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{C 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation from September 2, 2026 to September 3, 2026. FOLLOW-UP TO TYPE B VIOLATION. The Type B Violation is abated. Non-compliance continues.	{C 000}		
C 141	10A NCAC 13G .0406 (a)(1) Other Staff Qualification 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (1) have a job description that reflects actual duties and responsibilities and is signed by the administrator and the employee; This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure 2 of 2 sampled staff had a job	C 141		

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C 141	Continued From page 1 description that reflected their duties and responsibilities signed by the Administrator and employee. The findings are: 1.Review of Staff E's personnel record on 09/03/26 revealed: -She was employed at the care home since 05/30/18. -She was a Registered Nurse (RN) since 01/27/20. -Her personnel record did not have a job description. Attempted telephone interview with Staff E on 09/03/26 at 5:30pm was unsuccessful. Refer to interview with the Administrator on 09/03/26 at 4:25pm. 2.Review of Staff F's personnel record on 09/03/26 revealed: -Her personnel record did not have the job description. -She was a RN at the facility. Interview with Staff F on 09/03/26 at 5:54pm revealed: -She worked various shifts as the supervisor-in-charge (SIC) and performed various tasks that included administering medications and providing personal care to residents. -She had many years of experience as a nurse supervisor in her previous positions. -She worked alone and with a personal care aide (PCA) at times. -She was in charge when the Administrator was not working or available. -She did not know what the SIC job description entailed.	C 141		

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C 141	Continued From page 2 -She did not know she was required to sign a job description for the SIC role at the facility. Refer to interview with the Administrator on 09/03/26 at 4:25pm. _____ Interview with the Administrator on 09/03/26 at 4:25pm revealed: -He did not have a SIC job description available for review. -Staff E and Staff F were RNs and did not have SIC job descriptions in their personnel file. -He did not know signed job descriptions were required for all hired staff.	C 141		
C 171	10A NCAC 13G .0504(a) Competency Validation For Licensed Health 10A NCAC 13G .0504 Competency Evaluation and Validation For Licensed Health Professional Support Tasks (a) When a resident requires one or more of the personal care tasks listed in Subparagraphs (a)(1) through (a)(28) of Rule .0903 of this Subchapter, the task may be delegated to non-licensed staff or licensed staff not practicing in their licensed capacity after a licensed health professional has validated the staff person is competent to perform the task. This Rule is not met as evidenced by:	C 171		

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C 171	Continued From page 3 Based on interviews and record reviews, the facility failed to ensure 4 of 4 sampled staff (A, B, C & D) were validated by a licensed health professional to transfer semi-ambulatory or non-ambulatory residents and clean dressing changes, care of residents who were physically restrained and the use of care practices as alternatives to restraints, and care for pressure ulcers up to and including a Stage II pressure ulcer (A, B and C). The findings are: Review of Resident #1's current FL2 dated 06/29/26 revealed: -Diagnoses included dementia with agitation, hypertension, osteoarthritis, and depression. -Resident #1 was non-ambulatory. -Resident #1 had an order for wound care-hospice nurse/ care giver to perform wound care to stage 2 wounds on sacrum, clean with wound cleanser, pat dry with gauze, cover with foam dressing, change 2 times per week and as needed for loose or soiled dressing. Review of Resident #1's Resident Register revealed an admission date of 07/01/26. Review of Resident #1's care plan dated 07/21/26 revealed: -Resident #1 required total assistance from staff on all activities of daily living (eating, toileting, bathing, dressing, grooming/ hygiene and transferring). -Resident #1 required zinc barrier cream with incontinent brief changes to erythema (redness) to sacrum as needed. Review of Resident #2's current FL2 dated 05/12/26 revealed:	C 171		

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C 171	Continued From page 4 -Diagnoses included Alzheimer's disease, heart failure, venous insufficiency, hypertension and dementia. -The resident was non-ambulatory and required assistance with bathing and dressing. Review of Resident #2's Resident Register revealed he was admitted to the facility on 05/15/26. Review of Resident #2's care plan dated 05/15/26 revealed: -He required extensive assistance with transfers. -He was totally dependent on staff assistance with toileting, ambulation, bathing, dressing, and grooming/personal hygiene. Review of Resident #2's Licensed Health Professional Support (LHPS) dated 06/15/26 revealed there were no tasks for care of residents who were physically restrained and the use of care practices as alternatives to restraints. Observation of Resident #2 on 09/02/26 from 9:25am to 12:20pm revealed he was in his bed watching television with both full bedrails in the raised position and remained there until the surveyors left the facilty for lunch at 12:20pm. Observation of Resident #2 on 09/02/26 from 1:25pm to 5:30pm revealed he was in his bed watching television with both bedrails in the raised position. Review of Resident #3's current FL2 dated 06/18/26 revealed: -Diagnoses included dementia, hypertension and coronary artery disease. -The resident was semi-ambulatory and required assistance with bathing and dressing.	C 171		

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C 171	Continued From page 5 Review of Resident #3's Resident Register revealed she was admitted to the facility on 06/22/26. Review of Resident #3's care plan dated 06/22/26 revealed: -She required limited assistance with eating. -She was totally dependent on staff assistance with toileting, ambulation, bathing, dressing, grooming/personal hygiene and transfers. Review of Resident #3's LHPS dated 06/22/26 revealed there was no task listed for ambulation using assistive devices that required physical assistance. Observation of Resident #3 on 09/02/26 from 9:25am to 12:20pm revealed at 9:30am, the PCA assisted Resident #3 out of the bed and placed her in a wheelchair, brought her to the living room where she watched television and remained there until the surveyors left the facilty for lunch at 12:20pm. 1. Review of Staff A's personnel record revealed: -She was hired on 05/11/26 as a personal care aide (PCA). -There was no documentation she completed LHPS skills validation for ambulation using assistive devices, transferring semi-ambulatory or non-ambulatory residents, care of residents who were physically restrained and the use of care practices as alternatives to restraints; and care for pressure ulcers up to and including a Stage II pressure ulcer. Telephone interview with Staff A on 09/02/26 at 5:17pm revealed the facility's Registered Nurse (RN) did not complete a LHPS task validation for	C 171		

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C 171	Continued From page 6 ambulation using assistive devices, transferring semi-ambulatory or non-ambulatory residents, care of residents who were physically restrained and the use of care practices as alternatives to restraints, and care for pressure ulcers up to and including a Stage II pressure ulcer. Telephone interview with the facility's RN on 09/03/26 at 5:54pm revealed: -She was responsible for completing the LHPS competency validation for staff. -Staff A was a CNA but she had not LHPS task validated her for ambulation using assistive devices, transferring semi-ambulatory or non-ambulatory residents, care of residents who were physically restrained and the use of care practices as alternatives to restraints, and care for pressure ulcers up to and including a Stage II pressure ulcer. Refer to interview with the Administrator on 09/03/26 at 1:30pm. 2. Review of Staff B's personnel record revealed: -She was hired on 10/19/25 as a PCA. -There was no documentation she completed LHPS skills validation for ambulation using assistive devices, transferring semi-ambulatory or non-ambulatory residents, care of residents who were physically restrained and the use of care practices as alternatives to restraints, and care for pressure ulcers up to and including a Stage II pressure ulcer. Telephone interview with Staff B on 09/03/26 at 4:59pm revealed the facility's RN did not complete a LHPS tasks on her for ambulation using assistive devices, transferring semi-ambulatory or non-ambulatory residents, care of residents who were physically restrained	C 171		

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C 171	Continued From page 7 and the use of care practices as alternatives to restraints, and care for pressure ulcers up to and including a Stage II pressure ulcer. Telephone interview with the facility RN on 09/03/26 at 5:54pm revealed: -She was responsible for completing the LHPS competency validation for staff. -Staff B was a CNA but she had not LHPS validated her for ambulation using assistive devices, transferring semi-ambulatory or non-ambulatory residents, care of residents who were physically restrained and the use of care practices as alternatives to restraints, and care for pressure ulcers up to and including a Stage II pressure ulcer. Refer to interview with the Administrator on 09/03/26 at 1:30pm. 3. Review of Staff C's personnel record revealed: -She was hired on 05/11/26 as a PCA. -There was no documentation she completed LHPS skills validation for ambulation using assistive devices, transferring semi-ambulatory or non-ambulatory residents, care of residents who were physically restrained and the use of care practices as alternatives to restraints, and care for pressure ulcers up to and including a Stage II pressure ulcer. Telephone interview with Staff C on 09/02/26 at 5:05pm revealed the facility's RN did not complete a LHPS tasks on her for ambulation using assistive devices, transferring semi-ambulatory or non-ambulatory residents, care of residents who were physically restrained and the use of care practices as alternatives to restraints, and care for pressure ulcers up to and including a Stage II pressure ulcer.	C 171		

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C 171	Continued From page 8 Telephone interview with the facility RN on 09/03/26 at 5:54pm revealed: -She was responsible for completing the LHPS competency validation for staff. -Staff C was a CNA but she had not LHPS validated them for for ambulation using assistive devices, transferring semi-ambulatory or non-ambulatory residents, care of residents who were physically restrained and the use of care practices as alternatives to restraints, and care for pressure ulcers up to and including a Stage II pressure ulcer. Refer to interview with the Administrator on 09/03/26 at 1:30pm. 4. Review of Staff D's personnel record revealed: -She was hired on 11/22/21 as a PCA. -There was documentation she completed LHPS skills validation dated 03/01/23 for ambulation using assistive devices, transferring semi-ambulatory or non-ambulatory residents and care for pressure ulcers up to and including a Stage II pressure ulcer. -There was no documentation she was LHPS skills validated for the care of residents who were physically restrained and the use of care practices as alternatives to restraints. Telephone interview with Staff D on 09/03/26 at 4:47pm revealed she was trained by the facility RN on 03/01/23 but she was not LHPS skills validated for the care of residents who were physically restrained and the use of care practices as alternatives to restraints because the facility did not have restraints until Resident #2 was admitted in May 2026. Telephone interview with the facility RN on	C 171		

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C 171	Continued From page 9 09/03/26 at 5:54pm revealed: -She was responsible for completing the LHPS competency validation for staff. -Staff D was validated in 2023 but not for the care of residents who were physically restrained and the use of care practices as alternatives to restraints because the facility did not have restraints until Resident #2 was admitted in May 2026. Refer to interview with the Administrator on 09/03/26 at 1:30pm. _____ Interview with the Administrator on 09/03/26 at 1:30pm revealed: -The facility had a contract with a nurse to train the staff for LHPS competencies. -He thought all LHPS validations were completed on all PCAs. -He was responsible to notify the facility's contracted nurse when a new PCA started work and when a new task was needed. -He did not complete an audit of the PCA staff records to check for completion of LHPS task validations.	C 171		
C 175	10A NCAC 13G .0506 Training On Physical Restraints 10A NCAC 13G .0506 Training On Physical Restraints (a) A family care home shall assure that all staff responsible for caring for residents with medical symptoms that warrant restraints are trained on the use of alternatives to physical restraint use and on the care of residents who are physically restrained.	C 175		

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C 175	Continued From page 10 (b) Training shall be provided by a registered nurse and shall include the following: (1) alternatives to physical restraints; (2) types of physical restraints; (3) medical symptoms that warrant physical restraint; (4) negative outcomes from using physical restraints; (5) correct application of physical restraints; (6) monitoring and caring for residents who are restrained; and (7) the process of reducing restraint time by using alternatives. This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to ensure 4 of 4 staff (A, B, C and D) were trained on the use of alternatives to physical restraints and on the care of a resident who was physically restrained. The findings are: Review of Resident #2's current FL2 dated 05/12/26 revealed: -Diagnoses included Alzheimer's disease, heart failure, venous insufficiency, hypertension and dementia. -The resident was non-ambulatory and required assistance with bathing and dressing. -The resident was incontinent of bowel and bladder. Review of Resident #2's Resident Register revealed he was admitted to the facility on 05/15/26. Review of Resident #2's care plan dated 05/15/26	C 175		

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C 175	Continued From page 11	C 175		

revealed:
-He required limited assistance with eating.
-He required extensive assistance with transfers.
-He was totally dependent on staff assistance with toileting, ambulation, bathing, dressing, and grooming/personal hygiene.

Observation of Resident #2 on 09/02/26 from 9:25am to 12:20pm revealed he was in his bed watching television with both full bedrails in the raised position and remained there until the surveyors left the facilty for lunch at 12:20pm.

Observation of Resident #2 on 09/02/26 from 1:25pm to 5:30pm revealed he was in his bed watching television with both bedrails in the raised position.

Observation of Resident #2 on 09/03/26 from 9:50am to 12:55pm revealed he was in his bed with the head of the bed and and lower part of the bed were raised and both full bed rails were in the raised position.

1. Review of Staff A's personnel record revealed:
-She was hired on 05/11/26 as a personal care aide (PCA).
-There was no documentation Staff A received training on alternatives to physical restraints, types of physical restraints, medical symptoms that warrant physical restraints, negative outcomes from using physical restraints, correct application of physical restraints, monitoring and caring for residents who are restrained and the process of reducing restraint time by using alternatives.

Telephone interview with Staff A on 09/02/26 at 5:17pm revealed:
-The facility nurse or a Licensed Health

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C 175	Continued From page 12 Professional Support (LHPS) nurse did not complete a LHPS tasks on her for the care of residents who were physically restrained and the use of care practices as alternatives to restraints because there were no restraint in the facility until Resident #2 was admitted in May 2026 and she used full side rails to keep Resident #2 from falling out of the bed. Refer to interview with the facility nurse on 09/03/26 at 5:54pm. Refer to interview with the Administrator on 09/03/26 at 1:30pm. 2. Review of Staff B's personnel record revealed: -She was hired on 10/19/25 as a PCA. -There was no documentation Staff B received training on alternatives to physical restraints, types of physical restraints, medical symptoms that warrant physical restraints, negative outcomes from using physical restraints, correct application of physical restraints, monitoring and caring for residents who are restrained and the process of reducing restraint time by using alternatives. Telephone interview with Staff B on 09/03/26 at 4:59pm revealed: -She was a CNA and was trained at the nursing home where she worked full time. -The facility RN or a LHPS nurse did not complete a LHPS tasks on her for the care of residents who were physically restrained and the use of care practices as alternatives to restraints. Telephone interview with the faility nurse on 09/03/26 at 5:54pm revealed: -She was responsible for completing the LHPS competency validation form for staff.	C 175		

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C 175	Continued From page 13 -Staff B was a CNA but she had not LHPS validated them for for the care of residents who were physically restrained and the use of care practices as alternatives to restraints. Refer to interview with the Administrator on 09/03/26 at 1:30pm. 3. Review of Staff C's personnel record revealed: -She was hired on 05/11/26 as a PCA. -There was no documentation Staff C received training on alternatives to physical restraints, types of physical restraints, medical symptoms that warrant physical restraints, negative outcomes from using physical restraints, correct application of physical restraints, monitoring and caring for residents who are restrained and the process of reducing restraint timeby using alternatives. Telephone interview with Staff C on 09/02/26 at 5:05pm revealed: -She was a CNA and was trained at the nursing home where she worked full time. -The facility RN or a LHPS nurse did not complete a LHPS tasks on her for the care of residents who were physically restrained and the use of care practices as alternatives to restraints because she was already trained as a CNA. Refer to telephone interview with the facility nurse on 09/03/26 at 5:54pm. Refer to interview with the Administrator on 09/03/26 at 1:30pm. 4. Review of Staff D's personnel record revealed: -She was hired on 11/22/21 as a PCA. -There was no documentation Staff D received training on alternatives to physical restraints,	C 175		

