 2:05pm revealed: -On 07/10/26, Resident #4 could bend and straighten her legs and was not complaining of any leg pain. -He and the staff attempted to move Resident #4 in her wheelchair and she started yelling that her legs hurt on 07/12/26. -Resident #4 was unable to use her legs to help move her wheelchair that did not have foot pedals on 07/12/26. -Resident #4 began yelling that she hurt while the staff moved and positioned her in the Geri chair on 07/12/26. -He was not informed when Resident #4's legs started hurting. -He was called Monday morning, 07/13/26 and informed Resident #4 was going to be sent to the hospital for leg pain. -The hospital informed the family that Resident #4 had two fractured legs. Interview with a personal care aide (PCA) on 08/10/26 at 10:00am revealed: -On Saturday morning, 07/11/26 Resident #4 still complained about her legs hurting and she and the SIC got her up and gave her a bed bath. -After her bath they transferred Resident #4 into her wheelchair and took her to the kitchen to eat breakfast. -She and the SIC helped Resident #4 into her wheelchair that morning, she required more help, she could stand but she needed more help and she was complaining about her legs.	C 246		

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C 246	Continued From page 11 -Resident #4 complained that her legs hurt. Second interview with a PCA on 09/03/26 at 8:00am revealed: -She worked Friday and Saturday nights from 11:00pm to 9:00am. -She would notify whoever she was working with if a resident was experiencing pain or had a change in condition. -Resident #4 returned from the hospital on 07/10/26 at 11:30pm. -She and the SIC got Resident #4 up around 6:30am to 7:00am on Saturday 07/11/26 and she was complaining of pain in her legs. -She and the SIC got Resident #4 up Sunday morning, 07/12/26. -She and the SIC noticed a bruise on the back of Resident #4's right thigh. -She did not inform the other PCA about the bruise on Resident #4's right thigh, she thought the SIC would. Interview with a second PCA on 07/14/26 at 11:10am revealed: -She worked on Sunday, 07/12/26 at 11:00pm and got off Monday, 07/13/26 at 8:00am or 8:30am. -She observed Resident #4's right leg to be bruised and swollen when she went to check on her on Sunday night, 07/12/26, not sure of the time. -She asked the other PCA what was wrong with Resident #4's leg and she did not know anything about her leg being bruised or swollen. -Resident #4's leg was not swollen or bruised on Friday, 07/10/26 morning because she and the other PCA put her in the shower around 12:00pm. -Resident #4 was not feeling well and had been weak earlier on Friday 07/10/26. -Resident #4 was sent out to a local hospital on	C 246		

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07/10/26 because she was not feeling well.
-She returned to work on the night of 07/12/26 and checked on Resident #4 and her leg was swollen, bruised, and purplish in color.
-She and the other PCA gave Resident #4 a bed bath on 07/13/26 and she complained of right leg pain while they bathed her.
-Neither she nor the other PCA asked Resident #4 if she had fallen or anything while they bathed her.
-On the morning of 07/13/26, she told the other PCA that she needed to call the Administrator due to Resident #4's leg was still swollen and bruised.
-The Administrator asked them to take a picture of Resident #4's leg and send it to her.
-Staff were told that when they observe changes in the residents' health or if there are accidents call the Administrator.
-She should have called Administrator but the other PCA was already in the facility and she knew about the bruises.

Second interview with the second PCA on 09/02/26 at 4:29pm revealed:
-She worked from Sunday to Friday night shift 11:00pm to 8:00am.
-She came to work on Sunday 07/12/26 at 11:00pm.
-She checked on Resident #4 and her right leg was bruised and swollen.
-Resident #4's leg was not bruised or swollen on Friday, 07/10/26 when she helped the other PCA give her a bath around 11:00am-12:00pm.
-She should have called the Administrator on 07/12/26 about Resident #4's leg, but she did not.
-She did not know why she did not notify the Administrator about Resident #4's bruised and swollen right leg on 07/12/26.

