STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099018	A. BUILDING: _____ B. WING _____	R 09/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATRIOT LIVING OF YADKINVILLE	409 HARRISON AVENUE YADKINVILLE, NC 27055

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey from 09/22/26 to 09/24/26.	{D 000}		
{D 234}	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 1 of 5 sampled residents (#5) had completed tuberculosis (TB) testing upon admission. The findings are: Review of Resident #5's FL2 dated 09/10/26 revealed diagnoses included mechanical heart valve and vascular dementia. Review of Resident #5's Resident Register revealed the resident was admitted to the facility 02/20/24. Review of Resident #5's immunization records revealed there was no documentation of a	{D 234}		

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{D 234}	Continued From page 1 negative TB skin test. Interview with Resident #5 on 09/24/26 at 9:25am revealed he did not think he had a two-step TB skin test completed after being admitted to the facility. Interview with the Administrator on 09/24/26 at 3:39pm revealed: -She was not aware Resident #5 did not have a completed TB testing upon admission. -She was responsible for ensuring TB skin tests were completed upon residents' admissions to the facility. -Management staff completed chart audits. -There was no set schedule for completing chart audits, but management staff were in resident charts "all the time". -She was not sure why Resident #5 did not have a completed TB testing upon admission. -She expected all residents to have a completed TB skin test prior to admission.	{D 234}		
{D 338}	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure 1 of 1 resident (#1) was protected from abuse related to a resident who reported a staff member grabbed and dug their nails into both of the resident's	{D 338}		

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{D 338}	Continued From page 2	{D 338}		

hands and was threatened with discharge (#1); and 6 of 6 residents (#1, #2, #3, #5, #6, #10) were treated with respect and dignity related to the residents being restricted from leaving the facility and residents who were kept from smoking outside.

The findings are:

Review of the Facility's Resident Agreement revealed:
-Each resident had the right to express complaints or suggestions without fear of reprisal, interference, coercion or discrimination.
-Every resident had the following rights: to be treated with respect, consideration, dignity, and full recognition and to be free of mental and physical abuse, neglect, and exploitation.

1. Review of Resident #1's FL2 dated 02/24/26 revealed diagnoses included schizophrenia, dementia, diabetes mellitus, post-traumatic stress syndrome, schizoaffective disorder, chronic pain and lower back pain, and malignant essential hypertension.

Review of Resident #1's incident report dated 09/14/26 revealed:
-Resident #1 called the office and made a statement that he had been abused.
-The resident was upset that he was only allowed to smoke once daily at 3:00pm.
-Resident #1's responsible party was contacted at 6:00pm.

Review of Resident #1's progress notes dated 08/24/26 to 09/15/26 revealed:
-On 08/29/26, the resident was asked by the Operations Manager (OM) not to give other residents cigarettes and staff reported to the OM

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{D 338}	Continued From page 3 the resident was smoking in his room. -On 09/14/26, the resident called the facility's office staff and stated that the OM assaulted him which involved an incident from 08/29/26 when the OM tried to take his lighter. -On 09/14/26 Resident #1 called the facility's office and reported that he was being abused and hit by the OM. -Resident #1 had not mentioned the incident to staff since it happened 3 weeks ago. Interview with Resident #1 on 09/22/26 at 9:10am revealed: -The OM grabbed the top of both of his hands with the her hands and fingernails and jerked his hands toward her when he refused to provide the lighter. -Resident #1 complained his left hand continued to hurt from the incident with the OM. Observation of Resident #1 on 09/22/26 at 9:10am revealed there was no visible bruise or scratch on his hands but he favored his left hand and rubbed his left hand with his right hand. Interview with Resident #1 on 09/23/26 at 9:40am revealed: -The OM grabbed and jerked both of his hands towards her when he refused to give her his lighter. -He refused to give the OM his cigarette lighter because she provided no reason for requesting his cigarette lighter and other residents had cigarette lighters. -He was not told he could not have a cigarette lighter until the day of the incident between him and the OM. -The OM came at him again after he pushed her away and he then placed his hands up to defend himself but the OM left the room.	{D 338}		