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C 175	Continued From page 14 types of physical restraints, medical symptoms that warrant physical restraints, negative outcomes from using physical restraints, correct application of physical restraints, monitoring and caring for residents who are restrained and the process of reducing restraint timeby using alternatives. Telephone interview with Staff D on 09/03/26 at 4:47pm revealed she was trained by the facility RN on 03/01/23 but she was not LHPS skills validated for the care of residents who were physically restrained and the use of care practices as alternatives to restraints because the facility did not have restraints until Resident #2 was admitted in May 2026. Refer to interview with the facility nurse on 09/03/26 at 5:54pm. Refer to interview with the Administrator on 09/03/26 at 1:30pm. _____ Telephone interview with the facility nurse on 09/03/26 at 5:54pm revealed: -She was responsible for completing the LHPS competency validation form for staff. -She did not train staff on use of bedrails. -Staff A, B and C were CNAs but she had not LHPS validated them for training on alternatives to physical restraints, types of physical restraints, medical symptoms that warrant physical restraints, negative outcomes from using physical restraints, correct application of physical restraints, monitoring and caring for residents who are restrained and the process of reducing restraint timeby using alternatives. -Staff D was validated in 2023 but not for the training on alternatives to physical restraints,	C 175		

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C 175	Continued From page 15 types of physical restraints, medical symptoms that warrant physical restraints, negative outcomes from using physical restraints, correct application of physical restraints, monitoring and caring for residents who are restrained and the process of reducing restraint timeby using alternatives because the facility did not have restraints until Resident #2 was admitted in May 2026. Interview with the Administrator on 09/03/26 at 1:30pm revealed: -The facility had a contract with a nurse to train the staff for LHPS competencies. -He thought all LHPS validations were completed on all PCAs. -He was responsible to notify the facility's contracted nurse when a new PCA started work and when a new task was needed. -He did not complete an audit of the PCA staff records to check for completion of LHPS task validations.	C 175		
C 176	10A NCAC 13G .0507 Training on Cardio-Pulmonary Resuscitation 10A NCAC 13G .0507 Training on Cardio-Pulmonary Resuscitation Each family care home shall have one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute and Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person	C 176		

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C 176	Continued From page 16 trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation. This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to ensure at least one staff person was always in the facility who had completed a Cardio-Pulmonary Resuscitation (CPR) and choking management course within the last 24 months for 3 of 4 sampled staff (A, B, C). The findings are: Review of the facility's staffing schedules dated 08/30/26 to 09/03/26 revealed: -On 08/30/26 from 6:00am to 6:00pm there was one PCA scheduled to work alone. -On 08/30/26 from 6:00pm until 08/31/26 at 6:00am the Administrator was scheduled to work alone. -On 08/31/26 from 6:00am until 09/01/26 at 2:00pm the Administrator was scheduled to continue to work alone. -On 09/01/26 at 2:00pm until 09/02/26 at 12:00am there was one PCA scheduled to work alone until 7:00 (unknown if am or pm) when another PCA was scheduled to work until 7:00 (unknown if am or pm) was scheduled to work. -On 09/02/26 at 6:00am the Administrator was scheduled to work after 7:00am until a PCA was scheduled to work at 2:00pm until 12:00am and there was no staff scheduled to work from 12:00am until 6:00am. -On 09/03/26 at 6:00am until 2:00pm the Administrator was scheduled to work alone, and at 2:00pm there was one PCA scheduled to work	C 176		

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C 176	Continued From page 17 alone until 8:00am. Request for staff schedules and times cards on 09/02/26 at 9:30am were not provided by the survey exit date. 1. Review of Staff A's personnel record revealed: -She was hired on 05/11/26 as a personal care aide (PCA). -There was no documentation Staff A completed CPR training. Interview with Staff A on 09/02/26 at 5:17pm revealed: -She worked mostly day shift with the Administrator and only left alone maybe a time or two for about an hour. -She had not received her CPR yet. 2. Review of Staff B's personnel record revealed: -She was hired on 10/19/25 as a PCA. -There was no documentation Staff B completed CPR training since 06/14/24. Telephone interview with Staff B on 09/02/26 at 4:59pm revealed: -She had not renewed her CPR and her full time job did not have a class yet. -She worked first and second shift and only alone for about 2-3 hours here and there while the other staff ran errands. 3. Review of Staff C's personnel record revealed: -She was hired on 05/11/26 as a PCA since 06/20/24. -There was no documentation Staff B completed CPR training since 06/20/24. Observation of Staff C on 09/02/26 from 11:37am to 11:57am revealed Staff A was by herself in the	C 176		

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C 176	Continued From page 18 facility. Interview with Staff C on 09/02/26 at 09/02/26 at 5:05pm revealed: -She did not know her CPR card expired in June 2026. -She had worked 2 - 3 times for about 1 -2 hours when the other staff member ran an errand or get food. _____ Interview with the Administrator on 09/03/26 at 1:30pm revealed: -He was responsible to make sure all staff were CPR certified when hired and maintained their renewals. -He held a class at the beginning of the year for CPR recertification but it did not include all new PCAs. -All of the PCAs worked at another facility and he thought they were all recertified. -He did not perform staff record audits to check for expired CPR cards.	C 176		
C 188	10A NCAC 13G .0601 (g) Management And Other Staff 10A NCAC 13G .0601 Management And Other Staff (g) Additional staff shall be employed as needed for housekeeping and the supervision and care of the residents in accordance with the rules of this Subchapter.	C 188		

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C 188	Continued From page 19 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to ensure there were enough staff on duty at night for the residents to provide care and supervision to the residents. The findings are: Observation of the facility on 09/02/26 at 9:25am revealed: -There were three residents in the living room, and two residents in their rooms, in bed. -There was one personal care aide (PCA) and the Administrator present in the facility. Observation of the facility on 09/03/26 at 9:50am revealed: -There were three residents in the living room, and two residents in their rooms, in bed. -There was one PCA and the Administrator present in the facility. Review of the facility's current license issued by the Division of Health Service Regulation effective January 1, 2026, revealed the facility was licensed for a capacity of 5 non-ambulatory beds. Review of the facility's census for 09/02/26 to 09/03/26 revealed there were 5 residents. Interview with the Administrator on 09/02/26 at 9:30am revealed: -There were two male residents who were bedbound. -There were two female residents who were	C 188		

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non-ambulatory.
-There was one female resident who was ambulatory and used a walker.

Review of the facility's staffing schedules dated 08/30/26 to 09/03/26 revealed:
-On 08/30/26 from 6:00am to 6:00pm there was one PCA scheduled to work alone.
-On 08/30/26 from 6:00pm until 08/31/26 at 6:00am the Administrator was scheduled to work alone.
-On 08/31/26 from 6:00am until 09/01/26 at 2:00pm the Administrator was scheduled to continue to work alone.
-On 09/01/26 at 2:00pm until 09/02/26 at 12:00am there was one PCA scheduled to work alone until 7:00 (unknown if am or pm) when another PCA was scheduled to work until 7:00 (unknown if am or pm) was scheduled to work.
-On 09/02/26 at 6:00am the Administrator was scheduled to work after 7:00am until a PCA was scheduled to work at 2:00pm until 12:00am and there was no staff scheduled to work from 12:00am until 6:00am.
-On 09/03/26 at 6:00am until 2:00pm the Administrator was scheduled to work alone, and at 2:00pm there was one PCA scheduled to work alone until 8:00am.

Request for staff schedules and times cards on 09/02/26 at 9:30am were not provided by the survey exit date.

1. Review of Resident #1's current FL2 dated 06/29/26 revealed:
-Diagnoses included dementia with agitation, hypertension, osteoarthritis, and depression.
-Resident #1 was non-ambulatory.
-Resident #1 was incontinent of bowel and bladder.

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C 188	Continued From page 21 -Resident #1's diet was pureed with nectar thickened liquids. -There was an order for wound care. -A hospice nurse/caregiver was to perform wound care to stage 2 wounds on sacrum, clean with wound cleanser, pat dry with gauze, cover with foam dressing, change 2 times per week and as needed for loose or soiled dressing. Review of Resident #1's Resident Register revealed an admission date of 07/01/26. Review of Resident #1's record revealed Resident #1 was admitted to the facility with hospice services on 07/01/26. Review of Resident #1's care plan dated 07/21/26 revealed: -Resident #1 required total assistance from staff on all activities of daily living (eating, toileting, bathing, dressing, grooming/ hygiene and transfers). -Resident #1 required zinc barrier cream with incontinent brief changes to erythema (redness) to sacrum as needed. Review of Resident #1's record revealed: -There was no documentation of personal care tasks provided for Resident #1. -There was no documentation of the facility rounding sheets documenting frequency of personal care. Observation of Resident #1 on 09/02/26 from 9:25am to 12:20pm revealed he was in his bed and remained there until the surveyors left the facilty for lunch at 12:20pm. Observation of Resident #1 on 09/02/26 from 1:25pm to 1:55pm revealed:	C 188		

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C 188	Continued From page 22 -He was in bed laying on his back and the television was on. -At 1:35pm, the Administrator removed two saturated incontinence briefs, one folded and used for the front area and a second one full of a very loose bowel movement. -There was a resuseable incontinent pad under Resident #1's bottom. -The Administrator used wet wipes and a no rinse foam cleanser. -After Resident #1 was all cleaned up there was a reddened area to Resident #1's right buttock near his coccyx the size of a 50 cent piece. -The Administrator applied zinc to Resident #1's coccyx, applied a folded brief to the front area and a brief over it all. -Resident #1 was very verbally and physically aggressive during the incontinence care. -It took 20 minutes for the Administrator to perform incontinent care to Resident #1. Interview with the Administrator on 09/02/26 at 1:35pm revealed: -It usually take him about 20-30 minutes to provide incontinent care to Resident #1 depending if clothes and bed sheet needed to be changed also. -He provided personal care for Resident #1 before breakfast, after lunch, supper and during the night if Resident #1 woke up. -He provided feeding assistance with breakfast, lunch and supper which took about 20-30 minutes each meal. -When he was alone in the facility and providing personal care or feeding assistance to Resident #1, the other residents were left unsupervised and without personal care until he finished with Resident #1. Observation of Resident #1 on 09/02/26 from	C 188		

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C 188	Continued From page 23 2:00pm to 5:30pm revealed: -He was in his bed and remained there until the surveyors left the facilty at 5:30pm. -At 2:12pm until 3:00pm, a family member visited. Interview with a second day shift PCA on 09/03/26 at 4:47pm revealed: -Resident #1 was bedbound and was totally dependent on her for incontinent care. -Resident #1 could position himself in bed. -Resident #1 was bedbound she did not get him out of bed. -She bathed him in the morning and performed his incontinence care three times a day. -She did not turn or reposition him during her shift. Telephone interview with Resident #1's Hospice Registered Nurse (RN) on 09/03/26 at 7:59am revealed: -Resident #1 was bedbound and was dependent on care from the staff. -Resident #1 was a heavy wetter and his skin should be protected to avoid breakdown. -Resident #1 required turning, repositioning and frequent checks for incontinent episodes because Resident #1 was constantly confused and had a history of a stage 2 sacral wound. Interview with the Administrator on 09/03/26 at 9:47am revealed: -Resident #1 required two of the other staff to transfer him out of the bed, but he could do it himself. -Resident #1 required total assistance with incontinent care, eating a pureed diet, bathing, and repositioning. -During the night he put two briefs on Resident #1 to help with incontinent episodes and changed Resident #1 if he called out.	C 188		

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C 188	Continued From page 24 -He did not notice Resident 1's sacral area had increased redness until a surveyor observed the incontinent care on 09/02/26. Refer to interview with a day shift PCA on 09/02/26 at 5:05pm. Refer to interview with a second day shift PCA on 09/03/26 at 4:47pm. Refer to interview with the Administrator on 09/03/26 at 9:47am. 2. Review of Resident #2's current FL2 dated 05/12/26 revealed: -Diagnoses included Alzheimer's disease, heart failure, venous insufficiency, hypertension and dementia. -The resident was non-ambulatory and required assistance with bathing and dressing. -The resident was incontinent of bowel and bladder. Review of Resident #2's Resident Register revealed he was admitted to the facility on 05/15/26. Review of Resident #2's record revealed he was admitted under Hospice services on 05/15/26. Review of Resident #2's care plan dated 05/15/26 revealed: -He required limited assistance with eating. -He required extensive assistance with transfers. -He was totally dependent on staff assistance with toileting, ambulation, bathing, dressing, and grooming/personal hygiene. Review of Resident #2's Licensed Health Professional Support (LHPS) dated 06/15/26	C 188		

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C 188	Continued From page 25 revealed personal care tasks for transferring semi-ambulatory or non-ambulatory residents and ambulation using assistive devices that require physical assistance. Observation of Resident #2 on 09/02/26 from 9:25am to 12:20pm revealed he was in his bed watching television and remained there until the surveyors left the facilty for lunch at 12:20pm. Observation of Resident #2 on 09/02/26 from 1:25pm to 5:30pm revealed he was in his bed watching television. Observation of Resident #2 on 09/03/26 from 9:50am to 12:55pm revealed he was in his bed with the head of the bed and lower part of the bed was raised and both full bed rails were in the raised position. Telephone interview with Resident #2's Power of Attorney (POA) on 09/03/26 at 8:02am revealed: -She visits every Saturday at 2:00pm and there was usually one staff member there. -The Administrator told her there was only a PCA working at the facility alone at night and assured her Resident #2 would get as needed medications if requested because he lived close by. -Resident #2 was in pain in his back and legs all of the time. -Resident #2 required frequent repositioning because of the pain in his back and legs. -Resident #2 used to get up and sit in his recliner but one time he was left there and no one came back to put him to bed and the pain was uncontrolled that now he will not let the staff get him out of bed. -It was easier for the staff now to leave him in bed because there was no back and forth for them to	C 188		

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get him up, place him in the recliner and put him back in bed 2 hours later.
-Staff gave Resident #2 a bed bath because it was too hard to get Resident #2 into the shower with just one staff, and he required at least 2 staff.

Interview with a second day shift PCA on 09/03/26 at 4:47pm revealed:
-Resident #2 was a bedbound resident who was totally dependent on her for incontinent care in the morning, after lunch and after supper.
-Resident #2 could position himself in bed.
-Resident #1 was bedbound she did not get him out of bed.
-She bathed him in the morning and performed his incontinence care three times a day.
-She did not turn or reposition him during her shift.

Interview with Resident #2's Hospice RN on 09/03/26 at 7:59am revealed:
-Resident #2 transferred to this hospice agency upon admission on 05/15/26.
-Resident #2 was bedbound because he required repositioning at least every 2-hours to decrease the pain he had in his legs and back.
-He used to sit in the recliner some of the day but he was not strong enough to reposition himself and the staff would leave him in the recliner all day and that would cause him to be in extreme pain.
-He also required increase checks because Resident #2 was a heavy wetter and depended on the staff for toileting and incontinent care.
-The staff used bedrails to keep Resident #2 from falling out of the bed and for turning during incontinent care therefore checks every 30-minutes were required for his safety.