Interview with a third PCA on 07/14/26 at

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C 246	Continued From page 13 12:05pm revealed: -Resident #4 went to the hospital on Friday, 07/10/26 because she was not feeling well and the other PCA wanted to bathe her before she went to the hospital. -Resident #4 was weak on Friday, 07/10/26 and she said she felt bad, her "mobility was gone." -After breakfast, on 07/11/26 she moved Resident #4 from the table and tried to put her in the Geri-chair but she was unable to transfer Resident #4. -She called the SIC to come and assist Resident #4 into the Geri chair. -Resident #4 was able to grab onto things to assist them while they were moving her but on Friday, 07/10/26 she could not do any of that. -It took the SIC and her to transfer Resident #4 on 07/10/26. -On the morning of 07/11/26, Resident #4 complained of pain in her legs when staff put her in the Geri chair she said she could not pick both of her feet up. -On Monday 07/13/26, she noticed swelling to the back of Resident #4's leg when she assisted her to the bathroom. -The facility protocol was for staff to call the Resident Care Coordinator (RCC) if she was in the facility or the Administrator when the residents complain of pain, have a status change, or have an accident and if the staff observe resident injuries/wounds. -On Friday, 07/10/26, Resident #4 was not eating, talking, or wanting to move, and she was not her usual self. Second telephone interview with the third PCA on 09/03/26 at 2:33pm revealed: -On 07/11/26, Resident #4 was complaining of pain in knees and legs. -On 07/13/26, the SIC was helping another PCA	C 246		

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to get Resident #4 up that morning and she could not move her legs.
-She notified the RCC and the Administrator Monday morning, 07/13/26 that Resident #4 could not move her legs.
-The Administrator requested for her to take pictures of Resident #4's legs.
-She did not know what happened to Resident #4; she did not fall.

Interview with the SIC on 07/14/26 at 11:36am revealed:
-A PCA called her to the facility on Friday, 07/10/26 because they were getting Resident #4 ready to go to the hospital.
-It took 3 staff members to hold Resident #4 up to transfer her.
-Resident #4 returned to the facility the same night from the hospital without any new medications or orders.
-She did not see Resident #4 on Friday night, 07/10/26 when she came back from the hospital and it was about 10:30pm when they brought her back to the facility.
-She administered Resident #4 her morning medications on 07/11/26 around 8:00am.
-One of the PCAs came over to her building and asked her to come over and look at Resident #4's leg on Monday morning, 07/13/26.
-One of the facility staff called the Administrator.
-The Administrator told them that they needed to send Resident #4 out to the hospital.
-When there were changes in a residents' condition or accidents they were told to notify the Administrator or RCC, call 911, and call the family.

Second interview with the SIC on 09/02/26 at 3:48pm revealed:
-Resident #4 complained about pain in her legs

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C 246	Continued From page 15 Saturday morning, 07/11/26. -She returned that afternoon at 4:00pm on 07/11/26 to administer Resident #4's medications and Resident #4 was sitting in the living room and kept saying her leg hurt. -She administered Resident #4's scheduled pain medication at 4:00pm, on 07/11/26. -She was not sure why she did not call the RCC or the Administrator when the bruise was found on Resident #4's right leg Sunday morning, 07/12/26. -She did not think she needed to call the Administrator about the bruise on Resident #4's right leg. -On Sunday, 07/12/26, Resident #4 was complaining of leg pain around 2:00pm after she was transferred from her wheelchair to her Geri chair. -She did not call the PCP, RCC, or the Administrator when Resident #4 kept complaining of pain. -She was not sure why she did not call anyone related to Resident #4's change in condition or pain. -She should have sent Resident #4 to the ED for treatment. Interview with the RCC on 07/14/26 at 10:45am revealed: -Staff assisted Resident #4 when she went to the bathroom. -Resident #4 started complaining about her leg the morning of 07/13/26. -The PCA told her that Resident #4 had not fallen. -She had no idea how Resident #4 could have fractured both her legs. Second interview with the RCC on 09/03/26 at 9:54am revealed: -The SIC should notify her when there was a	C 246		

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change in condition of a resident.
-The Administrator should be notified if the staff could not reach her.
-She would have been expected to be notified that Resident #4 required something more for pain and if she was not available call the Administrator or send the resident to the ED.