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{D 338}	Continued From page 4 -He reported the incident to a family member when it first happened but he could not recall the date. -He reported the situation to the facility's office staff within the last week because he was concerned about retaliation from the OM if he reported the incident when it occurred. Confidential interview with a resident revealed: -Several weeks ago, Resident #1 and the OM were heard in the living room arguing about a cigarette lighter. -Resident #1 asked the OM why the staff wanted his lighter. -Resident #1 told the OM not to come near him. Telephone interview with Resident #1's guardian on 09/23/26 at 11:30am revealed: -The OM called her about Resident #1 violating the facility's new smoker policy and an incident between the OM and Resident #1 which involved Resident #1 not giving his cigarette lighter to the OM on 08/15/26. -She was Resident #1's court-appointed guardian as of 04/08/14 and she never received communication from the facility or signed a new smoking policy for Resident #1. -The OM told Resident #1's family member that Resident #1 had slapped the OM in the face when she attempted to take Resident #1's cigarette lighter related to the facility's smoking policy. -The OM called her on 09/14/26 to report Resident #1's abuse allegation against the OM which involved her grabbing and jerking both of Resident #1's hands. -The OM threatened the guardian with discharging Resident #1 with an IVC (Involuntary Commitment) if Resident #1 continued his patterns with smoking.	{D 338}		

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{D 338}	Continued From page 5 -Resident #1's family member talked to the Administrator and was told that the situation was dramatic and should never have happened to Resident #1. Review of Resident #1's Smoking Policy agreement: -Resident #1 signed the agreement on 03/18/24. -There was no updated smoker's policy or signed agreement for Resident #1 with the Resident #1's family member signature. Interview with the local department of social services (DSS) representative on 09/23/26 at 8:14am revealed: -She received an incident report for Resident #1 from the facility of the abuse allegations on the OM and she was at the facility on 09/14/26 when Resident #1 reported the incident to the facility's office. -The OM told her that Resident #1 was grabbed and scratched by the OM when she attempted to take his lighter. -The OM told her that Resident #1 had slapped her in the face and the facility called the local law enforcement. -She was not aware of any other incident between Resident #1 and the OM until another member of Resident #1's family called her on 09/14/26 to discuss an incident on 08/15/26. Interview with the OM on 09/24/26 at 12:15pm revealed: -Staff reported to her that Resident #1 was smoking in his room on 09/14/26. -She requested Resident #1's cigarette lighter and he refused to surrender the cigarette lighter to her. -Resident #1 slapped her on the left side of her face when she reached to get the cigarette lighter	{D 338}		

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{D 338}	Continued From page 6	{D 338}		

from his bed.
-She told Resident #1 to keep the lighter but he was breaking the new smoking rules.
-She never put her hands on Resident #1 and would not have expected him to report abuse allegations on her.

Interview with the Administrator on 09/24/26 at 12:45pm revealed:
-She was aware Resident #1 had reported the OM for alleged abuse on 09/14/26 because Resident #1 called the facility's office.
-She was aware of a situation between Resident #1 and the OM on 08/29/26 but had not considered it "assault" as the resident had indicated the staff had taken his lighter away from him.
-She investigated and gathered statements from the staff from the incident on 09/14/26 but had not substantiated the alleged abuse on Resident #1 from the OM.

2. Review of facility's Resident Contract revealed there was no documentation that indicated the facility was a secured assisted living unit.

a. Review of Resident #1's Resident Contract revealed:
-Resident #1's family member signed signed the Resident Contract on 07/16/23.
-The Administrator signed the Resident Contract on 07/16/23.
-There was no documentation that indicated the facility was a secured locked unit.