Interview with the Administrator on 09/02/26 at

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C 188	Continued From page 27 1:55pm revealed: -It usually take him about 15-20 minutes to provide incontinent care to Resident #2 depending if clothes and bed sheet needed to be changed also. -He provided personal care for Resident #2 before breakfast, after lunch, supper and during the night if Resident #2 rang his bell. -When he was alone in the facility and providing personal care to Resident #2, the other residents were left unsupervised and without personal care until he finished with Resident #2. Interview with the Administrator on 09/03/26 at 9:47am revealed: -Resident #2 let the staff know when he needed anything. -The staff used the bedrails to help keep resident #2 from falling out of the bed and repositioning himself. -Resident #2 wore incontinence briefs and was considered a "heavy wetter". -He used double briefs and a pad because incontinence care was provided in the morning before breakfast, after lunch and after supper before bed. -During the night he used the double briefs to help with incontinent episodes and changed Resident #2 if he called out. -Resident #2 was confused at times. -Resident #2 was dependant on staff for all activities of daily living (ADLs) except eating. -Staff did not complete 30-minute safety checks on Resident #2 because Resident #2 could ring his bell if Resident #2 needed anything. Refer to interview with a day shift PCA on 09/02/26 at 5:05pm. Refer to interview with a second day shift PCA on	C 188		

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C 188	Continued From page 28 09/03/26 at 4:47pm. Refer to interview with the Administrator on 09/03/26 at 9:47am. 3. Review of Resident #3's current FL2 dated 06/18/26 revealed: -Diagnoses included dementia, hypertension and coronary artery disease. -The resident was semi-ambulatory and required assistance with bathing and dressing. -The resident was constantly disorientated. -The resident was incontinent of bowel and bladder. Review of Resident #3's Resident Register revealed she was admitted to the facility on 06/22/26. Review of Resident #3's record revealed she was admitted to home health (HH) for wound monitoring on 06/24/26. Review of Resident #3's care plan dated 06/22/26 revealed: -She required limited assistance with eating. -She was totally dependent on staff assistance with toileting, ambulation, bathing, dressing, grooming/personal hygiene and transfers. Review of Resident #3's Licensed Health Professional Support (LHPS) dated 06/22/26 revealed personal care tasks for transferring semi-ambulatory or non-ambulatory residents. Review of Resident #3's Home Health Nurse's (HHN) visit notes revealed: -On 06/22/26, she was admitted to the facility with a skin tear on her left lower leg and right lower arm and HH would follow her for wound	C 188		

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monitoring.
-On 07/01/26, HHN provided wound care to left lower leg, right lower arm and a new wound to left heel documented.
-On 07/07/26, HHN documented wound to left lower leg healed and wound care provided for left heel.
-On 07/16/26, 07/21/26, 07/29/26, 08/05/26, 08/12/26, 08/18/26 and 08/25/26, HH nurse provided wound care for left heel.
-On 08/30/26, HHN provided wound care to an unstageable pressure ulcer to Resident #3's left heel and a new pressure ulcer to Resident #3's left ankle documented.

Observation of Resident #3 on 09/02/26 from 9:25am to 12:20pm revealed at 9:30am, the personal care aide (PCA) assisted Resident #3 out of the bed and placed her in a wheelchair, brought her to the living room where she watched television and remained there until the surveyors left the facilty for lunch at 12:20pm.

Observation of Resident #3 on 09/03/26 from 9:50am to 12:55pm revealed she was in her wheelchair with her feet resting on the foot pedals.

Telephone interview with Resident #3's Power of Attorney (POA) on 09/03/26 at 5:51pm revealed:
-He usually visits Resident #3 most days before lunch.
-Resident #3 had pressure ulcers on her left heel and now her left ankle.
-She depended on the staff for all ADLs except eating.
-The staff were to be repositioning Resident #3 often to help prevent skin breakdown and worsening of the pressure ulcers.
-During the past two weeks most of the time there

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have been two staff members there during lunch when he visited but not every day.

Interview with a second day shift PCA on 09/03/26 at 4:47pm revealed:
-Residents #3 was totally dependent on her for incontinent care in the morning, getting them out of bed, into their wheelchairs, taking Resident #3 into the living room, incontinent care after lunch and supper and then transferring Resident #3 back to her beds for the night.
-She would give Resident #3 a bed bath on the early mornings she worked.
-She was able to transfer Resident #3 to the wheelchair and back to bed by herself when necessary.

Telephone interview with a Registered Nurse (RN) from Resident #3's HH agency on 09/03/26 at 12:41pm revealed:
-Resident #3 was last seen by the HH nurse on 08/31/26 and provided wound care for an unstageable pressure ulcer on Resident #3's left heel.
-The unstageable pressure ulcer located on Resident #3's left heel was documented as 2cm wide x 2cm in length x 0.2cm deep.
-The wound care provided was the pressure ulcer was cleaned with normal saline, medihoney was applied with a pretaped foam dressing covering the pressure ulcer.
-The HH nurse documented an open area on Resident #3's left ankle that was 1.5cm in length x 1.5cm in width x 0.2cm in depth.
-Since 06/24/26, Resident #3 required off loading with turning and repositioning every 2-hours to keep pressure off of the ankle and heel to prevent further breakdown.
-Any pressure including sitting in a wheelchair great than 2 hours at a time without repositioning

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by lifting legs up,or laying in the bed without repositioning every 2 hours would significantly increase the risk of new pressure ulcer formation and decreased wound healing in previous pressure ulcers.

Interview with the Administrator on 09/02/26 at 1:35pm revealed:
-It usually take him about 30-40 minutes to provide incontinent care to Resident #3 depending if clothes needed to be changed because he had to wheel her to the bathroom or to her bed for incontinent care, transfer her back and forth from the wheelchair and then back to the living room.
-He provided personal care for Resident #3 before breakfast, after lunch, supper and during the night if Resident #3 woke up.
-When he was alone in the facility and providing personal care for Resident #3, the other residents were left unsupervised and without personal care until he finished with Resident #3.

Interview with the Administrator on 09/03/26 at 9:47am revealed:
-Resident #3 was dependent on staff for all ADLs except eating.
-He thought it was ok to leave Resident #3 in her wheelchair all day and let her legs hang down as long as she had on her shoes.
-He did not know Resident #3 required repositioning and off loading to prevent pressure ulcers and previous pressure ulcers from getting worse.
-Resident #3 was admitted to the facility from a larger assisted living facility with a new pressure ulcer to her left heel but did not know that the left heel pressure ulcer was now unstageable and now had a pressure ulcer to her left ankle.
-He used double briefs and because incontinence

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care was provided in the morning before breakfast, after lunch and after supper before bed.
-During the night he used the double briefs to help with incontinent episodes and changed Resident #2 if she called out.

Refer to interview with a day shift PCA on 09/02/26 at 5:05pm.

Refer to interview with a second day shift PCA on 09/03/26 at 4:47pm.

Refer to interview with the Administrator on 09/03/26 at 9:47am.

_____

Interview with a day shift PCA on 09/02/26 at 5:05pm revealed:
-She did not have a set schedule and would come to work when she called to ask for some time to work.
-The Administrator called occasionally and asked her to work at the facility.
-Today, 09/02/26, she was to work for 7:00am to 7:00pm.
-When she worked, she did not administer medications and only provided personal care for the residents.
-Her typical shift was to get the residents up out of bed with the exception of Resident #1 and #2 who were bedbound
-She provided morning care such as a bed bath, change brief and get the residents dressed.
-She would get Resident #3 and #4 out of bed and into their wheelchairs and take them into the living room where they would eat breakfast.
-She would complete a round after lunch and provide incontinent care for 4 of the 5 residents.
-She would complete a final round after supper

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and change Resident #1 and #2's briefs and place Resident #3 and #4 back in bed and change their briefs.
-She started working in May 2026 and had worked about 5-7 times since she started.
-She did not work night shift.
-Sometimes the Administrator worked night shift.
-There were about 3 or 4 times she had been left alone in the facility for about 1 to 2 hours while the other staff went to grab food or run an errand.

Interview with a second day shift PCA on 09/03/26 at 4:47pm revealed:
-She typically worked 12-hour shifts during the day.
-When she worked weekends, (08/29/26 and 08/30/26) she worked during the day by herself and called the Administrator to pass medications and if need to administer as needed (PRN) medications.
-Her biggest concern when she worked alone was when she was providing care to a resident, there were four other resident who were without supervision anywhere from 15 to 30 minutes depending on the resident and care provided.

Interview with the Administrator on 09/03/26 at 9:47am revealed:
-There were no set schedules made, just himself and two other family members to work all three shifts.
-There was always one staff at night.
-He would call PRN staff in to help out during the day or at night when regular staff could not make their shift.
-One of the PRN staff was another family member who was in nursing school and when she was in the facility during the day or night by herself, he would come in for the scheduled medication passes and if a PRN needed to be

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C 188	Continued From page 34 given. -He considered one staff per shift to be enough to provide care for two bedbound residents who required total care, 2 total care residents who were in their wheel chairs until time to go back to bed and one resident who was ambulatory. -There were no personal care needs during the night because the residents were asleep. -He did not require staff to sign in and out. [Refer to tag 0242, 10A NCAC 13G .0901(a) Personal Care and Supervision (Type A2 Violation)] [Refer to tag 0452, 10A NCAC 13G .1301 Use of Physical Restraints and Alternatives (Type B Violation)] _____ The facility failed to ensure there were staff in the facility to provide personal care and supervision to a resident who was bedbound, incontinent of bowel and bladder, required wound care treatment to coccyx area with incontinent care, and required assistance with repositioning in bed (#1), a resident who was incontinent of bowel and bladder and required total staff assistance with toileting and mobility (#2), and a resident who required repositioning during the night due to an unstageable pressure ulcer to the left heel and a new pressure ulcer to the left ankle (#3). This failure was detrimental to health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131-D-34 on 09/03/26 for this violation.	C 188		

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C 188	Continued From page 35 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 18, 2026.	C 188		
C 189	10A NCAC 13G .0601 (h) Management And Other Staff 10A NCAC 13G .0601 Management And Other Staff (h) The facility shall post daily staffing information in a location accessible to residents and visitors in accordance with G.S.131D-4.3(a)(5). The information shall include: (1) the name and contact information of the administrator and supervisor in charge; (2) the number of required supervisors on each shift; and (3) the number of aides required on each shift. This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure daily staffing information in a location accessible to residents and visitors. The findings are: Observation of the common area, living room, kitchen and resident rooms on 09/02/26 and 09/03/26 revealed there were no posted staff schedules accessible to residents and visitors. Review of the staff schedule for the week dated 09/02/26 revealed: -It was not posted and accessible for residents	C 189		

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C 189	Continued From page 36 and visitors to review. -There was no documentation for the name and contact of the Supervisor-in-charge (SIC) when the Administrator was not available. -There was no documentation of a number of required supervisors for each shift. -The staff schedule did not accurately list changes in staff assignment. Interview with the Administrator on 09/03/26 at 4:25pm revealed: -He did not post a staff schedule because he knew when staff were working or not working. -He communicated with staff about their schedule via text message. -At times, he did not record and post staff schedule changes. -He did not know he was required to post a staff schedule accessible to residents and visitors. [Refer to tag 0188, 10A NCAC 13G .0601(g) Management and Other Staff]	C 189		
C 236	10A NCAC 13G .0802 (a) (c) Resident Care Plan 10A NCAC 13G .0802 Resident Care Plan (a) The facility shall develop and implement a care plan for each resident based on the resident's assessment completed in accordance with Rule .0801 of this Section. The care plan shall be resident-centered and include the resident's preferences related to the provision of care and services. A copy of each resident's current care plan shall be maintained in a location in the facility where it can be accessed by facility staff who are responsible for the implementation of the care plan. (c) The care plan shall include the following:	C 236		

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C 236	Continued From page 37 (1) a description of services, supervision, tasks, and level of assistance to be provided to address the resident's needs identified in the resident's assessment in Rule .0801 of this Section; (2) frequency of the services or tasks to be performed; (3) revisions of tasks and frequency based on reassessments in accordance with Rule .0801 of this Section; (4) licensed health professional tasks required according to Rule .0903 of this Section; (5) a dated signature of the assessor upon completion; and (6) a dated signature of the resident's physician or physician extender as defined in Rule .0102 of this Subchapter within 15 days of completion of the care plan certifying the resident is under this physician's care and has a medical diagnosis with associated physical or mental limitations warranting the provision of the personal care services in the above care plan in accordance with G.S. 131D-2.15. This shall not apply to residents assessed through the Medicaid State Plan Personal Care Services Assessment for the portion of the assessment covering tasks needed for each activity of daily living of this Rule for which care planning and signing are directed by Medicaid. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 3 of 3 sampled residents (#1, #2 and #3) Licensed Health Professional Support (LHPS) tasks were documented on the care plan (#1, #2, and #3).	C 236		

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C 236	Continued From page 38 The findings are: 1. Review of Resident #3's current FL2 dated 06/18/26 revealed: -Diagnoses included dementia, hypertension and coronary artery disease. -The resident was semi-ambulatory and required assistance with bathing and dressing. -The resident was constantly disorientated. -The resident was incontinent of bowel and bladder. Review of Resident #3's Resident Register revealed she was admitted to the facility on 06/22/26. Review of Resident #3's care plan dated 06/22/26 revealed: -She required limited assistance with eating. -She was totally dependent on staff assistance with toileting, ambulation, bathing, dressing, grooming/personal hygiene and transfers. -There was no documentation for ambulation using assistive devices, transferring semi-ambulatory or non-ambulatory residents, and care for pressure ulcers up to and including a Stage II pressure ulcer in the Licensed Health Professional Support (LHPS) task section. Review of Resident #3's record revealed she was admitted to home health (HH) for wound monitoring on 06/24/26. Refer to telephone interview with the facility's Registered Nurse (RN) on 09/03/26 at 5:54pm. Refer to interview with the Administrator on 09/03/26 at 1:30pm. 2. Review of Resident #2's current FL2 dated	C 236		

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C 236	Continued From page 39 05/12/26 revealed: -Diagnoses included Alzheimer's disease, heart failure, venous insufficiency, polyneuropathy (a condition where the peripheral nerves throughout the body malfunction and can cause pain) hypertension and dementia. -The resident was non-ambulatory and required assistance with bathing and dressing. -The resident was incontinent of bowel and bladder. -The resident's skin was documented as normal. Review of Resident #2's Resident Register revealed he was admitted to the facility on 05/15/26. Review of Resident #2's record revealed he was admitted under Hospice services on 05/15/26. Review of Resident #2's care plan dated 05/15/26 revealed: -He required limited assistance with eating. -He required extensive assistance with transfers. -He was totally dependent on staff assistance with toileting, ambulation, bathing, dressing, and grooming/personal hygiene. -There was no documentation for ambulation using assistive devices, transferring semi-ambulatory or non-ambulatory residents, care of residents who were physically restrained and the use of care practices as alternatives to restraints, and care for pressure ulcers up to and including a Stage II pressure ulcer in the Licensed Health Professional Support (LHPS) task section. Refer to telephone interview with the facility's RN on 09/03/26 at 5:54pm. Refer to interview with the Administrator on	C 236		