Interview with the Administrator on 07/15/26 at 11:49am revealed:
-She did not remember calling to check on Resident #4 on Saturday, 07/11/26 or Sunday, 07/12/26 and none of the staff called her to report any concerns.
-A PCA said when they bathed Resident #4 on Friday morning, 07/10/26 that she was not bruised.

Second interview with the Administrator on 09/03/26 at 10:25am revealed:
-Staff were supposed to call the RCC or herself when there was a change in condition of a resident or they were having pain.
-Then they would make the decision to send the resident to the ED or call the PCP for orders.
-She had not been notified of anything that took place related to Resident #4 from Friday, 07/10/26 until Monday morning, 07/13/26.
-She was notified Monday morning, 07/13/26 that Resident #4 had a bruise and pain in her leg.
-She requested that the staff take pictures and send them to her on 07/13/26.
-She advised them to call 911 and Resident #4's family on 07/13/26.
-She was informed by a PCA that Resident #4 had not had any falls.
-She had not been called related to Resident #4 experiencing pain over the weekend, from 07/11/26 to 07/13/26.
-It was her expectation that staff would call the

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C 246	Continued From page 17 RCC or herself for any resident change in condition or if they were experiencing pain. -The staff should have notified the RCC or herself when the bruise was found on Resident #4 Sunday morning, 07/12/26. Telephone interview with facility's PCP on 08/26/26 at 8:05am revealed: -Resident #4's last visit was on 07/08/26 for routine medication management. -At this visit, she listened to Resident #4's heart and lungs, bowel sounds she did a general assessment and she was alert and oriented times 2. -Resident #4 had chronic pain and she was on pain medications due to that pain. -She had not been notified that Resident #4 had a change of condition, pain in her legs, or bruising. -She had called the facility on 07/13/26 and was informed that Resident #4 was sent to the hospital for bruising to her knee Based on interviews and record reviews, it was determined Resident #4 was not interviewable. _____ The facility failed to notify Resident #4's primary care provider (PCP) when Resident #4 reported pain in her legs and was unable to pick up her feet on 07/11/26. She continued to complain of pain on 07/12/26 and staff observed bruising to her right leg. Resident #4 was not sent to the Emergency Department for an evaluation until 07/13/26, when staff observed swelling to her right leg. Resident #4 was diagnosed with bilateral femur fractures that required her to be transferred to another hospital for surgical repair of the fractures and the revision of her bilateral knee arthroplasty. This failure resulted in serious physical harm and neglect and constitutes a Type A1 Violation.	C 246		

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C 246	Continued From page 18 The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/25/26 for this violation. CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 3, 2026	C 246		
C 254	10A NCAC 13G .0903(c) Licensed Health Professional Support 10A NCAC 13G .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist, respiratory care practitioner, or physical therapist in the on-site review and evaluation of the residents' health status, care plan, and care provided, as required in Paragraph (a) of this Rule, is completed within 30 days after admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph.	C 254		

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C 254	Continued From page 19 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure a Licensed Health Professional Support (LHPS) evaluation was completed on 3 of 4 sampled residents (#2, #3, #4) to include the identified task of fingerstick blood sugars (FSBS) (#2, #3) and wounds (#4). The findings are: 1. Review of Resident #4's current FL-2 dated 09/22/25 revealed: -Diagnoses included mild dementia, hypertension, chronic anemia, chronic kidney disease, and chronic obstructive pulmonary disease (COPD). -She was incontinent of bowel and bladder. -Current level of care was domiciliary. Review of Resident #4's record on 09/02/26 revealed there were licensed health professional support (LHPS) evaluations dated 02/03/26 and 04/30/26 but there was no documentation of the task of caring for wounds. Review of the home health (HH) nurse's facility documentation dated 01/09/26 revealed: -She was called related to a skin issue for Resident #4. -She assessed Resident #4's left hip and found a broken area of skin. -She removed the top layer of skin from Resident #4's left hip. -Wound care was completed. Review of the HH nurse's facility documentation dated 02/23/26 revealed: -Resident #4's left hip wound continued to heal. -Resident #4 had a black necrotic area on her lateral left great toe.	C 254		