Review of Resident #1's FL2 dated 02/24/26 revealed:
-Diagnoses included schizophrenia, dementia, diabetes mellitus, post-traumatic stress syndrome, schizoaffective disorder, chronic pain,

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{D 338}	Continued From page 7 lower back pain, and malignant essential hypertension. -Recommended level of care was documented as domiciliary (rest home). Review of Resident #1's Resident Contract revealed: -Resident #1's family member signed signed the Resident Contract on 07/16/23. -The Administrator signed the Resident Contract on 07/16/23. -There was no documentation that indicated the facility was a secured assisted living. Review of Resident #1's Resident Register revealed -Resident #1 was admitted to the facility on 02/25/16. -Resident #1's guardian signed the Resident Register on 07/16/23 but there was no responsible party marked on Resident #1's Resident Register. Interview with Resident #1 on 09/23/26 at 9:40am revealed: -He was not informed the facility was a secured assisted living and he was restricted from signing out of the facility. -He could not understand why since all the residents were able to come and go until the last couple of months -He told his family member who made his decisions for him and she had advised him he should be able to come and go from the facility as he wished. -He did not understand why he was not allowed to smoke at certain times because other residents were able to come and go to the smoking area as they pleased. -Staff told Resident #1 he could not smoke	{D 338}		

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{D 338}	Continued From page 8 outside until 3:00pm every day and that he was allowed to smoke if a staff member was present outside. Telephone interview with Resident #1's guardian on 09/23/26 at 11:30am revealed: -She was Resident #1's court-appointed guardian as of 04/08/14. -She never received communication from the staff at the facility that it was a secured assisted living. -She never received communication from the facility or signed a new smoking policy for Resident #1 and she expected Resident #1 to be able to come and go to the smoking area as he pleased and not at only one appointed time. -She expected Resident #1 to be able to come and go as he pleased at this point. Refer to the interview with the Operations Manager (OM) on 09/24/26 at 12:15pm. Refer to the interview with the Administrator on 09/23/26 at 3:32pm and on 09/24/26 at 11:20am. Refer to the interview with the facility's mental health provider (MHP) on 09/24/26 at 1:02pm. b. Review of Resident #2's FL2 dated 04/14/26 revealed: -Diagnosis included Type 2 diabetes mellitus, hyperlipidemia, gastro-esophageal reflux disease (GERD), hyponatremia, cognitive communication deficit, and allergic rhinitis. -Recommended level of care was documented as domiciliary (rest home). Review of Resident #2's Resident Contract revealed: -Resident #2 signed the Resident Contract on	{D 338}		

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{D 338}	Continued From page 9 01/16/20. -The Administrator signed the Resident Contract on 01/16/20. -There was no documentation that indicated the facility was a secured assisted living. Review of Resident #2's Resident Register revealed: -Resident #2 was admitted to the facility on 01/17/20. -Resident #2 was responsible for her own decisions and there was no Power of Attorney (POA) or Responsible Party (RP) indicated for Resident #2. Interview with Resident #2 on 07/08/2026 at 9:30am revealed: -She was admitted to the facility in January 2020. -She was responsible for herself and did not have a guardian or POA. -She was not informed that the facility was a secured assisted living and she was restricted from signing out of the facility. Refer to the interview with the Operations Manager (OM) on 09/24/26 at 12:15pm. Refer to the interview with the Administrator on 09/23/26 at 3:32pm and on 09/24/26 at 11:20am. Refer to the interview with the facility's mental health provider (MHP) on 09/24/26 at 1:02pm. c. Review of Resident #3's FL2 dated 08/07/26 revealed: -Diagnoses included depression and diabetes mellitus. -Recommended level of care was documented as assisted living facility.	{D 338}		

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{D 338}	Continued From page 10 Review of Resident #3's record revealed there was no signed Resident Contract. Interview with Resident #3 on 09/23/26 at 4:03pm revealed: -She was not informed that it was a secured assisted living. -No one had explained to her what a secured assisted living was. -She knew she could not leave the facility when she wanted to because of the key pads on all exit doors. -When she asked staff about leaving the facility to go to the store to buy personal items she needed, she was told "they would see". Refer to the interview with the Operations Manager (OM) on 09/24/26 at 12:15pm. Refer to the interview with the Administrator on 09/23/26 at 3:32pm and on 09/24/26 at 11:20am. Refer to the interview with the facility's mental health provider (MHP) on 09/24/26 at 1:02pm. d. Review of Resident #5's FL2 dated 09/10/26 revealed: -Diagnoses included major depressive disorder and vascular dementia. -He was intermittently disoriented. -Recommended level of care was documented as domiciliary (rest home). Review of Resident #5's Resident Register revealed: -Resident #5 was admitted to the facility on 02/20/24. -He was listed as his own responsible party. Interview with Resident #5 on 09/23/26 at 4:03pm	{D 338}		