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C 236	Continued From page 40 09/03/26 at 1:30pm. 3. Review of Resident #1's current FL2 dated 06/29/26 revealed: -Diagnoses included dementia with agitation, hypertension, osteoarthritis, and depression. -Resident #1 was non-ambulatory. -Resident #1 was incontinent of bowel and bladder. -Resident #1 diet was pureed with nectar thickened liquids. -Resident #1 had an order for wound care-hospice nurse/caregiver to perform wound care to stage 2 wounds on sacrum, clean with wound cleanser, pat dry with gauze, cover with foam dressing, change 2 times per week and as needed for loose or soiled dressing. Review of Resident #1's Resident Register revealed an admission date of 07/01/26. Review of Resident #1's record revealed Resident #1 was admitted to the facility with hospice services on 07/01/26. Review of Resident #1's care plan dated 07/21/26 revealed: -Resident #1 required total assistance from staff on all activities of daily living (eating, toileting, bathing, dressing, grooming/ hygiene and transferring). -Resident #1 required zinc barrier cream with incontinent brief changes to erythema (redness) to sacrum as needed. -There was no documentation for ambulation using assistive devices, transferring semi-ambulatory or non-ambulatory residents, and care for pressure ulcers up to and including a Stage II pressure ulcer in the Licensed Health Professional Support (LHPS) task section.	C 236		

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C 236	Continued From page 41 Refer to telephone interview with the facility's RN on 09/03/26 at 5:54pm. Refer to interview with the Administrator on 09/03/26 at 1:30pm. _____ Telephone interview with the facility's RN on 09/03/26 at 5:54pm revealed: -She was responsible to complete the resident's care plan and have the physician sign it. -She did not know she had to fill out the LHPS task section of the care plan because there was a seperate paper that listed the LHPS tasks. -The staff were instructed by her or the Administrator on what to do for each resident's needs. Interview with the Administrator on 09/03/26 at 1:30pm revealed: -He was responsible to notify the RN when a care plan needed to be completed. -He did not know the LHPS task section was not completed. There were no audits completed to check to see if the care plans were complete.	C 236		
C 242	10A NCAC 13G .0901(a) Personal Care and Supervision 10A NCAC 13G .0901 Personal Care and Supervision (a) Family 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 themselves. This Rule is not met as evidenced by:	C 242		

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C 242	Continued From page 42 TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide personal care and to attend to personal care needs for 3 of 4 sampled residents (#1, #2 and #3) who were non-ambulatory including failure to provide incontinence care and the residents being saturated with urine (#2 and #3) and a resident who was saturated with urine and feces with a reddened area and a history of a pressure ulcer his coccyx (#1) and a resident who required turning and repositioning for an unstageable pressure ulcer to the left heel and a new open area to the left ankle (#3). The findings are: Observation of the facility on 09/02/26 at 9:25am revealed: -There were three residents in the living room, and two bedbound residents in their rooms, in bed. -There was one personal care aide (PCA) and the Administrator present in the facility. Observation of the facility on 09/03/26 at 9:50am revealed: -There were three residents in the living room, and two bedbound residents in their rooms, in bed. -There was PCA and the Administrator present in the facility. 1. Review of Resident #3's current FL2 dated 06/18/26 revealed: -Diagnoses included dementia, hypertension and coronary artery disease. -The resident was semi-ambulatory and required assistance with bathing and dressing.	C 242		

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C 242	Continued From page 43 -The resident was constantly disorientated. -The resident was incontinent of bowel and bladder. Review of Resident #3's Resident Register revealed she was admitted to the facility on 06/22/26. Review of Resident #3's care plan dated 06/22/26 revealed: -She required limited assistance with eating. -She was totally dependent on staff assistance with toileting, ambulation, bathing, dressing, grooming/personal hygiene and transfers. Review of Resident #3's record revealed she was admitted to home health (HH) for wound monitoring on 06/24/26. Review of Resident #3's Home Health Nurse's (HHN) visit notes revealed: -On 06/22/26, she was admitted to the facility with a skin tear on her left lower leg and right lower arm and HH would follow her for wound monitoring. -On 07/01/26, HHN provided wound care to left lower leg, right lower arm and a new wound to left heel documented. -On 07/07/26, HHN documented wound to left lower leg healed and wound care provided for left heel. -On 07/16/26, 07/21/26, 07/29/26, 08/05/26, 08/12/26, 08/18/26 and 08/25/26, HHN provided wound care for left heel. -On 08/30/26, HHN provided wound care to Resident #3's left heel and a new wound to the left ankle was documented. Observation of Resident #3 on 09/02/26 from 9:25am to 12:20pm revealed at 9:30am, the PCA	C 242		

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C 242	Continued From page 44 assisted Resident #3 out of the bed and placed her in a wheelchair, brought her to the living room where she watched television and remained there until the surveyors left the facilty for lunch at 12:20pm. Observation of Resident #3 on 09/02/26 from 1:25pm to 5:30pm revealed: -At 2:44pm, a family member stopped by and visited her until 3:46pm while she was in the living room. -At 3:46pm, she yelled out "I need to go to the bathroom" -The PCA was sitting across from her in the living room and the Administrator was in the bedroom next to the living room on the phone. -Another resident kept yelling at the PCA to take Resident #3 to the bathroom. -At 3:49pm, the PCA responded the resident did not need to go to the bathroom and the resident always said she needed to go to the bathroom. -At 3:57pm, the PCA took Resident #3 to the bathroom after Resident #3 yelled again that she needed to use the restroom. -At 4:09pm, the PCA took the briefs that were removed from Resident #3 to the outside trash can. Observation of Resident #3 on 09/03/26 from 9:50am to 12:55pm revealed she was in her wheelchair with her feet resting on the foot pedals. Telephone interview with a Registered Nurse (RN) from Resident #3's HH agency on 09/03/26 at 12:41pm revealed: -Per the office record for Resident #3, she was last seen by the HHN on 08/31/26 and provided wound care for an unstageable pressure ulcer on Resident #3's left heel.	C 242		

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C 242	Continued From page 45 -On 07/01/26, the HHN reported a new open area located on Resident #3's left heel and was documented as 2cm wide x 2cm in length x 0.2cm deep. -The wound care provided was the pressure ulcer was cleaned with normal saline, medihoney was applied with a pre-taped foam dressing covering the pressure ulcer. -On 08/31/26 the HHN documented an open area on Resident #3's left ankle that was 1.5cm in length x 1.5cm in width x 0.2cm in depth and an order was given to clean Resident #3's left ankle with normal saline, apply medihoney to a pre-taped foam dressing and apply to Resident #3's left ankle. -Since 06/24/26, Resident #3 required off loading with turning and repositioning every 2-hours to keep pressure off of the ankle and heel to prevent further breakdown. -Any pressure including sitting in a wheelchair great than 2 hours at a time without repositioning by lifting legs up,or laying in the bed without repositioning every 2-hours would significantly increase the risk of new pressure ulcer formation and decreased wound healing in previous pressure ulcers. Telephone interview with Resident #3's HHN on 09/03/26 at 1:03pm revealed: -On 06/24/26, Resident #3 was admitted to home health services. -On 07/01/26, she observed a new open area, 2cm wide x 2cm length x 0.2cm deep to Resident #3's left heel. -She contacted the physician and received an order to provide wound care weekly to Resident #3's left heel consisting of cleaning the wound with normal saline and apply medihoney to a pre-taped foam dressing. -On 08/31/26, the pressure ulcer to Resident #3's	C 242		

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C 242	Continued From page 46 left heel was considered unstageable and a new open area to Resident #3's left ankle was observed. -On 08/31/26, she provided wound care including cleaning Resident #3's left heel with normal saline, and applied medihoney to a pre-taped foam dressing and received an order to to the same wound care to the new open area to Resident #3's left ankle. -All orders for wound care, requirements for repositioning and off loading a minimum of every 2 hours and plan of care for Resident #3 was given to the Administrator in writing and verbally. -She spoke to the Administrator after every visit informing him of her services provided. -She documented hew visits every time she saw Resident #3 in the HHN visit notes located in Resident #3's facility record and in her computer. -Leaving Resident #3 in her wheelchair all day with her legs hanging down could lead to worsening of her pressure ulcers and formation of new ones. -Worsening of Resident #3's pressure ulcers and the development of new one could lead to infection. Interview with the Administrator on 09/03/26 at 9:47am revealed: -Resident #3 had pressure ulcers to her left heel and ankle. -Resident #3 was dependent on staff for all activities of daily living (ADLs) except eating. -Resident #3 was checked for incontinent needs before breakfast, and after lunch and supper. -During the night he used the double briefs to help with incontinent episodes and changed Resident #3 if she called out. Refer to interview with a day shift PCA on 09/02/26 at 5:05pm.	C 242		

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C 242	Continued From page 47 Refer to interview with a second day shift PCA on 09/03/26 at 4:47pm. 2. Review of Resident #2's current FL2 dated 05/12/26 revealed: -Diagnoses included Alzheimer's disease, heart failure, venous insufficiency, polyneuropathy (a condition where the peripheral nerves throughout the body malfunction and can cause pain) hypertension and dementia. -The resident was non-ambulatory and required assistance with bathing and dressing. -The resident was incontinent of bowel and bladder. -The resident's skin was documented as normal. Review of Resident #2's Resident Register revealed he was admitted to the facility on 05/15/26. Review of Resident #2's record revealed he was admitted under Hospice services on 05/15/26. Review of Resident #2's care plan dated 05/15/26 revealed: -He required limited assistance with eating. -He required extensive assistance with transfers. -He was totally dependent on staff assistance with toileting, ambulation, bathing, dressing, and grooming/personal hygiene. Review of Resident #2's record revealed: -There was no documentation of personal care tasks provided for Resident #2. -There was no documentation of the facility rounding sheets documenting frequency of personal care. Observation of Resident #2 on 09/02/26 from	C 242		

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C 242	Continued From page 48 9:25am to 12:20pm revealed he was in his bed with the head of the bed and and lower part of the bed were raised and both full bed rails were in the raised position, watching television and remained there until the surveyors left the facilty for lunch at 12:20pm. Observation of Resident #2 on 09/02/26 from 1:25pm to 5:30pm revealed he was in his bed with the head of the bed and and lower part of the bed were raised and both full bed rails were in the raised position watching television. Observation of Resident #2 on 09/03/26 from 9:50am to 12:55pm revealed he was in his bed with the head of the bed and and lower part of the bed were raised and both full bed rails were in the raised position. Interview with Resident #2 on 09/02/26 at 1:30pm revealed: -When he was first admitted the staff placed him in a recliner all day unable to reposition himself which caused his pain to become severe, and now he was in the bed all of the time and repositioning the best he can and the pain is still bad. -The pain required scheduled pain medication and stronger pain medication for breakthrough or uncontrollable pain. Interview with Resident #2's Hospice RN on 09/03/26 at 7:59am revealed: -Resident #2 transferred to this hospice agency upon admission on 05/15/26. -Resident #2 was bedbound because he required repositioning at least every 2-hours to decrease the pain he had in his legs and back. -The Administrator was educated on Resident #2 requiring repositioning every 2-hours for pain	C 242		

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C 242	Continued From page 49	C 242		

control and to reduce skin breakdown.
-When he was first admitted to the facility he used to sit in the recliner some of the day but he was not strong enough to reposition himself and the staff would leave him in the recliner all day and that would cause him to be in "severe" pain.
-He also required increased checks because Resident #2 was a heavy wetter and depended on the staff for toileting and incontinent care.
-The staff used bedrails to keep Resident #2 from falling out of the bed and for turning during incontinent care therefore safety checks according to the facility's policy were required for his safety.
-Resident #2's main hospice goal was to promote comfort and pain control through medications, repositioning for pain control and to reduce the risk of skin breakdown.

Interview with the Administrator on 09/03/26 at 9:47am revealed:
-Resident #2 let the staff know when he needed anything.
-The staff used the bedrails to help keep resident #2 from falling out of the bed and repositioning.
-Resident #2 wore incontinence briefs and was considered a "heavy wetter".
-Resident #2 was confused at times.
-Resident #2 was dependant on staff for all activities of daily living (ADLs) except eating.
-Resident #2 was repositioned and checked for incontinent needs before breakfast, and after lunch and supper.
-During the night he used the double briefs to help with incontinent episodes and changed Resident #2 if he called out.

Attempted telephone interview with Resident #2's Nurse Practitioner for Hospice on 09/03/26 at 10:00am was unsuccessful.

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C 242	Continued From page 50 Refer to interview with a day shift PCA on 09/02/26 at 5:05pm. Refer to interview with a second day shift PCA on 09/03/26 at 4:47pm. 3. Review of Resident #1's current FL2 dated 06/29/26 revealed: -Diagnoses included dementia with agitation, hypertension, osteoarthritis, and depression. -Resident #1 was non-ambulatory. -Resident #1 was incontinent of bowel and bladder. -Resident #1 diet was pureed with nectar thickened liquids. -Resident #1 had an order for wound care-hospice nurse/caregiver to perform wound care to stage 2 wounds on sacrum, clean with wound cleanser, pat dry with gauze, cover with foam dressing, change 2 times per week and as needed for loose or soiled dressing. Review of Resident #1's Resident Register revealed an admission date of 07/01/26. Review of Resident #1's record revealed Resident #1 was admitted to the facility with hospice services on 07/01/26. Review of a hospice physician order dated 07/02/26 revealed Resident #1's wound care was discontinued. Review of Resident #1's care plan dated 07/21/26 revealed: -Resident #1 required total assistance from staff on all activities of daily living (eating, toileting, bathing, dressing, grooming/ hygiene and transferring).	C 242		

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C 242	Continued From page 51 -Resident #1 required zinc barrier cream with incontinent brief changes to erythema (redness) to sacrum as needed. Review of Resident #1's record revealed: -There was no documentation of personal care tasks provided for Resident #1. -There was no documentation of the facility rounding sheets documenting frequency of personal care. Observation of Resident #1 on 09/02/26 from 9:25am to 12:20pm revealed he was in his bed and remained there until the surveyors left the facilty for lunch at 12:20pm. Observation of Resident #1 on 09/02/26 from 1:25pm to 1:55pm revealed: -He was in bed laying on his back and the television was on. -The Administrator removed two saturated incontinence briefs, one folded and used for the front area and a second one full of a very loose bowel movement. -There was a reusable incontinent pad under Resident #1's bottom. -The Administrator used wet wipes and a no rinse foam cleanser. -After Resident #1 was all cleaned up there was a reddened area to Resident #1's right buttock near his coccyx the size of a 50 cent piece. -The Administrator applied zinc to Resident #1's coccyx, applied a folded brief to the front area and a brief over it all. -Resident #1 was verbally and physically aggressive during the incontinence care. -It took 20 minutes for the Administrator to perform incontinent care on Resident #1. Interview with Resident #1's Power of Attorney	C 242		

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C 242	Continued From page 52 (POA) on 09/02/26 at 2:12pm revealed: -She visited every other day usually between 11:00am and 3:00pm. -Resident #1 was admitted to the facility with a pressure wound on his sacrum which was better but not gone yet. -When the Hospice RN first came, she was at the facility and the Hospice RN told the Administrator to use the blue wedge for positioning every two hours and the heel protectors all of the time. -Resident #1 liked to lay on his back with his legs crossed at the ankles and when she visited he was always in that position. -Resident #1 was a heavy wetter and had diarrhea daily so he required frequent changing. Interview with the Administrator on 09/02/26 at 1:35pm revealed: -He used two briefs on Resident #1 because Resident #1 was considered a "heavy wetter" and usually had a loose bowel movement. -It usually take him about 20-30 minutes to provide incontinent care to Resident #1 depending if clothes and bed sheet needed to be changed also. -He did not feel that using a pad and two briefs could cause moisture to be trapped and cause skin breakdown. Observation of Resident #1 on 09/03/26 from 9:50am to 12:55pm revealed Resident #1 was in his bed laying on his back. Interview with Resident #1's Hospice Nurse on 09/03/26 at 7:59am revealed: -She expected Resident #1 to be repositioned every 2 hours, off loaded from the sacral wound via the wedge provided and barrier cream used during incontinent care. -The Administrator was educated after every visit	C 242		