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C 254	Continued From page 20 -She called Resident #4's primary care provider (PCP) to obtain an order for betadine to be initiated when supplies were received. Review of the HH nurse's facility documentation dated 03/05/26 revealed: -Resident #4's left hip wound was healed. -Wound care to Resident #4's lateral left great toe was completed. Review of the HH nurse's facility documentation dated 04/27/26 revealed: -Resident #4's right ankle wound healed. -Wound care to Resident #4's lateral left great toe was completed. Review of the HH nurse's facility documentation dated 06/26/26 revealed they admitted Resident #4 for wound vacuum application and wound vacuum applied to the right hip. Review of the HH nurse's facility documentation dated 07/03/26 revealed: -Resident #4's wound vacuum was applied to the right hip. -The HH nurse instructed the facility to make sure the clamps were open on the wound vacuum as she had found them clamped. Review of the HH nurse's facility documentation dated 07/07/26 revealed Resident #4's wound vacuum was applied. Review of the emergency department (ED) Hospital notes dated 07/14/26 to 07/27/26 revealed Resident #4 had wound care provided for stage 1 and stage 4 pressure injuries on the left and right hips, and a stage 2 sacral ulcer. Interview with Resident #4's HH nurse on	C 254		

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C 254	Continued From page 21 09/03/26 at 8:16am revealed: -The wound vacuum was changed from three times weekly to twice weekly and the wound clinic changed it on Tuesdays and she changed it on Fridays due to Resident #4's insurance. -She had been called on 01/09/26 by staff related to a wound on Resident #4's left hip that was a skin abrasion. -The wound on Resident #4's left hip progressed to stage 2 by 01/23/26. -She had taught the facility staff to reinforce the wound vacuum dressing and to change the canister if needed. Second telephone interview with the HH nurse on 09/03/26 at 3:37pm revealed: -She did not remember a wound on Resident #4's back, she had one on her toe and ankle. -She did not think Resident #4 was at the point of needing a higher level of care. Interview with the Administrator on 09/03/26 at 10:25am revealed: -She knew that Resident #4 had a wound on her hip that required a wound vacuum. -She did not know that it was a stage IV wound. -She could not remember any other wounds on Resident #4. Attempted telephone interview with Resident #4's PCP on 09/03/26 at 9:04am was unsuccessful. Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable. Attempted telephone interview with the LHPS Nurse on 09/03/26 at 3:00pm was unsuccessful. Refer to interview with the Administrator on	C 254		

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C 254	Continued From page 22 09/03/26 at 4:43pm. 2. Review of Resident #2's current FL-2 dated 05/12/26 revealed: -Diagnoses included coronary artery disease, hypertension, hypothyroidism, and vascular dementia. -There was an order for finger stick blood sugars twice a day. -There was an order for Trulicity 1.5mg inject subcutaneously every week (used to treat type 2 diabetes that helps control blood sugar and may reduce cardiovascular risk). Review of Resident #2's primary care provider's (PCP) visit note dated 05/12/26 revealed a diagnosis of type 2 diabetes mellitus. Review of Resident #2's record on 09/02/26 revealed there were licensed health professional support (LHPS) evaluations dated 07/28/26 and 04/30/26 but there was no documentation of the tasks of finger stick blood sugars or for medications administered by injection. Review of Resident #2's August 2026 medication administration record revealed: -There was an entry for fingerstick blood sugars twice a day which were documented as being done twice a day from 08/01/26 to 08/31/26. -There was an entry for Trulicity 1.5mg inject subcutaneously every week which was documented as administered weekly. Attempted telephone interview with the LHPS Nurse on 09/03/26 at 3:00pm was unsuccessful. Refer to interview with the Administrator on 09/03/26 at 4:43pm.	C 254		