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{D 338}	Continued From page 11 revealed: -He was not informed that the facility was locked facility. -No one had explained to him what a secured assisted living was. -He had not asked to leave the facility but assumed he could not leave based on the facility being short staffed. Refer to the interview with the Operations Manager (OM) on 09/24/26 at 12:15pm. Refer to the interview with the Administrator on 09/23/26 at 3:32pm and on 09/24/26 at 11:20am. Refer to the interview with the facility's mental health provider (MHP) on 09/24/26 at 1:02pm. e. Review of Resident #6's FL2 dated 04/02/26 revealed: -Diagnoses included diabetes mellitus, chronic kidney disease stage 2, bipolar disorder, depression with psychotic features, chronic obstructive pulmonary disease, and acute osteomyelitis. -Recommended level of care was documented as domiciliary (rest home). Review of Resident #6's Resident Register revealed: -Resident #6 was admitted to the facility on 03/18/26. -He was listed as his own responsible party. Interview with Resident #6 on 09/23/26 at 4:03pm revealed: -When admitted to the facility, he was not informed that it was a locked facility . -No one had explained to him what a secured assisted living was.	{D 338}		

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{D 338}	Continued From page 12 -If he wanted to leave the facility, he would not have been able to. -When he asked staff about leaving the facility to go outside, he was told "they would look into it". Refer to the interview with the Operations Manager (OM) on 09/24/26 at 12:15pm. Refer to the interview with the Administrator on 09/23/26 at 3:32pm and on 09/24/26 at 11:20am. Refer to the interview with the facility's mental health provider (MHP) on 09/24/26 at 1:02pm. f. Review of Resident #10's FL2 dated 02/05/26 revealed: -Diagnoses included diabetes mellitus, hyperlipidemia hypertension, mild cognitive impairment, depression, bipolar disorder, and tobacco use disorder. -There was not documentation related Resident #10's orientation. -Recommended level of care was documented as domiciliary (rest home). Review of Resident #10's Resident Register revealed: -Resident #10 was admitted to the facility on 11/26/19. -Resident #10's guardian signed the Resident Contract on 11/26/19. Observation of Resident #10 on 09/23/26 at 11:10am revealed: -Resident #10 asked the staff to go outside while standing at the door leading to the outside smoking area. -Staff told Resident #10 she was not allowed to smoke outside during this designated smoking break time.	{D 338}		

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{D 338}	Continued From page 13 -Resident #10 asked what she had done today that she was not allowed to smoke with the other residents. -The staff member responded to Resident #10's question because she told her so and not to ask again. -Staff never provided any justification to Resident #10 as to why she was not allowed to smoke outside. Interview with Resident #10 on 09/23/26 at 11:15am revealed: -She had waited in line with the other smokers today and the staff shut the door in her face when she attempted to go outside to the resident smoking area. -She was upset that other residents were allowed to smoke and the staff provided no reason for not allowing her to smoke but the staff did that to her often. Refer to the interview with the Operations Manager (OM) on 09/24/26 at 12:15pm. Refer to the interview with the Administrator on 09/23/26 at 3:32pm and on 09/24/26 at 11:20am. Refer to the interview with the facility's mental health provider (MHP) on 09/24/26 at 1:02pm. Attempted telephone interview with Resident #10's guardian on 09/24/26 at 1:30pm was unsuccessful. _____ Interview with the Operations Manager (OM) on 09/24/26 at 12:15pm revealed: -Some residents were allowed to smoke outside on their own in the resident smoking area and some residents were not allowed to be in the resident smoking unless there was a staff	{D 338}		

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	HAL099018	A. BUILDING: _____ B. WING _____	R 09/24/2026

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{D 338}	Continued From page 14	{D 338}		

member present due to mental health concerns.
-She was not aware some residents were complaining they could not leave the facility as they pleased.
-It was her understanding that this was a locked facility and some residents required permission from there responsible party to leave the facility unless the resident was responsible for themselves.

-Interview with the facility's MHP on 09/24/26 at 1:02pm revealed:
-She was the facility's MHP for some of the residents and most of the residents she cared for required a secured assisted living.
-Some of the residents could come and go as they please but it was her understanding the facility was a secured assisted living due to the number of residents with mental health concerns.