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C 242	Continued From page 53 on Resident #1 requiring a wedge for repositioning every 2-hours and heal protectors to reduce skin breakdown. -Resident #1's wound care order was discontinued on 07/02/26. -Resident #1's hospice goal was to provide comfort and pain control by using the repositioning to help prevent skin breakdown and pain control along with medications. -Using two briefs and a pad increased the risk of skin breakdown and not providing incontinent care at least every 2 hours due to moisture getting trapped and the resident sitting in urine and feces. Interview with the Administrator on 09/03/26 at 9:47am revealed: -Resident #1 was repositioned and checked for incontinent needs before breakfast, and after lunch and supper. -During the night he used the double briefs to help with incontinent episodes and changed Resident #1 if he called out. Attempted telephone interview with Resident #1's Nurse Practitioner for Hospice on 09/03/26 at 10:00am was unsuccessful. Refer to interview with a day shift PCA on 09/02/26 at 5:05pm. Refer to interview with a second day shift PCA on 09/03/26 at 4:47pm. _____ Interview with a day shift PCA on 09/02/26 at 5:05pm revealed: -She did not have a set schedule and would come to work when she called to ask for some time to work.	C 242		

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	FCL060157	A. BUILDING: _____ B. WING _____	R 09/03/2026

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C 242	Continued From page 54 -The Administrator called occasionally and asked her to work at the facility. -Today, 09/02/26, she was to work for 7:00am to 7:00pm. -When she worked, she did not administer medications and only provided personal care for the residents. -Her typical shift was to get the residents up out of bed with the exception of Resident #1 and #2 who were bedbound -She provided morning care such as a bed bath, incontinent care, and get the resident dressed. -She would get Resident #3 out of bed and into her wheelchair and take her into the living room to eat breakfast. -She would complete a round after lunch and provide incontinent care for 4 residents. -She would complete a final round after supper and change Resident #1 and #2's briefs and place Resident #3 back in bed and change her brief. Interview with a second day shift PCA on 09/03/26 at 4:47pm revealed: -She typically worked 12-hour shifts during the day. -When she worked weekends, (08/29/26 and 08/30/26) she worked during the day by herself and called the Administrator to pass medications and if need to administer as needed (PRN) medications. -Residents #1 and #2 were bedbound residents and were totally dependent on her for incontinent care in the morning, after lunch and after supper. -Residents #3 was totally dependent on her for incontinent care in the morning, getting her out of bed, into her wheelchair, taking her into the living room, incontinent care after lunch and supper and then transferring them back to her bed for the night.	C 242		

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C 242	Continued From page 55 -Residents #1 and #2 could position themselves in bed and Residents #3 slept mostly in her wheelchair during the day. -She gave Resident #1, #2 and #3 bed baths on the early mornings she worked. -She did not turn and reposition any of the residents every two hours. -Her biggest concern when she worked alone was when she was providing care to a resident, there were four other resident who were without supervision anywhere from 15 to 30 minutes depending on the resident and care provided. [Refer to tag 0188, 10A NCAC 13G .0601(g) Management and Other Staff (Type B Violation)] [Refer to tag 0452, 10A NCAC 13G .1301 Use of Physical Restraints and Alternatives (Type B Violation)] _____ The facility failed to provide personal care to Resident #1 who was bedbound, required total assistance, frequent incontinence care and repositioning due to history of a wound on his buttocks; Resident #2 that had weakness and pain in his back and legs, required frequent incontinence care who was left in the bed and was not repositioned or turned; Resident #3 who was wheelchair bound that developed pressure ulcers to her left ankle and heel when she was left in the wheelchair resulting in all three residents not receiving incontinence care more than three times a day, or repositioned for pressure and pain relief leading to risk for skin breakdown and discomfort. This failure of the facility resulted in substancial risk for serious physical harm of the residents and constitutes a Type A2 Violation. _____	C 242		

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C 242	Continued From page 56 The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/03/26 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 5, 2026.	C 242		
C 252	10A NCAC 13G .0903(a) Licensed Health Professional Support 10A NCAC 13G .0903 Licensed Health Professional Support (a) The facility shall assure that an appropriate licensed health professional participates in the on-site review and evaluation of the residents' health status, care plan, and care provided for residents requiring one or more of the following personal care tasks: (1) applying and removing ace bandages, TED hose, binders, and braces and splints; (2) feeding techniques for residents with swallowing problems; (3) bowel or bladder training programs to regain continence; (4) enemas, suppositories, break-up and removal of fecal impactions, and vaginal douches; (5) positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter; (6) chest physiotherapy or postural drainage; (7) clean dressing changes, excluding packing wounds and application of prescribed enzymatic debriding agents; (8) collecting and testing of fingerstick blood samples; (9) care of well-established colostomy or	C 252		

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C 252	Continued From page 57 ileostomy. For the purpose of this Rule, "well-established colostomy or ileostomy" means having a healed surgical site without sutures or drainage; (10)care for pressure ulcers, up to and including a Stage II pressure ulcer, which is a superficial ulcer presenting as an abrasion, blister, or shallow crater; (11)inhalation medication by machine; (12)forcing and restricting fluids; (13)maintaining accurate intake and output data; (14)medication administration through a well-established gastrostomy feeding tube. For the purpose of this Rule, "well-established gastrostomy feeding tube" means having a healed surgical site without sutures or drainage and through which a feeding regimen has been successfully established; (15)medication administration through subcutaneous injection in accordance with Rule .1004(q) except for anticoagulant medications; (16)oxygen administration and monitoring; (17)the care of residents who are physically restrained and the use of care practices as alternatives to restraints; (18)oral suctioning; (19)care of well-established tracheostomy, not to include endotracheal suctioning. For the purpose of this Rule, "well-established tracheostomy" means the stoma is well-healed and the airway is patent; (20)administering and monitoring of tube feedings through a well-established gastrostomy feeding tube in accordance with Subparagraph (a)(14) of this Rule; (21)the monitoring of continuous positive air pressure devices (CPAP and BIPAP); (22)application of prescribed heat therapy; (23)application and removal of prosthetic devices	C 252		

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C 252	Continued From page 58 except as used in post-operative treatment for shaping of the extremity; (24)ambulation using assistive devices that requires physical assistance; (25)range of motion exercises; (26)any other prescribed physical or occupational therapy; (27)transferring semi-ambulatory or non-ambulatory residents; or (28)nurse aide II tasks according to the scope of practice as established in the Nursing Practice Act and rules promulgated under that Act in 21 NCAC 36. 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 2 of 3 sampled residents (# 2 and #3) to include the identified tasks of ambulation using assistive devices that required physical assistance (#3) and care of residents who were physically restrained and the use of care practices as alternatives to restraints (#2 and #3). The findings are: 1. Review of Resident #3's current FL2 dated 06/18/26 revealed: -Diagnoses included dementia, hypertension and coronary artery disease. -The resident was semi-ambulatory and required assistance with bathing and dressing. -The resident was constantly disorientated. -The resident was incontinent of bowel and	C 252		

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C 252	Continued From page 59 bladder. Review of Resident #3's Resident Register revealed she was admitted to the facility on 06/22/26. Review of Resident #3's care plan dated 06/22/26 revealed: -She required limited assistance with eating. -She was totally dependent on staff assistance with toileting, ambulation, bathing, dressing, grooming/personal hygiene and transfers. Review of Resident #3's LHPS dated 06/22/26 revealed there was no task listed for ambulation using assistive devices that required physical assistance. Observation of Resident #3 on 09/02/26 from 9:25am to 12:20pm revealed at 9:30am, the PCA assisted Resident #3 out of the bed and placed her in a wheelchair, brought her to the living room where she watched television and remained there until the surveyors left the facilty for lunch at 12:20pm. Interview with a PCA on 09/02/26 at 5:05pm revealed Resident #3 was non-ambulatory and required a wheelchair for transportation. Interview with a second PCA on 09/03/26 at 4:47pm revealed she used a wheelchair to transport Resident #3 where ever Resident #3 needed to go. Telephone interview with the facility's Registered Nurse (RN) on 09/03/26 at 5:54pm revealed: -She was responsible to complete the LHPS for Resident #3. -She forgot to add a task for ambulation using	C 252		

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C 252	Continued From page 60 assistive devices that required physical assistance. Refer to interview with the Administrator on 09/03/26 at 1:30pm. 2. Review of Resident #2's current FL2 dated 05/12/26 revealed: -Diagnoses included Alzheimer's disease, heart failure, venous insufficiency, polyneuropathy (a condition where the peripheral nerves throughout the body malfunction and can cause pain) hypertension and dementia. -The resident was non-ambulatory and required assistance with bathing and dressing. -The resident was incontinent of bowel and bladder. Review of Resident #2's Resident Register revealed he was admitted to the facility on 05/15/26. Review of Resident #2's record revealed he was admitted under Hospice services on 05/15/26. Review of Resident #2's care plan dated 05/15/26 revealed: -He required limited assistance with eating. -He required extensive assistance with transfers. -He was totally dependent on staff assistance with toileting, ambulation, bathing, dressing, and grooming/personal hygiene. Review of Resident #2's LHPS dated 06/15/26 revealed there were no tasks for care of residents who were physically restrained and the use of care practices as alternatives to restraints. Observation of Resident #2 on 09/02/26 from 9:25am to 12:20pm revealed he was in his bed	C 252		

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C 252	Continued From page 61 watching television with both full bedrails in the raised position and remained there until the surveyors left the facilty for lunch at 12:20pm. Observation of Resident #2 on 09/02/26 from 1:25pm to 5:30pm revealed he was in his bed watching television with both bedrails in the raised position. Observation of Resident #2 on 09/03/26 from 9:50am to 12:55pm revealed he was in his bed with the head of the bed and and lower part of the bed were raised and both full bed rails were in the raised position. Interview with a PCA on 09/02/26 at 5:05pm revealed: -Resident #2 was bedbound. -She used full bedrails to keep Resident #2 from falling out of the bed and to help when she was providing incontinent care for Resident #2. Interview with a second PCA on 09/03/26 at 4:47pm revealed Resident #2 was a bedbound resident who required full bed rails for safety and to help while incontinent care was being provided. Telephone interview with the facility's RN on 09/03/26 at 5:54pm revealed: -She was responsible to complete the LHPS for Resident #2. -She did not include a task for the care of residents who were physically restrained and the use of care practices as alternatives to restraints because she did not know using full bedrails for Resident #2 was considered a restraint. Refer to interview with the Administrator on 09/03/26 at 1:30pm.	C 252		

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C 252	Continued From page 62 Interview with the Administrator on 09/03/26 at 1:30pm revealed: -He was responsible to notify the RN with an identified LHPS task for each resident. -He did not know that it was not done.	C 252		
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 medications were administered as ordered for 2 of 3 sampled residents (#1 and #2) related to medications used to treat low potassium (#2), and dry eyes (#1). The findings are: 1. Review of Resident #2's current FL2 dated 05/12/26 revealed: -Diagnoses included Alzheimer's disease, heart failure, venous insufficiency, hypertension and dementia. -An order for potassium chloride 10% solution (a medication used to treat low potassium) (20mEq/15ml), dilute 7.5mls (10mEq) in 6oz water and drink three times weekly on Mondays,	C 330		

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C 330	Continued From page 63 Wednesdays and Fridays. Review of Resident #2's signed physician's order dated 06/30/26 revealed an order to discontinue the potassium chloride 10% solution. Observation of Resident #2's medication available for administration on 09/02/26 at 3:00pm revealed there was no potassium chloride 10% solution available for administration. Review of Resident #2's May 2026 electronic (if applicable) Electronic Medication Record (eMAR) revealed: -There was an entry for potassium chloride 10% solution (a medication used to treat low potassium) (20mEq/15ml), dilute 7.5mls (10mEq) in 6oz water and drink three times weekly on Mondays, Wednesdays and Fridays with an original date of 05/15/26 at 8:00am. -On 05/18/26, 05/20/26, 05/22/26, 05/25/26, 05/27/26, and 05/29/26, the potassium chloride was documented as administered. Review of Resident #2's June 2026 eMAR revealed: -There was an entry for potassium chloride 10% solution (a medication used to treat low potassium) (20mEq/15ml), dilute 7.5mls (10mEq) in 6oz water and drink three times weekly on Mondays, Wednesdays and Fridays with an original date of 05/15/26 at 8:00am. -On 06/01/26, 06/03/26, 06/05/26, 06/08/26, 06/10/26, 06/12/26, 06/15/26, 06/17/26, 05/19/26, 06/22/26, 06/24/26, 06/26/26 and 06/29/26, the potassium chloride was documented as administered. Telephone interview with a Pharmacist from the facility's contracted pharmacy on 09/03/26 at	C 330		

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C 330	Continued From page 64 1:10pm revealed: -The pharmacy received a signed physician's order dated 05/15/26 for potassium chloride 10% solution (a medication used to treat low potassium) (20mEq/15ml), dilute 7.5mls (10mEq) in 6oz water and drink three times weekly on Mondays, Wednesdays and Fridays. -There were 90mls (a 12-day supply) of potassium chloride dispensed to the facility on 05/17/26. -If the potassium chloride was administered as directed, Resident #2 would have run out of the potassium on 06/12/26 and required a refill. -It would have been the facility's responsibility to request a refill prior to running out of the potassium. -On 06/30/26, the pharmacy received a signed physician's order to discontinue the potassium. -Since the facility did not request a refill on the potassium, Resident #2 would have missed 7 doses of the potassium. -The potassium chloride was used to replace low potassium in the body. -When levels of potassium remain low, the heart could beat abnormally, and the muscles and kidneys could not work correctly. -It was the facility's responsibility to make sure the potassium was refilled and available for administration. Telephone interview with Resident #2's hospice nurse on 09/03/26 at 7:59am revealed: -Resident #2 was admitted to the facility on potassium to treat low potassium levels in the body. -On 06/30/26, the physician discontinued the potassium because Resident #2's goal with hospice were for comfort and pain control. -She expected the staff to administer the medications as ordered.	C 330		

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C 330	Continued From page 65 -Dangerously low potassium could lead to dangerous heart rhythms which could lead to cardiac arrest. Interview with the facility RN on 09/03/26 at 5:54pm revealed: -She and the Administrator were responsible for administering medications and performing medication audits. -She could not remember an issue with Resident #3's potassium because she did not complete medication audits until one week ago and Interview with the Administrator on 09/03/26 at 1:30pm revealed: -He administered potassium chloride to Resident #2 in May 2026, June 2026 and July 2026 according to the eMAR. -The potassium chloride would be on the eMAR one month and then disappear and show up again off and on and he did not look into it. -He did not perform audits using Resident #2's eMAR against the physician's orders to check for accuracy. -Some of the physician's orders went straight to the pharmacy and he did not check the orders against the eMAR, just administered what was on the eMAR. -The facility RN was responsible to check the eMAR against the physician's orders. -He was responsible for re-ordering the potassium when there were 2-3 doses left. -He did not remember re-ordering the potassium. -He did not know the potassium was discontinued on 06/30/26 or that the potassium ran out on 06/12/26 and that Resident #2 missed 7 doses of the potassium. Attempted telephone interview with Resident #3's Nurse Practitioner for Hospice on 09/03/26 at	C 330		

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C 330	Continued From page 66 10:00am was unsuccessful. 2. Review of Resident #1's current FL2 dated 06/29/26 revealed: -Diagnoses included dementia with agitation, hypertension, osteoarthritis, and depression. -Resident #1 was non-ambulatory. -Resident #1 was incontinent of bowel and bladder. -Resident #1 had an order for artificial eye lubricant ointment (GenTeal Tear Ointment, a medication used as an emollient for relieving eye dryness and irritation), apply thin ribbon to bilateral eyes twice daily (8:00am & 8:00pm). Review of Resident #1's Resident Register revealed an admission date of 07/01/26. Review of Resident #1's record revealed Resident #1 was admitted to the facility with hospice services on 07/01/26. Review of a hospice physician order dated 7/2/26 revealed: -Resident #1's GenTeal Tear Ointment 83% - 15%, apply a thin ribbon to both eyes twice daily at 8:00am and 6:00pm was discontinued. Review of Resident #1's July 2026 electronic Medication Administration Record (eMAR) revealed: -There was an entry for GenTeal Tear Ointment, apply a thin ribbon to both eyes twice daily at 8:00am and 6:00pm. -There was documentation Resident #1's GenTeal Tear Ointment was administered from 07/02/26 to 07/31/26 twice daily at 8:00am and 6:00pm, despite the discontinued order dated 07/02/26. -There was no electronic documentation Resident	C 330		

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HAMILTON FAMILY CARE HOME	13418 HAMILTON ROAD CHARLOTTE, NC 28278

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C 330	Continued From page 67	C 330		

#1's GenTeal Tear Ointment was administered on 07/15/26 at 6:00pm and 07/20/26 at 6:00pm.
-There were handwritten initials documented (after the eMAR was printed on 09/02/26), for 07/15/26 at 6:00pm and 07/20/26 at 6:00pm that GenTeal Tear Ointment was administered.