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C 254	Continued From page 23 3. Review of Resident #3's current FL-2 dated 01/06/26 revealed: -Diagnosis included type 2 diabetes. -There was an order for finger stick blood sugars twice a day. -There was an order for Lantus inject 40 units subcutaneously at bedtime (a long-acting insulin used to control blood sugar in people with diabetes). -There was an order for Ozempic 1mg injection subcutaneously every week (used to treat type 2 diabetes and reduce the risk of cardiovascular and kidney complications in adults). Review of Resident #3's record on 09/02/26 revealed there were licensed health professional support (LHPS) evaluations dated 07/28/26 and 04/30/26 but there was no documentation of the tasks of finger stick blood sugars or for medications administered by injection. Review of Resident #3's August 2026 medication administration record revealed: -There was an entry for fingerstick blood sugars twice a day which were documented as being done from 08/01/26 to 08/31/26 and ranged from 99 -356. -There was an entry for Lantus inject 40 units subcutaneously at bedtime which was documented as administered daily at 8:00pm from 08/01/26 to 08/31/26. -There was an entry for Ozempic 1mg injection subcutaneously every week which was documented as administered weekly from 08/01/26 to 08/31/26. Attempted telephone interview with the LHPS Nurse on 09/03/26 at 3:00pm was unsuccessful. Refer to interview with the Administrator on	C 254		

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C 254	Continued From page 24 09/03/26 at 4:43pm. _____ Interview with the Administrator on 09/03/26 at 4:43pm revealed: -The LHPS nurse would come assess the residents and complete the forms quarterly. -She was not aware that the LHPS nurse was not completing the forms correctly. -She had talked with the LHPS nurse in the past about not completing the forms correctly. -She expected the LHPS nurse to assess each resident and to complete the forms accurately to show the exact needs required by each resident.	C 254		
C 311	10A NCAC 13G .0909 Residents' Rights 10A NCAC 13G .0909 Resident Rights A family 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 ensure a resident was free from physical abuse as evidenced by the failure to ensure safe transfers of a resident (#4) who was totally dependent on staff for personal care. The findings are: Review of the facility's policy and procedure for resident abuse, neglect, or misappropriation of property (not dated) revealed: -The health care facility shall investigate and document all allegations of resident abuse, neglect, and misappropriation of resident	C 311		

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property.
-The facility shall take reasonable measures to prevent patient abuse, patient neglect, or misappropriation of resident property.
-Including but not limited to orientation and instruction of facility staff on patients' rights and the requesting of references for all prospective employees.
-If the facility discovers that any resident is suspected of being mentally or physically abused or neglected by staff or other residents' the Administrator will be notified by staff immediately.
-The Administrator will first ensure the resident was safe and without harm or in need of emergency care.
-The employee will be asked to leave the building but remain on the premises.
-The Administrator will immediately notify the Department of Social Services (DSS) and the local law enforcement.
-The Administrator will assist law enforcement and DSS with the investigation of allegations reported.
-The Administrator will then notify the residents' responsible party or contact person as indicated.
-The Administrator will thoroughly investigate allegations of resident abuse, neglect, or misappropriation of property and document all relevant information pertaining to such investigation and take steps necessary to prevent further incidents of abuse, neglect, or misappropriation of resident property while the investigation was in progress and have witnesses that are able to provide a written statement.
-The staff involved in the incident will be immediately placed on unpaid leave until investigation was resolved and termination was probable depending on results of the investigation.
-The necessary forms will be completed by the

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C 311	Continued From page 26 Administrator and submitted to the North Carolina Health Care Personnel Registry (HCPR) within 24 hours of the facility becoming aware of the allegations which appear to a reasonable person to be related to of abuse, neglect, or misappropriation of resident property. -The Administrator will contact staff once investigation was completed for conference and potential termination based on findings. -The Administrator will submit a 5-day report after the investigation was completed. -The Supervisor-In-Charge will contact residents daily to ensure no concerns are voiced, and report to Administrator immediately with any problems or concerns. -The Administrator will contact residents monthly to ensure no concerns were voiced. Review of Resident #4's current FL-2 dated 09/22/25 revealed: -Diagnoses included mild dementia, hypertension, chronic anemia, chronic kidney disease, and chronic obstructive pulmonary disease (COPD). -She was semi-ambulatory and used a wheelchair. -She was incontinent of bowel and bladder. -The current level of care was domiciliary. Review of Resident #4's Resident Register revealed the resident's admission date to the facility was 02/15/16. Review of Resident #4's current care plan dated 01/08/26 revealed: -Resident #4 used a wheelchair. -Resident was totally dependent with eating, toileting, ambulation/locomotion, bathing, dressing, grooming/personal hygiene, and transferring.	C 311		

