STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049030	A. BUILDING: _____ B. WING _____	R 09/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT PLACE OF MOORESVILLE	128 BRAWLEY SCHOOL ROAD MOORESVILLE, NC 28117

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey from September 1, 2026 to September 2, 2026.	D 000		
D 254	10A NCAC 13F .0801 (c) Resident Assessment 10A NCAC 13F .0801 Resident Assessment (c) When a facility identifies a change in a resident's baseline condition based upon the factors listed in Parts (1)(A) through (M) of this Paragraph, the facility shall monitor the resident's condition for no more than 10 days to determine if a significant change in the resident's condition has occurred. The facility shall conduct an assessment of a resident within three days after the facility identifies that a significant change in the resident's baseline condition has occurred. The facility shall use the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows: (1) Significant change is one or more of the following: (A) deterioration in two or more activities of daily living including bathing, dressing, personal hygiene, toileting, or eating; (B) change in ability to walk or transfer, including falls if the resident experiences repeated falls, meaning more than one, on the same day, or multiple falls that occur over several days to weeks, new onset of falls not attributed to an identifiable cause, a fall with consequent change in neurological status, or physical injury; (C) pain worsening in severity, intensity, or duration, occurring in a new location, or new onset of pain associated with trauma; (D) change in the pattern of usual behavior, new	D 254		

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D 254	Continued From page 1	D 254		

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

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D 254	Continued From page 2 (C) an established, predictable cyclical pattern; or (D) steady improvement under the current course of care. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure an accurate assessment and care plan was completed for a resident following a significant change in condition related to receiving an indwelling catheter, being admitted under Hospice services, and including the licensed health professional support (LHPS) tasks for 1 of 5 sampled residents (#2). The findings are: Review of Resident #2's current FL2 dated 05/12/26 revealed: -Diagnoses included pneumonia, chronic obstructive pulmonary disease and muscle weakness. -He was semi-ambulatory. -He was intermittently disoriented. -He had an indwelling catheter. Review of Resident #2's record revealed he was admitted under Hospice services on 05/27/26. Review or Resident #2's Hospital Emergency	D 254		

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D 254	Continued From page 3 Department visit note dated 04/21/26 revealed he had received an indwelling catheter due to urinary retention. Review of Resident #2's care plan dated 07/02/26 revealed: -A significant change assessment was completed by the Special Care Unit Coordinator (SCC) on 06/03/26. -There was no documentation indicating the reason for the significant change care plan for Resident #2. -Resident #2 was totally dependent on staff for all care needs including eating, toileting, ambulation, bathing, dressing, grooming and transferring. -There was no documentation under the section for social and mental health history. -There was no documentation of Resident #2 having a catheter. -There was no documentation of Resident #2 being followed by Hospice services. -There was no documentation under the section for licensed health profession licensed health professional support (LHPS). Interview with a PCA on 09/02/26 at 11:49am revealed: -She had been employed at the facility for 2 weeks. -Resident #2 required assistance with all ADLs. -She knew Resident #2 was being followed by Hospice services and had an indwelling catheter. -She referred to charting notes and communicated with staff to find out resident needs. Interview with a second PCA on 9/02/26 at 1:05pm revealed: -Resident #2 required assistance with all activities of daily living (ADLs).	D 254		

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D 254	Continued From page 4	D 254		

-She knew Resident #2 was being followed by Hospice services and had an indwelling catheter.
-All staff received an assignment sheet for all residents identifying what assistance was needed with ADLs.

Interview with a medication aide (MA) on 09/02/26 at 12:58 pm revealed:
-Resident #2 was totally dependent on staff for all needs and ADLs.
-She knew Resident #2 was being followed by Hospice services and had an indwelling catheter.
-All staff received an assignment sheet for all residents identifying what assistance was needed with ADLs.

Interview with the SCC on 09/02/26 at 12:01pm revealed:
-She had completed Resident #2's care plan.
-She had completed a significant change care plan due to Resident #2 being admitted under Hospice services but did not know she had to document the reason for the significant change.
-She had not completed a significant change care after resident had received his indwelling catheter.
-She did not know the assessment had to indicate Resident #2 having an indwelling catheter.
-She did not know she had to complete and document a full assessment of Resident #2's care plan with all needs indicated.
-She did not know LHPS tasks should be listed on resident care plans.
-PCAs received an assignment sheet for all residents identifying what assistance was needed with ADLs.

Interview with the Administrator on 07/30/26 at 6:15pm revealed:
-The SCC was responsible for completing care

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D 254	Continued From page 5 plans due to there being no Health and Wellness Director (HWD). -She did not know Resident #2's care plan was not accurate and missing information. -She was aware the care plan required updating with a significant change in condition.	D 254		
D 259	10A NCAC 13F .0802 (a) (c) Resident Care Plan 10A NCAC 13F .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: (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 Subchapter; (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	D 259		

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D 259	Continued From page 6	D 259		

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 1 of 5 sampled residents had a care plan that was signed by a physician or a physician's extender within 15 days of the resident being assessed (#2)

The findings are:

Review of Resident #2's current FL2 dated 05/12/26 revealed:
-Diagnoses included pneumonia, chronic obstructive pulmonary disease and muscle weakness.
-He was semi-ambulatory.
-He was intermittently disoriented.
-He had an indwelling catheter.

Review of Resident #2's Resident Register revealed an admission date of 01/30/25.

Review of Resident #3's record revealed he was admitted under Hospice services on 05/27/26.

Review of Resident #2's care plan dated 07/02/26 revealed:
-The care plan was completed by the Special

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D 259	Continued From page 7 Care Unit Coordinator (SCC) on 06/03/26. -Resident #2 was totally dependent on staff for all care needs including eating, toileting, ambulation, bathing, dressing, grooming and transferring. -The care plan was signed by Resident #2's Nurse Practitioner (NP) on 07/02/26. Interview with the SCC on 09/02/26 at 12:01pm revealed: -She was responsible for completing the care plan assessment. -She did not know resident care plans needed to be signed by the resident's NP within 15 days of completing the assessment. -She thought the NP had a couple weeks to sign the resident's care plan. -Resident #2's Hospice Registered Nurse (RN) had taken the care plan to the resident's NP but did not return the care plan until later. Interview with the Administrator on 07/30/26 at 6:15pm revealed: -The SCC was responsible for completing care plans due to there being no Health and Wellness Director (HWD). -She did not know Resident #2's care plan had not been signed by the NP within 15 days.	D 259		