Review of Resident #1's August 2026 eMAR revealed:
-There was an entry for GenTeal Tear Ointment, apply a thin ribbon to both eyes twice daily at 8:00am and 6:00pm.
-There was documentation Resident #1's GenTeal Tear Ointment was administered from 08/02/26 to 08/31/26 twice daily at 8:00am and 6:00pm, despite the discontinued order dated 07/02/26.

Review of Resident #1's September 2026 eMAR revealed:
-There was an entry for GenTeal Tear Ointment, apply a thin ribbon to both eyes twice daily at 8:00am and 6:00pm.
-There was documentation Resident #1's GenTeal Tear Ointment was administered from 09/01/26 to 09/02/26 twice daily at 8:00am and 6:00pm, despite the discontinued order dated 07/02/26.

Observation of medications available for administration on 09/02/26 at 4:47pm revealed there was no GenTeal Tear Ointment on hand.

Interview with a pharmacist at the facility's contracted pharmacy on 09/02/26 at 1:30pm revealed:
-Resident #1 had an active order for Genteal Tear Ointment, apply a thin layer to both eyes twice daily at 8:00am and 6:00pm.
-Resident #1's GenTeal Tear Ointment was

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C 330	Continued From page 68 dispensed on 07/01/26 (15-day supply) and 08/03/26 (15-day supply). -There was no adverse side effect from continued use of the GenTeal Tear Ointment other than possible blurry vision. Interview with Resident #1's hospice nurse on 09/3/26 at 11:20am revealed: -Resident #1's GenTeal Tear Ointment was discontinued on 7/2/26. -She did not know why the discontinued order for GenTeal Tear Ointment was not sent to the pharmacy and removed from the eMAR. -She did not receive any report Resident #1 experienced side effects from continued use of GenTeal Tear Ointment. Interview with the facility RN on 09/03/26 at 5:54pm revealed: -She and the Administrator were responsible for administering medications and performing medication audits. -She started medication audits one week ago and could not remember seeing Resident #1's eye ointment. -She did not know Resident #1's eye ointment was discontinued on 07/02/26, remained on the eMARs, and continued to be administered. Interview with the Administrator on 09/03/26 at 9:47am revealed: -He was responsible for administering medications and documenting on the eMAR. -He and the facility nurse were responsible for auditing medications on hand and comparing the medications to orders. -Some of the physician's orders went straight to the pharmacy. -He administered what was on the eMAR and he did not check the orders against the eMAR.	C 330		

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C 330	Continued From page 69 -He could not locate Resident #1's GenTeal Tear Ointment and the prescription may have been completed. -He did not know Resident #1's GenTeal Tear Ointment was discontinued on 07/02/26. -He usually documented after administering each medication. -Resident #1 also had a prescription for Refresh Tears (used to treat dry irritated eyes), instill one drop in both eyes twice daily. -He could not recall if he administered Resident #1 both medications (eye ointment and eye drops) and documented both on the July 2026, August 2026 and September 2026 eMARs. -He did not know why he continued to document Resident #1's GenTeal Tear Ointment through 09/02/26 as given, although it was discontinued on 07/02/26. Based on observations, interviews, and record reviews it was determined that Resident #1 was not interviewable. Attempted telephone interview with Resident #1's Nurse Practitioner for Hospice on 09/03/26 at 10:00am was unsuccessful.	C 330		
{C 341}	10A NCAC 13G .1004 (i) Medication Administration 10A NCAC 13G .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's	{C 341}		

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{C 341}	Continued From page 70 medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure the staff person who administered medications documented on the medication administration records immediately after administration of medications to 4 of 5 residents (#1, #2, #3 and #4). The findings are: 1. Review of Resident #1's current FL2 dated 06/29/26 revealed diagnoses included dementia with agitation, hypertension, osteoarthritis, and depression. a. A review of Resident #1's current FL2 dated 06/29/26 revealed an order for GenTeal Tear (a medication used to treat dry eyes and irritation) apply a thin ribbon to both eyes twice daily at 8:00am and 6:00pm was discontinued. Review of Resident #1's July 2026 electronic medication record (eMAR) revealed: -There was an entry for GenTeal Tear Ointment, apply a thin ribbon to both eyes twice daily at 8:00am and 6:00pm. -There was documentation Resident #1's GenTeal Tear Ointment was administered from 07/02/26 to 07/31/26 twice daily at 8:00am and 6:00pm, despite the discontinued order dated 07/02/26. -There was no electronic documentation Resident #1's GenTeal Tear Ointment was administered on 07/15/26 at 6:00pm and 07/20/26 at 6:00pm.	{C 341}		

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{C 341}	Continued From page 71 -There were handwritten initials documented (after the eMAR was printed on 09/02/26), on 07/15/26 at 6:00pm and 07/20/26 at 6:00pm that GenTeal Tear Ointment was administered. b. Review of Resident #1's current FL2 dated 06/29/26 revealed an order for buspirone (a medication used to treat anxiety) 5mg one tablet three times daily at 8:00am, 2:00pm and 6:00pm. Review of a hospice physician order dated 07/29/26 revealed Resident #1 had an active order for buspirone 5mg, take one tablet by mouth 3 times daily at 8:00am, 2:00pm and 6:00pm. Review of Resident #1's July 2026 electronic medication record (eMAR) revealed: -There was an entry for buspirone 5mg, take one tablet daily at 8:00am, 2:00pm and 6:00pm. -There was documentation Resident #1's buspirone was administered from 07/01/26 to 07/31/26 at 8:00am, 2:00pm, and 6:00pm. -There was no electronic documentation Resident #1's buspirone was administered on 07/01/26 at 8:00am, 2:00pm and 6:00pm, on 07/15/26 at 2:00pm and 6:00pm, and on 07/20/26 at 6:00pm. -There were handwritten initials documented for Resident #1's Refresh Tear Drops (after the eMAR was printed on 09/02/26), on 07/15/26 at 6:00pm and 07/20/26 at 6:00pm that buspirone was administered. c. Review of a hospice physician order dated 07/02/26 revealed Resident #1 had an active order for Refresh Tear Drops (a medication used to dry eyes) 0.5%, instill one drop in both eyes twice daily at 8:00am and 8:00pm. Review of Resident #1's July 2026 electronic	{C 341}		

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{C 341}	Continued From page 72 medication record (eMAR) revealed: -There was an entry for Refresh Tear Drops (a medication used to dry eyes) 0.5%, instill one drop in both eyes twice daily at 8:00am and 8:00pm. -There was documentation Resident #1's Refresh Tear Drops were administered from 07/01/26 to 07/31/26 twice daily at 8:00am and 8:00pm. -There was no electronic documentation Resident #1's Refresh Tear Drops were administered on 07/01/26 at 8:00am and 8:00pm, on 07/02/26 at 8:00am and 8:00pm, on 07/03/26 at 8:00am and 8:00pm, on 07/04/26 at 8:00am and 8:00pm, on 07/15/26 at 8:00pm, and 07/20/26 at 6:00pm. -There were handwritten initials documented for Resident #1's Refresh Tear Drops (after the eMAR was printed on 09/02/26), on 07/01/26 at 8:00am and 8:00pm, on 07/02/26 at 8:00am and 8:00pm, on 07/03/26 at 8:00am and 8:00pm, on 07/04/26 at 8:00am and 8:00pm, on 07/15/26 at 8:00pm, and 07/20/26 at 8:00pm. Review of Resident #1's August 2026 eMAR revealed: -There was an entry for Refresh Tear Drops (a medication used to dry eyes) 0.5%, instill one drop in both eyes twice daily at 8:00am and 8:00pm. -There was documentation Resident #1's Refresh Tear Drops were administered from 08/01/26 to 08/31/26 twice daily at 8:00am and 8:00pm. -There was no electronic documentation Resident #1's Refresh Tear Drops were administered on 08/01/26 at 8:00am, on 08/04/26 at 8:00pm, and 08/25/26 at 8:00pm. -There were handwritten initials documented (after the eMAR was printed on 09/02/26), on 08/01/26 at 8:00am, on 08/04/26 at 8:00pm, and on 08/25/26 at 8:00pm.	{C 341}		

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{C 341}	Continued From page 73 Interview with the Administrator on 09/03/26 at 9:47am revealed he did not know Resident #1's GenTeal Tear Ointment was discontinued on 07/02/26. Refer to interview with the Administrator on 09/03/26 at 9:47am and 1:30pm. 2. Review of Resident #2's current FL2 dated 05/12/26 revealed: -Diagnoses included Alzheimer's disease, heart failure, venous insufficiency, hypertension and dementia. -There was an order for buspirone 5mg twice daily. -There was an order for hydrocodone/APAP (a medication used to treat pain) 10mg/325mg, two tablets every 8 hours. Review of Resident #2's Resident Register revealed he was admitted to the facility on 05/15/26. Review of Resident #2's August 2026 electronic Medication Administration Record (eMAR) revealed: -There was an entry for buspirone 5mg twice daily with an original date of 05/15/26 at 8:00am and 8:00pm. -On 08/01/26 at 8:00am, the buspirone was initialed with black marker after the eMAR was printed. -On 08/04/26 at 8:00am and 8:00pm, the buspirone was initialed with black marker after the eMAR was printed. -On 08/25/26 at 8:00am and 8:00pm, the buspirone was initialed with black marker after the eMAR was printed. -There was an entry for hydrocodone/APAP 10mg/325mg, two tablets every 8 hours with an	{C 341}		

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{C 341}	Continued From page 74 original date of 05/15/26 at 7:00am, 3:00pm and 11:00pm. -On 08/25/26 at 11:00pm, the hydrocodone was initialed with black marker after the eMAR was printed. -On 08/27/26 at 3:00pm and 11:00pm, the hydrocodone was initialed with black marker after the eMAR was printed. -On 08/28/26 at 7:00am, 3:00pm and 11:00pm, the hydrocodone was initialed with black marker after the eMAR was printed. -On 08/29/26 at 7:00am, 3:00pm and 11:00pm, the hydrocodone was initialed with black marker after the eMAR was printed. -On 08/30/26 at 7:00am, 3:00pm and 11:00pm, the hydrocodone was initialed with black marker after the eMAR was printed. -On 08/31/26 at 7:00am, 3:00pm and 11:00pm, the hydrocodone was initialed with black marker after the eMAR was printed. Review of Resident #2's September 2026 eMAR revealed: -There was an entry for hydrocodone/APAP 10mg/325mg, two tablets every 8 hours with an original date of 05/15/26 at 12:00am, 8:00am and 4:00pm. -On 09/01/26 at 12:00am, and 8:00am, the hydrocodone was initialed with black marker after the eMAR was printed. Refer to interview with the Administrator on 09/03/26 at 9:47am and 1:30pm. 3. Review of Resident #3's current FL2 dated 06/18/26 revealed: -Diagnoses included dementia, hypertension and coronary artery disease. -There was an order for divalproex (a medication used to treat mood) 125mg twice daily.	{C 341}		

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{C 341}	Continued From page 75 -There was an order for lantanoprost (a medication used to treat eye pressure) solution 0.005% 1 drop in each eye every evening. -There was an order for melatonin (a medication used to treat insomnia) 3mg at bedtime. -There was an order for vitamin D3 (a medication used to treat low vitamin D3) 25mcg every day. Review of Resident #3's Resident Register revealed she was admitted to the facility on 06/22/26. Review of Resident #3's August 2026 eMAR revealed: -There was an entry for divalproex 125mg twice daily with an original date of 06/22/26 at 8:00am and 8:00pm. -On 08/04/26 at 8:00pm, the divalproex was initialed with black marker after the eMAR was printed. -On 08/25/26 at 8:00pm, the divalproex was initialed with black marker after the eMAR was printed. -There was an entry for latanoprost solution 0.005%1 drop in each eye every evening with an original date of 0007/03/26 at 8:00pm. -On 08/04/26 at 8:00pm, the latanoprost was initialed with black marker after the eMAR was printed. -On 08/25/26 at 8:00pm, the latanoprost was initialed with black marker after the eMAR was printed. -There was an entry for melatonin 3mg at bedtime with an original date of 06/22/26 at 8:00pm. -On 08/04/26 at 8:00pm, the melatonin was initialed with black marker after the eMAR was printed. -On 08/25/26 at 8:00pm, the melatonin was initialed with black marker after the eMAR was	{C 341}		

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{C 341}	Continued From page 76 printed. -There was an entry for vitamin D3 25mcg every day with an original date of 06/22/26 at 8:00am. -On 08/01/26 at 8:00am, the vitamin D2 was initialed with black marker after the eMAR was printed. Refer to interview with the Administrator on 09/03/26 at 9:47am and 1:30pm. 4. Review of Resident #4's current FL2 dated 03/28/26 revealed: -Diagnoses included vascular dementia, TIAs (mini-strokes), and muscle weakness. -Resident #1 was non-ambulatory. -Resident #1 was incontinent of bowel and bladder. a. Review of a physician's order dated 04/02/25 revealed Resident #4 had an order for mirtazapine (a medication to treat depression) 15mg, take one tablet by mouth daily at 8:00pm. Review of Resident #4's July 2026 eMAR revealed: -There was an entry for mirtazapine 15mg, take one tablet by mouth daily at 8:00pm. -There was documentation Resident #4's mirtazapine 15mg, take one tablet by mouth once daily at 8:00pm, was administered from 07/01/26 to 07/14/26 at 8:00pm, from 07/15 to 07/19/26 at 8:00pm and from 07/21/26 to 07/31/26 at 8:00pm. -There was no documentation Resident #4's mirtazapine 15mg was administered on 07/15/26 at 8:00pm, and on 07/20/26 at 8:00pm. Review of Resident #4's August 2026 eMAR revealed: -There was an entry for mirtazapine 15mg, take one tablet by mouth daily at 8:00pm.	{C 341}		