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	FCL078098	A. BUILDING: _____ B. WING _____	09/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 311	Continued From page 27 Review of Resident #4's emergency medical services (EMS) patient record dated 07/13/26 revealed: -The clinical impression was extremity pain. -The onset of the extremity pain was 07/10/26. -Resident #4 had right knee pain and swelling. -Resident #4 was sent out by staff for evaluation of pain, swelling, and bruising of her right knee. -The facility denied that Resident #4 had fallen. -Resident #4 had been unable to bear weight on her right knee since 07/10/26. -Resident #4 could normally stand and walk. Review of Resident #4's Emergency Department (ED) record dated 07/13/26 revealed: -Resident#4 was a poor historian and could not ambulate independently. -Resident #4 arrived at the ED for right knee pain, no known fall or injury. -Resident #4 reported hip pain. -Final impression was closed fracture of distal end or left femur, unspecified fracture morphology. -Final impression was closed fracture of distal end or right femur, unspecified fracture morphology. -Transfer was arranged to another hospital to an orthopedic surgeon for surgical repair of fractures. Telephone interview with the orthopedic surgeon on 08/21/26 at 3:20pm revealed: -He was the surgeon who repaired Resident #4's fractured femurs of both knees on 07/16/26. -Resident #4 arrived with fractured distal femurs to both legs that were fractured and bleeding. -He could not tell how they were fractured or how long the injury had occurred but Resident #4 also had osteoporosis and her weak bones played a	C 311		

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role.
-There had to be some type of trauma that caused the fractures.
-He nor his team ever got a clear understanding of what happened to cause the fractures.
-This type of injury may have occurred from a fall on both knees or if the person was being transferred and was accidentally dropped and landed on their knees.
-This was not a common injury though Resident #4 was at high risk for any type of injury due to osteoporosis and her age.

Telephone interview with a family member on 09/02/26 at 2:05pm revealed:
-The family was at the facility visiting with Resident #4 on 07/12/26.
-On Sunday, 07/12/26, a personal care aide (PCA) was facing Resident #4 when she "grabbed" Resident #4 by her waist and "threw" her into the Geri chair.
-Resident #4 started yelling when she was moved and complained of pain.
-The same PCA two weeks prior, not sure of the date "grabbed" Resident #4 at the waist facing her and "threw" her into the Geri chair, and Resident #4 complained of pain in her legs.
-She told the PCA she could not "mistreat" Resident #4 like this each time they witnessed the mistreatment.
-The Supervisor-In-Charge (SIC) was present both times they witnessed the PCA "mistreating" Resident #4.
-The SIC also told the PCA that she could not "treat" Resident #4 that way.
-They did not report these incidents to the Administrator because the SIC was present both times.

Interview with the PCA on 09/03/26 at 2:33pm

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revealed:
-She no longer worked at the facility.
-Her last day working for the facility was on 08/24/26.
-She did not know what happened to Resident #4; she did not have a fall.
-She did not remember anyone informing her that she was not transferring Resident #4 correctly.

Interview with the SIC on 09/02/26 at 3:48pm revealed:
-She had witnessed the PCA "man handle" Resident #4 on 07/12/26.
-The picked Resident #4 up "roughly" and "swung" her around without giving her legs time to come around and then "dropped" her into the wheelchair.
-Resident #4 was yelling to give her time to get her legs around.
-She informed the PCA that she could not "treat" Resident #4 like that and she needed to slow down.
-Resident #4's family had told the PCA it would be easier to transfer her with a sheet.
-Resident #4 complained about her legs hurting after the incident.
-She did not notify the Resident Care Coordinator (RCC) or the Administrator about the PCA transferring Resident #4 this way.
-She knew that she was supposed to let the RCC and Administrator know.
-She did not know why she had not told them that Resident #4 was not transferred safely.