Interview with the Administrator on 09/24/26 at 11:20am revealed:
-There were residents who were not allowed to smoke if the residents did not have cigarettes.
-Management told the residents and the resident's responsible party's the facility was a locked facility verbally but had not provided a written statement.
-She preferred the facility's mental health provider (MHP) to answer further questions related to the facility's resident population.

_____
The facility failed to ensure residents' were protected from harm when a resident (#1) was grabbed by staff in an attempt to take his cigarette lighter away resulting in left hand pain and him feeling the need to defend himself; and 6 of 6 residents (#1, #2, #3, #5, #6, #10) were treated with dignity and respect and were kept from smoking outside while other residents

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{D 338}	Continued From page 15 smoked freely and were also restricted from leaving the facility. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided an acceptable plan of protection in accordance with G.S. 131D-34 on 09/24/26. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 7, 2026.	{D 338}		
{D 358}	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 5 residents during the 8:00am morning medication pass including a medication used to prevent constipation, a medication used to treat high blood pressure and a medication used to reduce stomach acid (#3), and for 1 of 5 sampled residents for record review including orders for a blood thinner (#5). The findings are:	{D 358}		

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{D 358}	Continued From page 16 The medication error rate was 11% as evidenced by the observation of 3 errors out of 27 opportunities during the 8:00am medication pass on 09/23/26. 1. Review of Resident #3's current FL2 dated 08/07/26 revealed diagnoses included irritable bowel syndrome, hypertension, and gastroesophageal reflux disease. a. Review of Resident #3's current FL2 dated 08/07/26 revealed there was an order for polyethylene glycol (used to prevent constipation) 17g daily. Observation of the morning medication pass on 09/23/26 at 8:00am revealed: -The Operations Manager (OM) prepared 11 oral medications for administration to Resident #3 at 8:15am. -The prepared 11 oral medications did not include polyethylene glycol 17g. -The OM administered the 11 prepared oral medications to Resident #3 at 8:26am. Observation of Resident #3's medications on hand on 09/23/26 at 3:00pm revealed there was a bottle of polyethylene glycol opened 09/22/26 available for administration. Review of Resident #3's September 2026 electronic medication administration record (eMAR) for 09/23/26 revealed: -There was an entry for polyethylene glycol 17g daily scheduled for administration at 8:00am. -There was documentation polyethylene glycol 17g was administered on 09/23/26 at 8:22am. Interview with Resident #3 on 09/24/26 at 9:50am revealed:	{D 358}		

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{D 358}	Continued From page 17 -On 09/23/26, she was not given her daily polyethylene glycol. -She was told that polyethylene glycol was not available yet and instead was given an "as needed" medication. Interview with Resident #3's primary care provider (PCP) on 09/24/26 at 11:14am revealed: -Resident #3 was prescribed polyethylene glycol 17g to prevent constipation. -She was not aware Resident #3 missed her dose of polyethylene glycol 17g on 09/23/26. -She had not assessed any adverse effects in Resident #3 due to missing her dose of polyethylene glycol. -She expected facility staff to administer medications as ordered. Interview with the OM on 09/23/26 at 2:50pm revealed: -She administered Resident #3's polyethylene glycol at a later time because she had to retrieve the bottle polyethylene glycol from the medication closet. -She knew she was to document medication administration after the medication was given, not before. Refer to interview with the Administrator on 09/24/26 at 1:30pm. b. Review of Resident #3's current FL2 dated 08/07/26 revealed there was an order for amlodipine (a medication used to treat high blood pressure) 10mg daily. Observation of the morning medication pass on 09/23/26 at 8:00am revealed: -The Operations Manager (OM) prepared 11 oral medications for administration to Resident #3 at	{D 358}		