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{C 341}	Continued From page 77 -There was documentation Resident #4's mirtazapine 15mg, take one tablet by mouth once daily at 8:00pm, was administered from 08/01/26 to 08/03/26 at 8:00pm, from 08/05/26 to 08/24/26 at 8:00pm and from 08/26/26 to 08/31/26 at 8:00pm. -There was no documentation Resident #4's mirtazapine 15mg was administered on 08/04/26 at 8:00pm, and on 08/25/26 at 8:00pm. b. Review of a physician's order dated 07/02/26 revealed Resident #5 had an order for trazadone (a medication to treat insomnia) 50mg, take one tablet by mouth daily at 8:00pm. Review of Resident #4's July 2026 eMAR revealed: -There was an entry for trazadone 50mg, take one tablet by mouth daily at 8:00pm. -There was documentation Resident #4's trazadone 50mg, take one tablet by mouth once daily at 8:00pm, was administered from 07/01/26 to 07/14/26 at 8:00pm, from 07/16 to 07/19/26 at 8:00pm and from 07/21/26 to 07/31/26 at 8:00pm. -There was no documentation Resident #4's trazadone 50mg was administered on 07/15/26 at 8:00pm, and on 07/20/26 at 8:00pm. Review of Resident #4's August 2026 eMAR revealed: -There was an entry for trazadone 50mg, take one tablet by mouth daily at 8:00pm. -There was documentation Resident #4's trazadone 50mg, take one tablet by mouth once daily at 8:00pm, was administered from 08/01/26 to 08/03/26 at 8:00pm, from 08/05/26 to 08/24/26 at 8:00pm and from 08/26/26 to 08/31/26 at 8:00pm. -There was no documentation Resident #4's trazadone 50mg was administered on 08/04/26 at	{C 341}		

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{C 341}	Continued From page 78 8:00pm, and on 08/25/26 at 8:00pm. c. Review of a physician's order dated 07/02/26 revealed Resident #4 had an order for acetaminophen (a medication to treat pain) 325mg, take two tablets by twice daily at 8:00am and 8:00pm. Review of Resident #4's August 2026 eMAR revealed: -There was an entry for acetaminophen 325mg, take two tablets by twice daily at 8:00am and 8:00pm. -There was documentation Resident #4's acetaminophen 325mg, take two tablets by mouth twice daily at 8:00am and 8:00pm, was administered from 08/01/26 to 08/24/26 at 8:00am and 8:00pm, on 08/25/25 at 8:00am, and from 08/26/26 to 08/31/26 at 8:00am and 8:00pm. -There was no documentation Resident #4's acetaminophen was administered on 08/25/26 at 8:00pm. d. Review of a physician's order dated 07/02/26 revealed Resident #4 had an order for desitin (a medication to treat a rash) 40%, spread topically to sacral area twice daily. Review of Resident #4's August 2026 eMAR revealed: -There was an entry for desitin 40%, spread topically to sacral area twice daily. -There was documentation Resident #4's desitin, spread topically to sacral area twice daily, was administered from 08/01/26 to 08/24/26 at 8:00am and 8:00pm, on 08/25/25 at 8:00am, and from 08/26/26 to 08/31/26 at 8:00am and 8:00pm. -There was no documentation Resident #4's desitin was administered on 08/25/26 at 8:00pm.	{C 341}		

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{C 341}	Continued From page 79 e. Review of a physician's order dated 07/02/26 revealed Resident #4 had an order for Refresh Tear Drops (a medication to treat dry eyes) 0.5%, instill one drop in both eyes 4 times daily at 8:00am, 12:00pm, 4:00pm, and 8:00pm. Review of Resident #4"s August 2026 eMAR revealed: -There was an entry for Refresh Tear Drops 0.5%, instill one drop in both eyes 4 times daily at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -There was documentation Resident #4"s Refresh Tear Drops was administered from 08/01/26 to 08/24/26 at 8:00am, 12:00pm, 4:00pm and 8:00pm, on 08/25/25 at 8:00am, 12:00pm, and 4:00pm and from 08/26/26 to 08/31/26 at 8:00am, 12:00pm, 4:00pm and 8:00pm. -There was no documentation Resident #4's Refresh Tear Drops was administered on 08/25/26 at 8:00pm. Refer to interview with the Administrator on 09/03/26 at 9:47am and 1:30pm. _____ Interview with the Administrator on 09/03/26 at 9:47am revealed: -He was responsible for administering medications and documenting on the eMAR. -He administered what was on the eMAR and usually documented on the eMAR immediately after administrating each medication. -He was responsible for documenting medications immediately after he administered the medications. -When he printed up the eMARs of the residents, for the surveyors, there were holes on the eMARs so he hand wrote his initials on them before he gave the eMARs to the surveyors on 09/02/26.	{C 341}		

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{C 341}	Continued From page 80 -At times he was not sure if he administered the medication and did not document his initials electronically immediately after.	{C 341}		
{C 342}	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record review and interviews the facility failed to ensure the electronic medication records were accurate for 3 of 4 sampled residents related to orders for a medications used to treat dry eyes, anxiety, and wound care (#1), and a medication to treat low potassium (#2) and medications to treat mood,	{C 342}		

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{C 342}	Continued From page 81 eye pressures, insomnia and low vitamin D (#3). The findings are: 1. Review of Resident #1's current FL2 dated 06/29/26 revealed: -Diagnoses included dementia with agitation, hypertension, osteoarthritis, and depression. -Resident #1 was non-ambulatory. -Resident #1 was incontinent of bowel and bladder. -Resident #1 had an order for artificial eye lubricant ointment (GenTeal Tear Ointment, a medication used as an emollient for relieving eye dryness and irritation), apply thin ribbon to bilateral eyes twice daily (8:00am and 8:00pm), buspirone 5mg (medication to treat anxiety), take 1 tablet by mouth 3 times daily at 8:00am, 2:00pm, and 6:00pm, and wound care: hospice nurse/ care giver to perform wound care to stage 2 wounds on sacrum, cleanse with wound cleanser, pat dry with gauze, cover with foam dressing twice weekly. Review of Resident #1's Resident Register revealed an admission date of 07/01/26. Review of Resident #1's record revealed Resident #1 was admitted to the facility with hospice services on 07/01/26. d. Review of a hospice physician order dated 07/02/26 revealed Resident #1 had a discontinued order for wound care: hospice nurse/ care giver to perform wound care to stage 2 wounds on sacrum, cleanse with wound cleanser, pat dry with gauze, cover with foam dressing twice weekly. Review of Resident #1's July 2026 electronic	{C 342}		

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{C 342}	Continued From page 82	{C 342}		

medication record (eMAR) revealed:
-There was an entry for wound care: hospice nurse/ care giver to perform wound care to stage 2 wounds on sacrum, cleanse with wound cleanser, pat dry with gauze, cover with foam dressing twice weekly.
-There was documentation Resident #1's wound care was provided on 07/06/26, 07/09/26, 07/16/26, 07/20/26, 07/23/26, 07/27/26, and 07/30/26 between 7:00am and 3:00pm.

Review of Resident #1's August 2026 electronic medication record eMAR revealed:
-There was an entry for wound care: hospice nurse/ care giver to perform wound care to stage 2 wounds on sacrum, cleanse with wound cleanser, pat dry with gauze, cover with foam dressing twice weekly.
-There was documentation Resident #1's wound care was provided on 08/03/26, 08/06/26, 08/10/26, 08/13/26, 08/17/26, 08/20/26, 08/24/26, 08/27/26 and 08/31/26 between 7:00am and 3:00pm, although the wound care was discontinued on 07/02/26.

Refer to interview with the Administrator on 09/03/26 at 9:47am.

2. Review of Resident #2's current FL2 dated 05/12/26 revealed:
-Diagnoses included Alzheimer's disease, heart failure, venous insufficiency, hypertension and dementia.
-There was an order for potassium chloride 10% solution (a medication used to treat low potassium) (20mEq/15ml), dilute 7.5ml's (10mEq) in 6oz water and drink three times weekly on Mondays, Wednesdays and Fridays.

Review of Resident #2's Resident Register

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{C 342}	Continued From page 83 revealed he was admitted to the facility on 05/15/26. Review of Resident #2's May 2026 eMAR revealed: -There was an entry for potassium chloride 10% solution (a medication used to treat low potassium) (20mEq/15ml), dilute 7.5ml's (10mEq) in 6oz water and drink three times weekly on Mondays, Wednesdays and Fridays with an original date of 05/15/26 at 8:00am. -On 05/18/26, 05/20/26, 05/22/26, 05/25/26, 05/27/26, and 05/29/26, the potassium chloride was documented as administered. -The potassium was documented as administrated a total of 6 times in May 2026. Review of Resident #2's June 2026 eMAR revealed: -There was an entry for potassium chloride 10% solution (a medication used to treat low potassium) (20mEq/15ml), dilute 7.5ml's (10mEq) in 6oz water and drink three times weekly on Mondays, Wednesdays and Fridays with an original date of 05/15/26 at 8:00am. -On 06/01/26, 06/03/26, 06/05/26, 06/08/26, 06/10/26, 06/12/26, 06/15/26, 06/17/26, 05/19/26, 06/22/26, 06/24/26, 06/26/26 and 06/29/26, the potassium chloride was documented as administered. -The potassium was documented as administrated a total of 13 times in June 2026. Review of Resident #2's July 2026 eMAR revealed: -There was an entry for potassium chloride 10% solution (a medication used to treat low potassium) (20mEq/15ml), dilute 7.5ml's (10mEq) in 6oz water and drink three times weekly on Mondays, Wednesdays and Fridays with an	{C 342}		

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{C 342}	Continued From page 84 original date of 05/15/26 at 8:00am. -On 07/01/26, 07/03/26, 07/05/26, 07/08/26, 07/10/26, 07/12/26, 07/15/26, 07/17/26, 07/20/26, 07/22/26, 07/24/26, 07/27/26 and 07/29/26, the potassium chloride was documented as administered. -The potassium was documented as administrated a total of 13 times in July 2026. Telephone interview with a Pharmacist from the facility's contracted pharmacy on 09/03/26 at 1:10pm revealed: -The pharmacy received a signed physician's order dated 05/15/26 for potassium chloride 10% solution (a medication used to treat low potassium) (20mEq/15ml), dilute 7.5ml's (10mEq) in 6oz water and drink three times weekly on Mondays, Wednesdays and Fridays. -There were 90ml's (a 90-day supply) of potassium chloride dispensed to the facility on 05/17/26. -If the potassium chloride was administered as directed, Resident #2 would have run out of the potassium on 06/12/26 and required a refill. -On 06/30/26, the pharmacy received a signed physician's order to discontinue the potassium. Interview with the Administrator on 09/03/26 at 1:30pm revealed: -He administered potassium chloride to Resident #2 in May 2026, June 2026 and July 2026 according to the eMAR. -He was responsible to document a medication immediately after he administered it. -The potassium chloride would be on the eMAR one month and then disappear and show up again off and on and he did not look into it. -He did not know why he continued to document the potassium when it was not in the building.	{C 342}		

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{C 342}	Continued From page 85 Refer to interview with the Administrator on 09/03/26 at 9:47am. _____ Interview with the Administrator on 09/03/26 at 9:47am revealed: -He was responsible for administering medications and documenting on the eMAR. -He and the facility nurse were responsible for auditing medications on hand and comparing the medications to orders. -At times he was not sure if he administered the medication and did not document his initials electronically.	{C 342}		
{C 367}	10A NCAC 13G .1008(a) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (a) A family care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, record review and interviews the facility failed to maintain a record of controlled substances with accurate reconciliation for 2 of 2 sampled residents (#1 and #2) related to medication used to treat pain (#2) and medication used to anxiety (#1). The findings are: Review of the facility's Medication Administration	{C 367}		

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{C 367}	Continued From page 86 Policies and Procedures dated 04/2006 revealed: -Controlled substances should have a method of accountability. -Discrepancies should be reported and records should be retained for accountability. -Refills of medications should be ordered from the pharmacy, and a delivery receipt of medications should be retained. 1. Review of Resident #2's current FL2 dated 05/12/26 revealed: -Diagnoses included Alzheimer's disease, heart failure, venous insufficiency, hypertension and dementia. -There was an order for hydrocodone/APAP (a medication used to treat pain) 10mg/325mg, two tablets every 6 hours. Review of Resident #2's signed physician's order dated 08/25/26 for hydrocodone/APAP 10mg/325mg, two tablets every 8 hours as needed for pain. Review of Resident 2#'s medication available for administration on 09/02/26 at 9:45am revealed: -There was a bubble pack with hydrocodone/APAP 10mg/325mg labeled two tablets every 8 hours as needed for pain, with a dispense date of 08/25/26, with 58 tablets to administer. -There was a second bubble pack with hydrocodone/APAP 10mg/325mg labeled two tablets every 8 hours as needed for pain, with a dispense date of 08/25/26, with 58 tablets to administer. -There was a third bubble pack with hydrocodone/APAP 10mg/325mg labeled two tablets every 8 hours as needed for pain, with a dispense date of 08/25/26, with 58 tablets to administer.	{C 367}		

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{C 367}	Continued From page 87 Review of Resident #2's September 2026 eMAR revealed: -There was an entry for hydrocodone/APAP 10mg/325mg, with an original date of 09/01/26 at 12:00am, 8:00am and 4:00pm. -On 09/01/26 at 12:00am, and 8:00am and 4:00pm the hydrocodone was documented as administered. Review of Resident #2's August 2026 Control Substance Sheet (CSCS) revealed: -A label containing Resident #2's name and hydrocodone/APAP 10mg/325mg, two tablets every 8 hours as needed for pain, quantity of 60 of 180 tablets filled on 08/25/26. -On 09/01/26 at 9:00am the Administrator documented hydrocodone 10mg/325mg 2 tablets were administered and the remaining was 30 tablets instead of 58 tablets. -A label containing Resident #2's name and hydrocodone/APAP 10mg/325mg, two tablets every 8 hours as needed for pain, quantity of 60 of 180 tablets filled on 08/25/26. -On 09/01/26 at 4:42pm the Administrator documented hydrocodone 10mg/325mg 2 tablets were administered and the remaining was 30 tablets instead of 58 tablets. -A label containing Resident #2's name and hydrocodone/APAP 10mg/325mg, two tablets every 8 hours as needed for pain, quantity of 60 of 180 tablets filled on 08/25/26. -On 09/01/26 at 10:00pm the Administrator documented hydrocodone 10mg/325mg 2 tablets were administered and the remaining was 30 tablets instead of 58 tablets. Telephone interview with a Pharmacist from the facility's contracted pharmacy on 09/03/26 at 1:10pm revealed:	{C 367}		

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{C 367}	Continued From page 88 -There was a signed physician's order dated 08/25/26 for hydrocodone/APAP 10mg/325mg, two tablets every 8 hours as needed for pain. -On 08/25/26, there were 180 tablets of hydrocodone/APAP 10mg/325mg dispensed to the facility to begin on 08/26/26. -The CSCS should match the number of tables left to administer once the medication was administered. Interview with the Administrator on 09/02/26 at 4:15pm revealed: -Resident #2's hydrocodone/APAP came in 3 bubble packs with 60 tablets, (2 tablets in each daily dose) in each bubble pack. -When he administered a dose, which was two tablets, he documented two tablets administered but for the quantity remaining he documented there were 29 doses left instead of 58 tablets. 2. Review of Resident #1's current FL2 dated 06/29/26 revealed: -Diagnoses included dementia with agitation, hypertension, osteoarthritis, and depression. -Resident #1 was non-ambulatory. -Resident #1 was incontinent of bowel and bladder. -Resident #1 had an order for lorazepam 0.5mg, one tablet by mouth daily at 6:00pm. Review of Resident #1's record revealed Resident #1 was admitted to the facility with hospice services on 07/01/26. Review of a hospice physician order dated 06/29/26 revealed Resident #1's had an order for lorazepam 0.5mg, one tablet by mouth daily at 6:00pm. Review of Resident #1's July 2026 eMAR	{C 367}		

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{C 367}	Continued From page 89	{C 367}		

revealed:
-There was an entry for lorazepam 0.5mg, one tablet by mouth daily at 6:00pm.
-There was documentation Resident #1's lorazepam 0.5mg, one tablet by mouth daily at 6:00pm, was administered from 07/01/26 to 07/31/26.