Interview with the RCC on 09/03/26 revealed:
-She had not received any information related to a staff member that performed an unsafe transfer of Resident #4.
-She was notified by Resident #4's family member on 07/13/26 that both of Resident #4's

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C 311	Continued From page 30 legs were fractured. -She notified the Administrator on 07/13/26 that Resident #4's legs were fractured. -She and the Administrator questioned the staff on 07/13/26 and it was a "mystery" what happened to Resident #4's legs. -There had not been a report made for a fall or incident involving Resident #4. -The staff were responsible for completing the incident/accident reports. -There had been no incident/accident reports completed for Resident #4 in the past year. Interview with the Administrator on 09/03/26 at 10:25am revealed: -She had not been informed that a staff member had not safely transferred Resident #4. -She expected that the staff member notify the RCC and herself immediately when they witnessed the unsafe transfer of Resident #4. Based on interviews, and record reviews, it was determined Resident #4 was not interviewable. [Refer to Tag 246 10A NCAC 13G .0902(b) Health Care] [Refer to Tag 153 10A NCAC 13G .0501(a) Personal Care Training and Competency] _____ The facility failed to ensure Resident #4 who was totally dependent on staff for transfers and used a wheelchair for mobility was free from physical abuse as evidenced by a staff who was witnessed on two occasions to "man handle" and throw Resident #4 into her wheelchair. During the transfers, the resident began to yell and complained of pain in her legs. Resident #4 was transferred to a hospital emergency department on 07/13/26 and required surgery to repair	C 311		

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C 311	Continued From page 31 bilateral femur fractures and revision of the resident's bilateral knee arthroplasty. This failure of the facility resulted in serious physical harm and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/03/26 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED October 3, 2026	C 311		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure that medications administered were ordered by a licensed provider for 1 of 4 residents (#4). The findings are: Review of the facility's medication administration guidelines (not dated) revealed staff should administer medication (prescription or over the counter) only upon written orders from the	C 330		

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C 330	Continued From page 32 physician. Review of Resident #4's current FL-2 dated 09/22/25 revealed diagnoses included dementia, hypertension, anemia, and chronic obstructive pulmonary disease (COPD). Review of Resident #4's Resident Register revealed the resident's admission date to the facility was 02/15/16. Review of Resident #4's July 2026 MAR revealed there was not an entry for Tylenol (Tylenol is used to treat minor aches and pains). Observation of Resident #4's medications on hand on 09/03/26 at 9:40am revealed there was no Tylenol labeled with Resident #4's name. Review of Resident #4's record revealed there were no orders for Tylenol. Interview with the Supervisor-In-Charge (SIC) on 09/02/26 at 3:48pm revealed: -A family member asked if she could administer Resident #4 some Tylenol for her pain. -She administered one Tylenol to Resident #4 on 07/12/26 at 2:00pm because she was complaining with her legs hurting. -She did not know the milligrams of the Tylenol. -She got the Tylenol from the facility's floor stock bottle. -She did not document that she administered Tylenol to Resident #4. -She was unable to locate the facility's floor stock Tylenol. Interview with the Resident Care Coordinator (RCC) on 09/03/26 at 9:54am revealed: -Resident #4 did not have any standing orders.	C 330		

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C 330	Continued From page 33 -Resident #4 was on scheduled pain medication. -She expected the SIC to notify her or the Administrator if a resident needed something more for pain. -Resident #4 could have been sent to the emergency department if she required more medication for pain. Interview with the Administrator on 09/03/26 at 10:25am revealed: -The SIC was not allowed to administer medications without a provider's order. -The SIC should have called the RCC or herself if a resident needed more medication for pain and they would contain the PCP. -The SIC was not responsible for calling the PCP. Attempted telephone interview with Resident #4's PCP on 09/03/26 at 9:04am was unsuccessful.	C 330		
C 428	10A NCAC 13G .1206 Health Care Personnel Registry 10A NCAC 13G .1206 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews, the facility failed to complete the Health Care	C 428		