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{D 358}	Continued From page 18 8:15am. -The prepared 11 oral medications did not include amlodipine 10mg. -The OM administered the 11 prepared oral medications to Resident #3 at 8:26am. Review of Resident #3's September 2026 electronic medication administration record (eMAR) for 09/23/26 revealed: -There was an entry for amlodipine 10mg daily scheduled for administration at 8:00am. -There was documentation amlodipine 10mg was administered on 09/23/26 at 8:22am. Interview with Resident #3 on 09/24/26 at 9:50am revealed on 09/23/26, she was given her morning medications one time. Interview with Resident #3's primary care provider (PCP) on 09/24/26 at 11:14am revealed: -Resident #3 was prescribed amlodipine 10mg to prevent high blood pressure. -She was not aware Resident #3 missed her dose of amlodipine 10mg on 09/23/26. -She had not assessed any adverse effects in Resident #3 due to missing her dose of amlodipine 10mg. -She expected facility staff to administer medications as ordered. Interview with the OM on 09/23/26 at 2:50pm revealed: -She administered Resident #3's amlodipine at a later time because she had to retrieve the new medication package from the medication room. -She knew she was to document medication administration after the medication was given, not before. Refer to interview with the Administrator on	{D 358}		

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{D 358}	Continued From page 19 09/24/26 at 1:30pm c. Review of Resident #3's current FL2 dated 08/07/26 revealed there was an order for pantoprazole 40mg daily. Observation of the morning medication pass on 09/23/26 at 8:00am revealed: -The Operations Manager (OM) prepared 11 oral medications for administration to Resident #3 at 8:15am. -The prepared 11 oral medications did not include pantoprazole 40mg. -The OM administered the 11 prepared oral medications to Resident #3 at 8:26am. Review of Resident #3's September 2026 electronic medication administration record (eMAR) for 09/23/26 revealed: -There was an entry for pantoprazole 40mg daily scheduled for administration at 8:00am. -There was documentation pantoprazole 40mg was administered on 09/23/26 at 8:22am. Interview with Resident #3 on 09/24/26 at 9:50am revealed: -On 09/23/26, she was given her morning medications one time. -She never ate breakfast in the mornings. Interview with Resident #3's primary care provider (PCP) on 09/24/26 at 11:14am revealed: -Resident #3 was prescribed pantoprazole 40mg to prevent acid reflux. -She was not aware Resident #3 missed her dose of pantoprazole 40mg on 09/23/26. -She had not assessed any adverse effects in Resident #3 due to missing her dose of pantoprazole 40mg. -She expected facility staff to administer	{D 358}		

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{D 358}	Continued From page 20 medications as ordered. Interview with the OM on 09/23/26 at 2:50pm revealed: -She administered Resident #3's pantoprazole 40mg before Resident #3 ate breakfast but did not document the administration at that time. -She knew she was to document medication administration at the time the medication was given. Refer to interview with the Administrator on 09/24/26 at 1:30pm 2. Review of Resident #5's FL2 dated 09/10/26 revealed diagnoses included mechanical heart valve and vascular dementia. Review of Resident #5's signed physician's orders dated 09/08/26 revealed there was an order to administer a one-time dose of warfarin (a blood thinning medication used to treat or prevent blood clots) 6mg on 09/08/26. Review Resident #5's September 2026 electronic medication administration record (eMAR) from 09/01/26 to 09/22/26 revealed: -There was an entry for warfarin 6mg on Thursday and Sunday scheduled for administration at 5:00pm. -There was no documentation that warfarin 6mg was administered on 09/08/26. Interview with Resident #5 on 09/24/26 at 9:30am revealed: -He was not aware of the one-time dose of warfarin 6mg. -He was never given a one-time dose of warfarin 6mg.	{D 358}		

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{D 358}	Continued From page 21 Interview with Resident #5's primary care provider (PCP) on 09/24/26 at 3:59pm revealed: -On 09/08/26, Resident #5 was prescribed a one-time dose of warfarin 6mg due to his blood not being thin enough. -She intended for the facility to administer the one-time dose of warfarin 6mg. -She was not aware Resident #5 did not receive his one-time dose of warfarin 6mg. -At a follow-up visit on 09/14/26, no adverse effects were assessed in Resident #5 due to not receiving his one-time dose of warfarin 6mg. Interview with the Operations Manager (OM) on 09/24/26 at 12:43pm revealed: -She administered Resident #5's medications most of the time. -She was not aware Resident #5 was prescribed a one-time dose of warfarin 6mg. -The Administrator was responsible for auditing charts and eMARs. Interview with the Administrator on 09/24/26 at 1:30pm revealed: -She was not aware Resident #5 was prescribed a one-time dose of warfarin 6mg on 09/08/26. -Management staff completed chart audits. -There was no set schedule for completing chart audits, but management staff were in resident charts "all the time". -When completing chart audits, she made sure any new physician orders were implemented. -She was not sure how Resident #5's one-time dose of warfarin 6mg on 09/08/26 was missed. Refer to interview with the Administrator on 09/24/26 at 1:30pm _____ Interview with the Administrator on 09/24/26 at	{D 358}		