Review of Resident #1's CSCS for July 2026 revealed:
-Twelve tablets of lorazepam were transferred from Resident #1's previous facility to the current facility.
-The transfer count of lorazepam was signed off by the hospice nurse.
-There was documentation one tablet of lorazepam was administered to Resident #1 each day from 07/01/26 to 07/14/26 at 6:00pm.
-There was no signature documentation of who administered the lorazepam 0.5mg to Resident #1 from 07/01/26 to 07/14/26.
-There was no documentation lorazepam 0.5mg, one tablet by mouth daily at 6:00pm, was administered from 07/15/26 to 07/31/26.

Review of Resident #1's August 2026 eMAR revealed:
-There was an entry for lorazepam 0.5mg, one tablet by mouth daily at 6:00pm with an original order date of 08/04/26.
-There was documentation lorazepam 0.5mg was administered from 08/05/26 to 08/31/26 at 6:00pm.

Review of Resident#1's CSCS for August 2026 revealed:
-A label containing Resident #1's name, lorazepam 0.5mg, one tablet daily at 6:00pm, quantity of 30 tablets was filled on 08/04/26.
-There was no documentation lorazepam was

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{C 367}	Continued From page 90 administered from 08/01/26 to 08/14/26. -On 08/15/2026 at 6:00pm, the Administrator documented lorazepam 0.5mg was administered and 30 tablets were remaining. - On 08/16/2026 at 6:00pm, the Administrator documented lorazepam 0.5mg was administered and 29 tablets were remaining. -On 08/17/2026 at 6:00pm, the Administrator documented lorazepam 0.5mg was administered and 28 tablets were remaining. -On 08/18/2026 at 6:00pm, the Administrator documented lorazepam 0.5mg was administered and 27 tablets were remaining. -On 08/19/26 at 6:00pm, the Administrator documented lorazepam 0.5mg was administered and 26 tablets were remaining. -On 08/20/26 at 6:00pm, the Administrator documented lorazepam 0.5mg was administered and 25 tablets were remaining. -On 08/21/26 at 6:00pm, the Administrator documented lorazepam 0.5mg was administered and 24 tablets were remaining. -On 08/22/26 at 6:00pm, the Administrator documented lorazepam 0.5mg was administered and 23 tablets were remaining. -On 08/23/2026 at 6:00pm, the Administrator documented lorazepam 0.5mg was administered and 22 tablets were remaining. -On 08/24/2026 at 6:21pm, the Administrator documented lorazepam 0.5mg was administered and 21 tablets were remaining. -On 08/25/2026 at 6:00pm, the Administrator documented lorazepam 0.5mg was administered and 20 tablets were remaining. -On 08/26/2026 at 6:25pm, the Administrator documented lorazepam 0.5mg was administered and 19 tablets were remaining. -On 08/27/2026 at 6:00pm, the Administrator documented lorazepam 0.5mg was administered and 18 tablets were remaining.	{C 367}		

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	FCL060157	A. BUILDING: _____ B. WING _____	R 09/03/2026

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{C 367}	Continued From page 91 -On 08/28/2026 at 6:00pm, the Administrator documented lorazepam 0.5mg was administered and 17 tablets were remaining. -On 08/29/2026 at 6:00pm, there was documentation lorazepam 0.5mg was administered and 16 tablets were remaining. -On 08/29/26 at 6:00pm, there was no signature in "the administered by" box. -On 08/30/26 at 6:00pm, there was documentation lorazepam 0.5mg was administered and 15 tablets were remaining. -On 08/30/26 at 6:00pm, there was no signature in "the administered by" box. -On 08/31/26 at 6:26pm, the Administrator documented lorazepam 0.5mg was administered and 14 tablets were remaining. -On 09/01/26 at 6:00pm, the Administrator documented lorazepam 0.5mg was administered and 13 tablets were remaining. Telephone interview with a pharmacist with the facility's contracted pharmacy on 09/03/26 at 1:30pm revealed: -Resident #1 had an active order for lorazepam 0.5mg, one tablet by mouth daily at 6:00pm, with an original hospice order date of 07/10/26, was last dispensed on 08/04/26, quantity of 30 tablets (30-day supply). Observation of Resident #1's medications on hand on 09/02/26 at 5:08pm revealed: -There was a bubble pack with lorazepam 0.5mg labeled one tablet daily, with a dispense date 08/04/26, 30 tablets with 11 tablets left to administer. Interview with the Administrator on 09/02/26 at 4:25pm revealed: -He administered Resident #1's lorazepam 0.5mg and signed the July 2026 eMAR after each	{C 367}		

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{C 367}	Continued From page 92 administration. -He was responsible for signing Resident #1's July 2026 CSCSs and he forgot to sign each entry after administering lorazepam 0.5mg. -He could not locate CSCSs from 07/15/26 to 08/14/26, showing Resident #1's lorazepam 0.5mg, one tablet daily at 6:00pm was administered. -He may have documented on the July 2026 and August 2026 eMARs on those dates (07/15/26 to 08/14/26) and did not go back to document those dates on the CSCSs. -He expected to have a better system by signing the eMARs and CSCSs after each administration.	{C 367}		
C 453	10A NCAC 13G .1301(a) Use of Physical Restraints and Alternatives 10A NCAC 13G .1301 USE OF PHYSICAL RESTRAINTS AND ALTERNATIVES (a) A family 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 which 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 that warrant the use of restraints and not for discipline or convenience purposes; (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; (3) the least restrictive restraint that would provide safety; (4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record.	C 453		

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C 453	Continued From page 93 (5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule; (6) applied correctly according to the manufacturer's instructions and the physician's order; and (7) used in conjunction with alternatives in an effort to reduce restraint use. 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 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 B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure physical restraints were used only after completing the assessment and care planning process, the use of less restrictive alternatives, and a physician's order for 1 of 1 sampled residents (#2) who had bedrails that were used to prevent him from rolling out of bed and to assist with positioning. The findings are: Review of the facility's undated policy and procedure for restraint use revealed:	C 453		

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C 453	Continued From page 94 -Restraints were for residents who may have harmed themselves. -Restraints were to be used only with the residents' consent or in an emergency to prevent harm to themselves or others. -Restraints were to be a last resort with other strategies and techniques always used before a restraint was considered as an option. -Staff were to consider what was an acceptable restraint, unacceptable restraint (where less restrictive alternatives were not considered) and unintentional (where staff do not realize their interventions constitute a restraint). -Restraints must be time limited and monitor the residents while in restraints. -Restraints were to be evaluated and reviewed as per stated time not greater than weekly and noted in the resident's care notes. -Prior to placing a resident in restraints there was to be a pre-restraint assessment and review to determine the need in the resident's record. -Restrains shall be only used upon a written order of a physician. -The physician's order was to contain the specific reason for the restraint, how the resident will be used to benefit the resident's symptoms, the type of restraint, period of time for use and the restraint will be checked every 30-minutes and released every 2 hours with documentation. -Documentation of the restraint was to include the episode leading up to the use of a restraint, a description of the symptoms that warranted the restraint, how the restraint used benefited the resident by addressing the symptom, type of restraint used, length of effectiveness of the restraint time and observation, range of motion and repositioning in the resident's record. -A care plan was to be completed and included a process, alternative and include measures taken to systematically reduce or eliminate the need for	C 453		

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C 453	Continued From page 95 a restraint. Review of Resident #2's current FL2 dated 05/12/26 revealed: -Diagnoses included Alzheimer's disease, heart failure, venous insufficiency, hypertension and dementia. -The resident was non-ambulatory and required assistance with bathing and dressing. -The resident was incontinent of bowel and bladder. -The resident's skin was documented as normal. Review of Resident #2's Resident Register revealed he was admitted to the facility on 05/15/26. Review of Resident #2's record revealed he was admitted under Hospice services on 05/15/26. Review of Resident #2's care plan dated 05/15/26 revealed: -He required limited assistance with eating. -He required extensive assistance with transfers. -He was totally dependent on staff assistance with toileting, ambulation, bathing, dressing, and grooming/personal hygiene. -There was no documentation Resident #2 required the use of bedrails or restraints while in bed. Review of Resident #2's Licensed Health Professional Support (LHPS) dated 06/15/26 revealed: -Resident #2's LHPS personal care task did not include restraints, bed rails and/or alternatives to restraints. -There was no documentation Resident #2 required the use of bedrails or restraints while in bed.	C 453		

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C 453	Continued From page 96 Review of Resident #2's record revealed: -There was no documentation of a signed physician's order for the use of bedrails or restraints. -There was no documentation that a restraint assessment had been completed. -There was no documentation of a signed consent form for the use of bed rails or restraints. -There was no documentation of alternative devices used before the restraints were used. -There was no documentation related to the safety checks every 30-minutes during the use of restraints. -There was no documentation of the restraints released every 2 hours. Observation of Resident #2 on 09/02/26 from 9:25am to 9:43am revealed he was awake in his bed, with the head of the bed at a 45 degree angle, lower end of the bed up and bent at the knees and able to move with the use of both full bed rails that were in the up and locked in position. Observation of Resident #2 on 09/02/26 from 10:30am to 12:20am revealed he was awake in his bed, with the head of the bed at a 45 degree angle, lower end of the bed up and bent at the knees and able to move with the use of both full bed rails that were in the up and locked in position. Observation of Resident #2 on 09/02/26 from 1:24pm to 4:35pm revealed revealed he was in his bed with the head of the bed at a 45 degree angle, lower end of the bed up and bent at the knees and both full bed rails up and locked in position.	C 453		

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C 453	Continued From page 97 Observation of Resident #2 on 09/03/26 from 9:50am to 12:55pm revealed he was in his bed with the head of the bed and and lower part of the bed were raised and both full bed rails were in the raised position. Interview with Resident #2 on 09/02/26 at 1:30pm revealed: -He was bedbound because he was in a lot of pain in his back and legs all of the time. -He was totally dependant on the staff for all of his care, but he was able to feed himself. -The bed rails were used since admission in May 2026 and were kept up so he did not fall out of the bed and something to hold on to when one staff changed him or provided incontinent care. -He was not able to let the rails down if needed. -He had weakness in his right hand and could not hold himself straight up in the bed without staff's help. -The Administrator told him that staff used the bedrails to keep him safe from falling out of the bed and to use when the staff change him or his bed. -Use of the bed rails worried him because he felt "trapped" and could not let the bedrails down by himself and depended on the staff to do that. -No one tried any other devices to help with positioning in the bed. -There were no extra checks on him except in the morning when he woke up, after lunch and before bed unless he called the staff by ringing his bell. Observation of Resident #2 on 09/02/26 from 4:35pm to 4:38pm revealed Resident #2 rang his bell and requested pain medication from the personal care aide (PCA) and the Administrator administered the pain medication to Resident #2. Telephone interview with Resident #2's Power of	C 453		

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C 453	Continued From page 98 Attorney (POA) on 09/03/26 at 8:02am revealed: -Resident #2 required help with repositioning because he had weakness in his left hand and pain in his back and legs. -Resident #2 could not get out of bed on his own and required the staff to put down the bedrails and assist him out of the bed because of pain and he could not stand on his own. -She knew the facility used full bedrails but she did not know they were considered to be restraints. -She was not informed Resident #2 was being repositioned every two hours and had safety checks every 30-minutes. Telephone interview with Resident #2's hospice nurse on 09/03/26 at 7:59am revealed: -Full bed rails were necessary for positioning. -Resident #2 could position/roll himself in the bed but was very limited due to him having no trunk strength. -Resident #2 did not like getting out of bed. -He could possibly get caught in the bed rails. -She did not know if there were any alternatives that had been implemented prior to the restraints such as a fall mat, wedge, or lowering the bed closer to the ground, more frequent checks on the resident, or a device that detects movement in the bed and alerts staff. Interview with a day shift PCA on 09/02/26 at 5:05pm revealed: -Full bed rails were always used with Resident #2 to keep Resident #2 from falling out of bed. -Resident #2 could not let the bed rails down and could not lift himself up in bed because he was too weak. -She knew Resident #2 could not put the bedrails down and had dementia but she did not know if he would try to get out of the bed on his own.	C 453		

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C 453	Continued From page 99 -She did not complete 30-minute checks to make sure Resident #2 was not tangled up in the rails. -She did not complete 2-hour release of the bedrails. Interview with a second day shift PCA on 09/03/26 at 4:47pm revealed: -She typically worked 12-hour shifts during the day. -Resident #2 was a bedbound resident who required staff assistance with all activities of daily living (ADLs) except eating. -Full bed rails were always used with Resident #2 to keep him from falling out of bed. -She did not know full bedrails were considered restraints. -She did not check on him every 30 minutes to make sure he had not become tangled in the rails or release the bedrails every 2 hours. -There was no documentation related to safety checks every 30 minutes or every 2 hours. -There was no order for restraints for Resident #2 that she knew of. Interview with the Administrator on 09/03/26 at 9:47am revealed: -There was no order for the use of restraints for Resident #2. -He had not completed a restraint assessment for the use of bed rails for Resident #2. -The bed rails for Resident #2 were requested as a safety measure to keep Resident #2 from falling out of bed. -There were no increased safety checks every 30 minutes, or documentation completed on Resident #2. -There were no alternatives used prior to implementing the full bedrails. -There was no 2-hour release of the bedrails just for meals completed or documented on Resident #2.	C 453		

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C 453	Continued From page 100 -Hospice brought the bed with full rails so he used them. [Refer to tag 0188, 10A NCAC 13G .0601(g) Management and Other Staff (Type B Violation)] [Refer to tag 0242, 10A NCAC 13G .0901(a) Personal Care and Supervision (Type A2 Violation)] _____ The facility failed to ensure that physical restraints were used only after obtaining a physician's order, conducting an assessment, developing a care plan, and considering less restrictive alternatives. Resident #2 had full bedrails in use that prevented the resident from rolling out of the bed and due to their physical limitations, put them at risk for physical injury if they attempted to use them without staff assistance while in bed. This failure was detrimental to the health, safety and welfare of the resident, which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131-D-34 on 09/03/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 18, 2026.	C 453		