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C 428	Continued From page 34 Personnel Registry (HCPR) 24 Hour Initial Investigation Report and the 5-day Investigation Report after the discovery of a resident's injury of unknown origin (#4). The findings are: Review of Resident #4's current FL-2 dated 09/22/25 revealed diagnoses included dementia, hypertension, anemia, and chronic obstructive pulmonary disease (COPD). Review of Resident #4's hospital emergency department (ED) visit dated 07/13/26 revealed: -Resident #4 presented with bilateral knee and hip pain. -Resident #4 was diagnosed with bilateral femur fractures. -It was unclear what mechanism caused the bilateral femur fractures. Telephone interview with Resident #4's family member on 09/02/26 at 2:05pm revealed: -On Sunday 07/12/26 a personal care aide (PCA) grabbed Resident #4 at the waist facing her and "threw" her into the Geri chair. -Resident #4 started yelling when she was moved and was complaining of pain. Interview with the Supervisor-In-Charge (SIC) on 09/02/26 at 3:48pm revealed: -She had witnessed a PCA "man handle" Resident #4 on 07/12/26. -She picked her up "roughly" and "swung" her around without giving her legs time to come around and then "dropped" her into the wheelchair. -Resident #4 was yelling to give her time to get her legs around. -She informed the PCA that she could not treat	C 428		

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C 428	Continued From page 35 Resident #4 like that and she needed to slow down. -Resident #4's family member told the PCA it would be easier to transfer her with a sheet. -Resident #4 complained with her legs hurting after the incident. Telephone interview with a staff member at the North Carolina Health Care Personnel Registry (HCPR) office on 09/03/26 at 9:48am revealed they had not received a 24-hour report or the 5-day investigation report from the facility regarding Resident #4. Telephone interview with the Administrator on 09/03/26 at 10:25am revealed: -She had not completed an HCPR 24-hour report or a 5-day investigation report regarding Resident #4 because she did not think that she had to. -She did interview staff to try and determine what happened after she was told Resident #4 had bilateral femur fractures. -She did not know how the injury happened since Resident #4 had not fallen. -She had not been informed that a staff member had not safely transferred Resident #4. -She expected that the staff member notify the Resident Care Coordinator and herself immediately when they witnessed the unsafe transfer of Resident #4. -She faxed a copy of the 24-hour report to Adult Home Specialist (AHS) but did not fax a copy to HCPR. -She knew she was supposed to fax the 24-hour report and 5-day investigation report to HCPR, but she just forgot. -She was responsible for completing the 24-hour report and 5-day investigation report and faxing the documents to HCPR. _____	C 428		

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C 428	Continued From page 36 The facility failed to report an injury of unknown origin to the Health Care Personnel Registry (HCPR) by completing a 24-hour initial and 5-day investigation report, Resident #4 was found with an injury of unknown origin and was sent to an emergency department for treatment and was diagnosed with bilateral femur fractures that required surgical repair and the revision of bilateral knee arthroplasty. This failure resulted in substantial risk for serious 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 09/03/26 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED October 3, 2026	C 428		
C 444	10A NCAC 13G .1213 Reporting Of Accidents And Incidents 10A NCAC 13G .1213 Reporting of Accidents and Incidents (a) A family care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews and record reviews, the	C 444		

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facility failed to notify the county Department of Social Services (DSS) of accidents or incidents (A/I) for 1 of 1 sampled residents requiring emergency evaluation (#4).

The findings are:

Review of Resident #4's current FL-2 dated 09/22/25 revealed diagnoses included dementia, hypertension, anemia, and chronic obstructive pulmonary disease (COPD).

Review of Resident #4's Resident Register revealed the resident's admission date to the facility was 02/15/16.

Interview with the county Department of Social Services (DSS) Adult Home Specialist (AHS) on 09/02/26 at 12:00pm revealed she did not receive an Accident/Incident (A/I) report in July 2026 regarding Resident #4's injury of unknown origin requiring emergency evaluation.

Interview with the personal care aide (PCA) on 09/03/26 at 2:33pm revealed she had never completed an A/I report on Resident #4.

Interview with the Resident Care Coordinator (RCC) on 09/03/26 at 9:54am revealed:
-The PCA was responsible for completing the A/I report.
-She had not received an A/I report on Resident #4 in the past year.

Interview with the Administrator on 09/03/26 at 10:25am revealed:
-She did not know if an A/I report was completed.
-The RCC was responsible to ensure that an A/I reported was completed and sent to the AHS.