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{D 358}	Continued From page 22 1:30pm revealed she expected all medications to be administered as ordered.	{D 358}		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to complete a 24-hour initial allegation report followed by a 5-day investigation report to the Health Care Personnel Registry (HCPR) concerning an allegation of physical abuse related to a staff member (Staff B). The findings are: Review of Resident #1's incident report dated 09/14/26 revealed: -The incident occurred at 3:00pm. -The incident report was completed by the staff involved in the incident and signed by the Administrator. -Resident #1 called the office and made a statement of abuse allegations by Staff B. -Resident #1's responsible party was contacted at 6:00pm. -There was no documentation as to the nature of the abuse allegations. Review of Resident #1's progress notes revealed from 08/24/26 to 09/15/26 revealed: -On 09/14/26, resident called the facility's office	D 438		

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D 438	Continued From page 23	D 438		

and stated that Staff B assaulted him which involved an incident from 08/29/26 where staff asked the resident for a lighter and he claimed assault for the staff taking the lighter from him.
-On 09/14/26 Resident #1 called the facility's office and reported that he was being abused and hit by Staff B.
-Staff B tried to take his lighter.
-Resident #1 had not mentioned the incident to staff since it happened 3 weeks ago.

Request for Resident #1's additional incident reports on 09/23/26 and 09/24/26 were not provided by the survey exit date.

Request for a 24-hour HCPR Initial Allegation Report was not provided by the survey exit date.

Interview with Resident #1 on 09/23/26 at 9:40am revealed:
-Staff B grabbed and jerked both of his hands towards her when he refused to give her his lighter.
-Staff B came at him again after he pushed her away and he then placed his hands up to defend himself but Staff B left the room.
-He reported the incident to a family member when it first happened but he could not recall the date.
-He reported the situation to the facility's office within the last week because he was concerned about retaliation from Staff B if he reported the incident when it occurred.

Telephone interview with Resident #1's family member on 09/23/26 at 11:30am revealed:
-Staff B called her about Resident #1 violating the facility's new smoker policy and an incident between Staff B and Resident #1 which involved Resident #1 not giving his cigarette lighter to Staff

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D 438	Continued From page 24 B on 08/15/26. -She was Resident #1's court-appointed guardian as of 04/08/14 and she never received communication from the facility or signed a new smoking policy for Resident #1. -Staff B told Resident #1's family member that Resident #1 had slapped Staff B in the face when she attempted to take Resident #1's cigarette lighter related to the facility's smoking policy. -Staff B called her on 09/14/26 to report Resident #1's abuse allegation against Staff B which involved Staff B grabbing and jerking both of Resident #1's hands. -Resident #1's family member talked to the Administrator on 09/14/26 and was told that the situation was dramatic and should never have happened to Resident #1. Interview with the local department of social services (DSS) representative on 09/23/26 at 8:14am revealed she received an incident report for Resident #1 from the facility of the abuse allegations on Staff B and she was at the facility on 09/14/26 when Resident #1 reported the incident to the facility's office. Interview with the Administrator on 09/24/26 at 12:45pm revealed: -She was aware Resident #1 had reported Staff B for alleged abuse on 09/14/26 because Resident #1 called the facility's office. -She investigated and gathered statements from the staff from the incident on 09/14/26 but had not substantiated the alleged abuse on Resident #1 related to Staff B. -She had not reported the incident to the HCPR and that was an oversight on her part. [Refer to tag 0338, 10A NCAC 13F .0909 Type B	D 438		

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D 438	Continued From page 25 Violation)].	D 438		